◇Case Report

〈本文p.979～982〉

A case of the coexistence of pemphigus vulgaris and bullous pemphigoid with an esophageal lesion as the first symptom

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Abstract

An 82-year-old man developed erythema and blistering on the extremities and trunk 3 months after the appearance of unclassifiable esophageal vesicles observed during an endoscopy. Histopathological findings showed subepidermal blisters of the skin and esophagus as well as acantholysis of the esophagus. A direct immunofluorescence study revealed the deposition of IgG in the basement membrane zone and the intercellular junctions of epithelial cells in both the skin and esophagus. The patient tested positive for anti-desmoglein 3 antibody and anti-BP180 antibody. Oral prednisolone therapy (50 mg/day) was effective. Autoimmune bullous disease can be difficult to diagnose if esophageal lesions precede the skin lesions. The coexistence of pemphigus vulgaris and bullous pemphigoid is rare.

〈本文p.983～986〉

A case of bullous pemphigoid, suspected Brunsting-Perry pemphigoid by initial skin lesions on the head

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Abstract

Brunsting-Perry pemphigoid is a rare sub-epidermal blistering disease characterized by scarring blisters on the head and neck. We report a 68-year-old male who initially presented with clinical features typical of Brunsting-Perry pemphigoid, but who subsequently developed sub-epidermal blisters on the trunk and limbs. An immunologic examination revealed that the patient's serum reacted with the BP180 NC16a domain, BP230, BP180 C terminal domain, and LAD-1. We diagnosed the patient as bullous pemphigoid, suggesting the possibility that antibodies against the BP180 C terminal domain, LAD-1, or other unknown antigen caused the initial skin lesions on the head.

◇Case Report

〈本文p.987～990〉

A case of an HIV-infected male who developed bullous pemphigoid during antiretroviral therapy.

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Abstract
A 56-years-old male admitted to our hospital with a one-month history of itchy erythema and tense bullae on his whole body. He had been diagnosed with HIV infection 10 years earlier and had been started with antiretroviral therapy. We diagnosed him as bullous pemphigoid on the basis of clinical and histopathological findings and anti-BP180 autoantibody positivity. He has suffered frequent recurrences and has been treated with systemic corticosteroid and immunosuppressants.

〈本文p.991～994〉

A case with skin symptoms of Bazex's syndrome which developed bullous pemphigoid

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Abstract
A 52-year-old female with alopecia, generalized hyperkeratotic erythema including of the ears and nose, flat red tongue, palmoplantar keratosis, nail plate thickening, and paronychial swelling and erythema. Bazex syndrome was suspected；however, no malignancy was detected. She frequently developed tense blisters and bullous pemphigoid was diagnosed. Treatment with oral etretinate and prednisolone was effective in resolving skin symptoms and nail and hair manifestations. When the characteristic skin symptoms of Bazex syndrome are observed, visceral malignancies should be sought. If blisters develop, serum antibody titers are required to check for bullous pemphigoid. Careful follow-up is necessary.

◇Case Report

〈本文p.995～998〉

A case of anti-BP180- type mucous membrane pemphigoid occurred in a patient with lung cancer

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Abstract

A 72-year-old man was diagnosed as lung cancer at the lower left lobe (stage Ⅲb) in 2011. The patient was treated with palliative care, because he did not hope the aggressive treatments. In May 2012, the patient was referred to our department for cutaneous blisters and erosions. In August 2012, he also developed multiple erosions on oral mucous membrane. Based on the clinical and the immunopathological data, a diagnosis of anti- BP180- type mucous membrane pemphigoid was made. The patient was treated with prednisolone 35 mg per day, but oral lesions were intractable. After he was treated with additional methylprednisolone 500 mg/ day for 3 days, the symptoms were improved. The oral prednisolone was tapered until reaching a dose of 17.5 mg per day, but he eventually died of the progression of lung cancer.

〈本文p.999～1002〉

A case of anti-BP180-type mucous membrane pemphigoid with oral mucosal erosions, paronychia and vesicular skin lesions

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Abstract

A 54-year-old female developed gum erosion and multiple small vesicles on the trunk and extremities. Subsequently, periungual swelling was developed on the all fingers. Histological examination of the gum lesion revealed subepithelial blisters. Direct immunofluorescence test showed deposition of IgG in the basal membrane zone. Serum anti-BP180 antibody showed positive reactivity. Immunoblot assays showed positive results for both IgG and IgA antibodies against BP180 NC16a domain and negative results for against BP180 C-terminal domain. Based on the clinical and immunological findings, a diagnosis of anti-BP180 type mucous membrane pemphigoid was made. The steroid pulse therapy resulted in the prompt resolution of symptoms.

◇Case Report

〈本文p.1003～1006〉

A case of pemphigoid-type drug eruption possibly caused by antidiabetic drugs

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Abstract

After administration of metformin for 19 months, and teneligliptin for 15 months, a 77-year-old man presented with erythemas, blisters and erosions with itching on the trunk and extremities. Antibodies to BP180, laminin 332, type Ⅶ collagen, and BP230 were negative in the serum. Histopathological finding from skin biopsy specimen revealed subepidermal blister with inflammatory cell infiltrates in the upper dermis. Direct immunofluorescence study of perilesional skin showed linear deposits of C3 at the dermal-epidermal junction. Oral steroid and cyclosporin, and steroid pulse therapy were not effective for the eruptions. After discontinuation of metformin and teneligliptin, erythemas and blisters disappeared. The eruption did not relapse even after the -discontinuation of oral steroid. Thus, a diagnosis of pemphigoid-type drug eruption possibly caused by antidiabetic drugs was made. We should take into account pemphigoid-type drug eruption for the patients treated with antidiabetic drugs, especially DPP4 inhibitors.

〈本文p.1007～1010〉

A case of bullous pemphigoid successfully treated with double filtration plasmapheresis

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Abstract

A 63 year-old Japanese man was taken to our hospital due to his one-month history of tense bullae on erythematous patches and urticarial plaques throughout the body. He was diagnosed as bullous pemphigoid based on results of skin biopsy, direct and indirect immunofluorescence tests, and blood tests. He was first treated with systemic corticosteroids and an immunosuppressant, but the eruptions continued. Therefore, double filtration plasmapheresis was performed and his symptoms improved rapidly. Consequently, we consider that double filtration plasmapheresis is an effective treatment of choice for bullous pemphigoid patients who are unresponsive to conventional treatment.

〈本文p.1011～1014〉

Pemphigoid nodularis treated as prurigo nodularis associated with hepatitis C and renal dysfunciton

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Abstract

A 78-year-old woman presented at the Dermatology Department with a 6-month-history of pruritic rash. Past medical history included hepatitis C and renal dysfunction. Physical examination revealed dark reddish or brownish nodules on the trunk and extremities. We diagnosed prurigo nodularis on the basis of morphology. Since topical corticosteroid therapy was not so effective, this patient was started on narrow-band UVB therapy. After 7 times of the phototherapy, blisters and erythematous lesions appeared. We finally diagnosed pemphigoid nodularis on results of blood examination：antiBP180 antibodies, and innunohistolpathologic findings.

◇Case Report

〈本文p.1015～1018〉

A case of nodular pemphigoid presenting with acquired perforating dermatosis

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Abstract

A 73-year-old female with a history of diabetes mellitus presented with refractory prurigo on her whole body. A diagnosis of acquired perforating dermatosis was confirmed by skin biopsy. Soon after the first diagnosis, tense blisters occurred on her feet. A diagnosis of bullous pemphigoid was confirmed by skin biopsy, direct immunofluorescence and ELISA tests for specific BP180 antibodies. A course of minocycline and nicotinic-acid amide was effective in the skin lesions. This case was finally diagnosed as nodular pemphigoid. It was suggested that a history of diabetes mellitus and scratching played a role in the induction of acquired perforating dermatosis.

〈本文p.1019～1022〉

A case of linear IgA bullous dermatosis worsened after taking Amoxicillin and Acetoaminophen

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Abstract

An 85-year-old woman was suspected as bullous pemphigoid for 11 years. She took amoxicillin and acetaminophen after the removal of a skin tumor of her back, erythema and tense bullae arose on her trunk limbs from the next day. Bilateral conjunctivitis and erosions on the tongue were also apparent. A biopsy specimen revealed a subepidermal blister with predominant inflammatory infiltrates of neutrophils. A direct immunofluorescence technique demonstrated linear IgA deposition along the basement membrane zone that was consistent with linear IgA bullous dermatosis. Forty mg of oral prednisone and fifty mg of diaminodiaphenyl sulfone were initiated, and the skin lesion had resolved within two weeks.

〈本文p.1023～1026〉

A case of linear IgA/IgG bullous dermatosis

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Abstract

We report a 71-year-old female presenting with an annular erythematous and bullous eruption. Her clinical finding was similar to those of linear IgA bullous dermatosis, bullous pemphigoid, pemphigus vulgaris and impetigo contagiosa. Direct immunofluorescence revealed linear deposition of IgA and IgG along the basement membrane zone (BMZ). Salt-split skin technique demonstrated that IgA antibodies bound exclusively to the epidermal side, while IgG antibodies bound not only to the epidermal side, but also to the dermal side. On immunoblot analysis, the patient IgA and IgG antibodies exclusively reacted with a band of 120-kDa.

◇Case Report

〈本文p.1027～1030〉

A case of pemphigoid gestationis improved by a combination therapy with topical corticosteroid and oral antihistamine

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Abstract

A 41-year-old woman during week 31 of her first pregnancy presented with 4-week history of severe itchy and bean-sized edematous and a few vesicular exudative erythemas on her extremities. Typical tense blisters did not develop. Histopathological findings revealed slight subepidermal blister, spongiosis and eosinophilic and lymphocytic perivascular infiltration. Direct immunofluorescence showed linear deposition of IgG and C3 at the basement membrane zone. BP180NC16a-ELISA of patient's serum showed positive. She was successfully treated by a combination therapy with topical corticosteroid and oral antihistamine. She delivered a healthy neonate without any skin lesion and recurrence was not observed during her second pregnancy.