

LETTERS TO THE EDITOR

Drug-induced Erythema Multiforme-like Bullous Pemphigoid

Sir,

Bullous pemphigoid (BP) is a common autoimmune blistering disease in the elderly, with an early manifestation of urticaria-like and pruritic erythematous lesions which subsequently lead to the formation of bullae. The diagnosis is confirmed by the histological and immunofluorescence findings (1). Despite its autoimmune origin, some reports demonstrate a clear induction of BP by PUVA and drugs (2).

We report here a case in which BP was induced by antipsychotics and antidepressant drugs. During the recovery period, doxycycline was observed to exert a positive effect on the BP.

CASE REPORT

A 73-year-old woman who gave an impression of drug-induced erythema multiforme (EM) was transferred to our clinic from a neurology department. She had previously undergone therapy with a variety of drugs, including antidepressants (citalopram), antipsychotics (thioridazine hydrochloride and flupenthixol decanoate), antiparkinson drugs (selegilin and procylidin hydrochloride) and phenolphthalein. During routine observation in the neurology department, the patient had exhibited a 2-month history of generalized pruritus and maculopapular exanthemas; blistering skin lesions had then developed, mainly on the palmo-plantar region. A dermatology consultation led to the impression of drug-induced EM. All previously used drugs were discontinued and 64 mg Medrol (methylprednisolone acetate) per day was administered for 2 weeks, with regular consultations with our department. The patient did not recover quickly enough and the lesions progressed; accordingly, she was transferred to our department.

The elderly patient had pruritus, tense bullae and ring-shaped erythematous plaques, mainly on the palms (Fig. 1), the flexure surfaces of both arms, the medial regions on the thighs, and the anterior chest wall. The mucous membranes were symptom-free and Nikolsky's sign was negative. Laboratory studies revealed a mildly elevated erythrocyte sedimentation rate (30 mm/h), a normal complete blood count, and liver function test results in the normal ranges. A search

for a tumour, including a chest X-ray, abdominal sonography and gynaecological consultation, did not furnish any indication at all of the existence of a tumour. Lesional biopsy of the skin revealed a sub-epidermal blister containing many eosinophils. There was neither acantholysis nor intraepidermal bullae. The dermis displayed a mild perivascular lymphocytic infiltration. Direct immunofluorescence examination on the lesional site demonstrated the linear deposition of IgG and C3 at the dermoepidermal junction.

The patient was treated with a morning dose of 80 mg prednisolone, together with 50 mg azathioprine three times a day, and in 2 weeks a satisfactory recovery was achieved. Meanwhile, the liver transaminase level increased, and the azathioprine was therefore discontinued. One month after admission the patient had recovered completely, the prednisolone was tapered to 50 mg every other day, and she was discharged. Unfortunately the patient died 4 months later from cardiopulmonary insufficiency.

DISCUSSION

Although it is an autoimmune disease, some reports emphasize that BP or BP-like disease may be induced by certain drugs (1). The most common drug implicated in this respect is furosemide, but several other drugs too are involved (1, 2). In the case reported here, we could not specify the exact drug, because the condition of the patient was not good enough to allow her to be re-exposed to the various drugs she had previously received, and also because she was receiving immunosuppressant drugs. An EM-like syndrome was considered in the differential diagnosis. However, the histological and immunofluorescence findings were not consistent with a diagnosis of EM. Despite the studies of Bastuji-Garin et al. (1), we believe that the antidepressants and antipsychotics were the most likely factor, and that phenolphthalein was also worthy of consideration. Antiparkinson drugs were excluded because these had been used by the patient for a number of years. We further emphasize the use of doxycycline (3): a much faster lesional recovery was observed after doxycycline was administered to treat her pyoderma. Overall, we believe that this case most probably involves the multi-drug induction of BP; it is interesting that none of the implicated drugs has been reported previously to induce BP.

REFERENCES

1. Bastuji-Garin S, Joly P, Picard-Dahan C, Bernard P, Vaillant L, Pauwels C, et al. Drugs associated with bullous pemphigoid. *Arch Dermatol* 1996; 132: 272–276.
2. Zürcher K, Krebs A. Cutaneous drug reactions: an integral synopsis of today's systemic drugs. Basel. New York: Karger, 1992: 339.
3. Berk MA, Lorincz AL. The treatment of bullous pemphigoid with tetracycline and niacinamide. *Arch Dermatol* 1986; 112: 670–674.

Accepted September 16, 1998

Mehrdad Mehravaran, Rolland Gyulai, Sándor Husz and Attila Dobozy. Department of Dermatology, Albert Szent-Györgyi Medical University, Korányi fasor 6. P.O. Box 480, HU-6701 Szeged, Hungary.



Fig. 1. Several tense bullae with erythematous base plaque on the palms and wrists.