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CASE REPORT

Case report on Bullous Pemphigoid: A Fatal Skin Condition

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Abstract

Bullous pemphigoid (BP) is a fatal skin condition which is manifested as diffuse eczematous, pruritic lesions which is afterwards; appear as tense blistering lesions filled with clear fluid which is commonly observed in elderly. Direct immunofluorescence is used as the definitive standard for the diagnosis of BP. Line of treatment for BP includes drugs which are anti-inflammatory such as topical steroids and sulfonamides; second line of treatment includes the immune-suppressant agents such as azathioprine, systemic steroids and last line of therapy includes the agent which increases the elimination of abnormal antibodies from plasma. These may include the treatment options such as plasmapheresis and intravenous immunoglobulin.

Keywords: Bullous Pemphigoid, Autoimmune disease, Skin conditions

1 | INTRODUCTION

Bullous pemphigoid is the autoimmune skin condition which is rare and one of the fatal skin condition.[1] It is manifested as diffuse eczematous, pruritic lesions which look like a blistering lesions filled with clear fluid giving it tensed appearance. Lesions are mainly located in the trunk and extremities. BP is diagnose by histological and immunopathological investigations.[2] In UK the incidence rate is one in 10,000 people affected by this condition which is comparatively low in India.[3] The purpose of current case report is to increase awareness about the skin condition and prevent physician from misdiagnosis.

2 | CASE REPORT

A 60 year old female patient presented at the General Medicine department of District General Hospital, Amravati with the chief complaints of painful diffused, bullous eruption mainly on chest, back, abdomen and upper extremities from 15 days. After an initial assessment and physical examination, the patient was advised certain investigations such as Complete Blood Count and HIV. Laboratory investi-

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gations and physical examination revealed leukocytosis and anemia. The patient's HIV test was negative. Based on the clinical manifestations of the patient and clinical findings, diagnosis of Bullous Pemphigoid was done. The patient was on IVF Normal Saline, Inj. Dexamethosone, Inj. Pheniramine, Inj. Ampicillin, KMnO4 crystal soaking guaze piece to be applied on lesions and Clobetasole cream for external application was indicated.

The patient's clinical outcome improved gradually after initiation of treatment. Injection Hydrocortisone was tapered every two days up to six days together with patient was discharged on the seventh day of admission. On discharge, patient was advised to take Tablet Prednisolone 60 mg/day which is tapered by ten mg every week for seven weeks.

TABLE 1: Laboratory Findings

Sr no.	Test	Observed value	Reference value
1	Hemoglobin	9.9 gm/dl	12.1 - 15.1 gm/dl
2	White blood cells	17 x 103/ul	4 – 11 x 103/ul

Before treatment

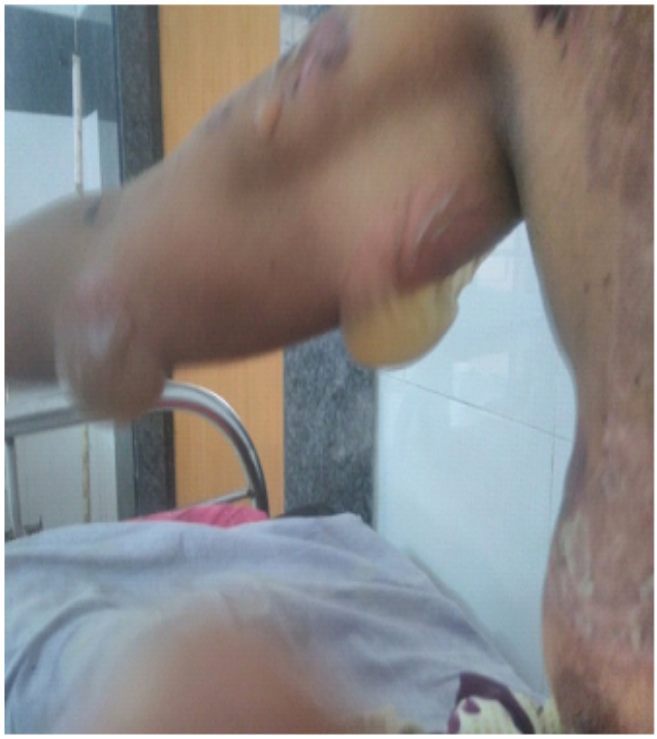

Figure:1 Diffused and erythematous bullae on Upper extremities

3 | DISCUSSION

BP is a self-limiting disease but it may last from several months to years. One half of the treated patient attained remission. Non-steroidal immunosuppressive drugs are added as adjuvant to increase the efficacy and to have asteroid sparing effect.[5]

BP is an autoimmune disorder which is mark by the presence of unusually high level of IgG antibodies which act against protein such as the keratinocytic hemidesmosomal proteins (BP180 and BP230). The antibody along with complement components accumulate at dermo-epidermal junction which causes fairly destructive autoimmune response and forms the characteristic blistering lesions on the skin.[1]

The blisters generally heal without scarring. Atypical forms of BP is occurred initially in the lower extremities, genital area which is known as a localized pemphigoid which later may turns to more generalized form. The dyshidrosiform pemphigoid affects

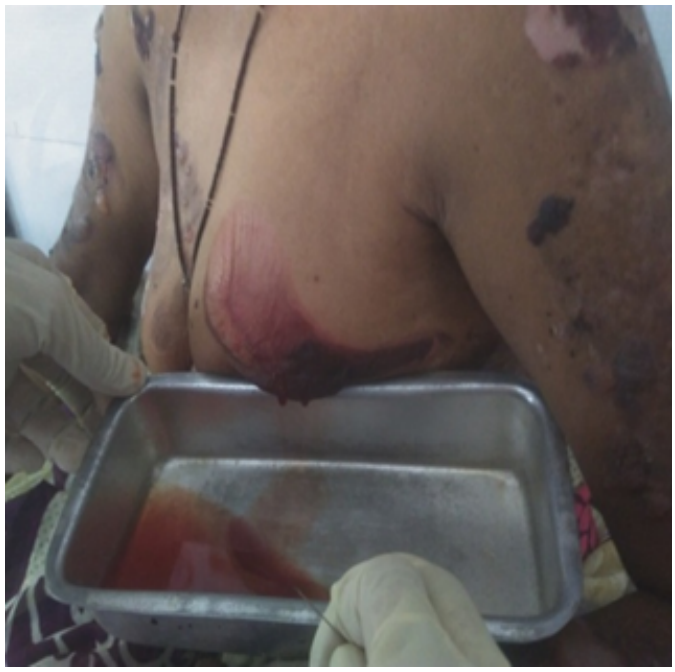

FIGURE 2: Diffused and erythematous bullae on Breast

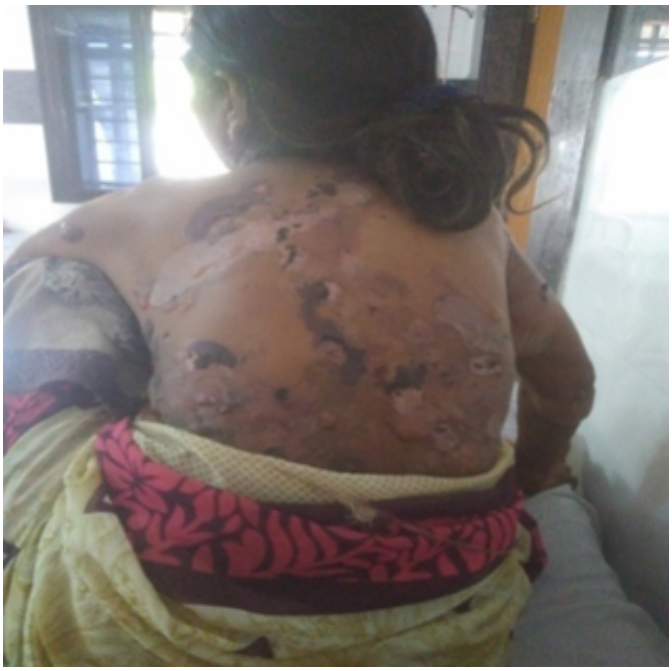

FIGURE 3: Diffused and erythematous bullae on back

the palms and soles.

Differential diagnosis for the BP is pemphigus foliaceus, eczema, urticaria, impetigo, erythema multiforme. For more accurate diagnosis clinical features, histological examination, and direct immunofluorescence (DIF) findings can be conclusive. For the confirmatory diagnosis of BP with histology, two punch biopsies should be performed. First, the biopsy of skin need to advice from the edge of a blister fixed on formaldehyde for haematoxylin and eosin (H&E) staining. Histopathological findings will include perivascular inflammatory infiltrate and eosinophils in the sub epidermal blister. Characteristic feature of BP is eosinophilic spongiosis. Second, biopsy of skin need to advice from normal perilesional tissue on DIF placed in saline or Michel's solution media. Linear IgG and C3 deposits along the basement membrane are the characteristic findings of DIF to conclusively diagnose BP.[2], [5], [6]

4 | CONCLUSION

As BP is a life threatening skin condition, proper diagnosis and treatment could prevent the condition from worsening. In case of misdiagnosis outcome may be worse for the patient because of inappropriate treatment. The purpose of current case report is to increase awareness about the skin condition, and to aware the physician about the diagnostic test used for BP and prevent physician from misdiagnosis. Also, proper medication on right time for right duration may improve the patient condition as physician can make confirmatory diagnosis earlier.

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