PAPULOSQUAMOUS DISEASE AND VESICULOBULLOUS DISEASE

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Group of skin diseases that share similar features: papules or plaques with scales
PRIMARY LESIONS
Papule

- Elevated (palpable), circumscribed
- <1 cm in diameter
- Elevation due to increased thickness of the epidermis and/or cells or deposits within the dermis
- May have secondary changes (e.g. scale, crust)
- The profile can be flat-topped (lichenoid), dome-shaped, umbilicated, or verrucous

Seborrheic keratosis

- Seborrheic keratosis
- Cherry hemangioma
- Compound or intradermal melanocytic nevus
- Verruca
- Molluscum contagiosum
- Lichen nitidus
- Elevated component of viral exanthems
- Small vessel vasculitis
Plaque
- Elevated (palpable), circumscribed
- >1 cm in diameter
- Elevation due to increased thickness of the epidermis and/or cells or deposits within the dermis
- May have secondary changes (e.g. scale, crust)
- Occasionally, a plaque is palpable but not elevated, as in morphea

Psoriasis

Sarcoidosis

Primarily epidermal
- Psoriasis
- Lichen simplex chronicus
- Nummular dermatitis
Dermal
- Granuloma annulare
- Sarcoidosis
- Hypertrophic scar, keloid
- Morphea
- Lichen sclerosus
SECONDARY FEATURES
<table>
<thead>
<tr>
<th>Scale</th>
<th>Psoriasis (silvery [micaceous] scale)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tinea (leading scale)</td>
</tr>
<tr>
<td></td>
<td>Erythema annulare centrifugum (trailing scale)</td>
</tr>
<tr>
<td></td>
<td>Pityriasis (tinea) versicolor (powdery [furfuraceous] scale)</td>
</tr>
<tr>
<td></td>
<td>Actinic keratoses (gritty scale)</td>
</tr>
<tr>
<td></td>
<td>Pityriasis rosea ( peripheral collarette of scale and central scale)</td>
</tr>
</tbody>
</table>

- Hyperkeratosis
- Accumulation of stratum corneum due to increased proliferation and/or delayed desquamation
PAPULOSQUAMOUS DISEASE

- Psoriasis
- Pityriasis rosea
- Pityriasis lichenoides chronica (PLC)
- Pityriasis lichenoides et varioliformis acuta (PLEVA)
- Pityriasis rubra pilaris
- Lichen planus
- Lichen nitidus
PSORIASIS
Psoriasis

- Chronic, immune-mediated disorder
- Polygenic predisposition combined with environmental triggers

**Triggering factors**

- External factors: trauma, koebner phenomenon (25%)
Koebner phenomenon 25% → all-or-none phenomenon which usually occurs 7 to 14 days after injury
Psoriasis

- Chronic, immune-mediated disorder
- Polygenic predisposition combined with environmental triggers

**Triggering factors**
- External factors: trauma, koebner phenomenon (25%)
- Systemic factors:
  - Infections: bacteria → streptococcal infection, HIV
  - Medications: lithium, IFNs, β-blockers, antimalarials, and rapid tape of systemic corticosteroids
  - Psychological stress
  - Alcohol consumption, smoking and obesity
Epidemiology and genetic

- Prevalence 2% of the world’s population
  - In the US and Canada, as high as 4.6% and 4.7%
- Psoriasis can first appear at any age
- Two peaks in age of onset: 20–30 years age and 50–60 years

Genetics

- 41% if both parents are affected
- 14% if one parents is affected
- 6% if one sibling is affected
Involves various classes of T cells and their interactions with dendritic cells and cells involved in innate immunity, including neutrophils and keratinocytes.
Clinical features

- The classic findings of erythema, thickening and scale
- Sharply defined, erythematous, scaly plaques
- Auspitz sign
- Woronoff’s ring: hypopigmented ring surrounding individual psoriatic usually associated with treatment; UV radiation or topical corticosteroids
Clinical features

- The most common sites: **scalp, elbows and knees and lumbosacral area**
  - nails, hands, feet and trunk (including the intergluteal fold)

- The involution of a lesion usually starts in its center, resulting in annular psoriatic lesions

- Prognosis: chronic, periods of complete remission do occur and remissions of 5 years have been reported in ~15% of patients
Clinical pattern

- Psoriasis vulgaris (chronic plaque psoriasis) ⇒ MC
- Guttate psoriasis
- Erythrodermic psoriasis
- Pustular psoriasis
  - Generalized pustular psoriasis
  - Pustulosis of the palms and soles
  - Acrodermatitis continua of Hallopeau
- Scalp psoriasis
- Inverse psoriasis
- Nail psoriasis
Psoriasis vulgaris (chronic plaque psoriasis) => MC

- **Guttate psoriasis**: preceded by an upper respiratory tract infection self-limited disease, lasting from 12 to 16 weeks without treatment

- Erythrodermic psoriasis
- Pustular psoriasis
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- Scalp psoriasis
- Inverse psoriasis
- Nail psoriasis
Clinical pattern

- Psoriasis vulgaris (chronic plaque psoriasis) \( \Rightarrow \) MC
- Guttate psoriasis

- **Erythrodermic psoriasis**: severe, persistent

- Pustular psoriasis
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  - Pustulosis of the palms and soles
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- Scalp psoriasis
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Psoriasis vulgaris (chronic plaque psoriasis)
Guttate psoriasis
Erythrodermic psoriasis

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Inverse psoriasis
Nail psoriasis
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Guttate psoriasis
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Scalp psoriasis
Inverse psoriasis
Nail psoriasis
# Nail psoriasis

## Nail Changes in Psoriasis

<table>
<thead>
<tr>
<th>Nail Segment Involved</th>
<th>Clinical Sign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proximal matrix</td>
<td>Pitting, onychorrhexis, Beau lines</td>
</tr>
<tr>
<td>Intermediate matrix</td>
<td>Leukonychia</td>
</tr>
<tr>
<td>Distal matrix</td>
<td>Focal onycholysis, thinned nail plate, erythema of the lunula</td>
</tr>
<tr>
<td>Nail bed</td>
<td>“Oil drop” sign or “salmon patch,” subungual hyperkeratosis, onycholysis, splinter hemorrhages</td>
</tr>
<tr>
<td>Hyponychium</td>
<td>Subungual hyperkeratosis, onycholysis</td>
</tr>
<tr>
<td>Nail plate</td>
<td>Crumbling and destruction plus other changes secondary to the specific site</td>
</tr>
<tr>
<td>Proximal and lateral nail folds</td>
<td>Cutaneous psoriasis</td>
</tr>
</tbody>
</table>
Psoriatic arthritis

- 5–30%
- Asymmetric oligoarthritis of the small joints of the hands and feet
- Risk factor for severe PSA: initial presentation at an early age, female gender, polyarticular involvement, genetic predisposition, and radiographic signs of the disease early on

Nail involvement is a strong predictor of concomitant psoriatic arthritis
NAPKIN PSORIASIS

Napkin psoriasis with a highly glazed erythematous appearance and sharp margins.

Napkin psoriasis with widespread dissemination.
LINEAR PSORIASIS
### Calculation of the Psoriasis Area and Severity Index

#### Severity of psoriatic lesions

[0, none; 1, slight; 2, moderate; 3, severe; 4, very severe]

<table>
<thead>
<tr>
<th></th>
<th>Head</th>
<th>Trunk</th>
<th>Upper limbs</th>
<th>Lower limbs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Erythema</td>
<td>0 to 4</td>
<td>0 to 4</td>
<td>0 to 4</td>
<td>0 to 4</td>
</tr>
<tr>
<td>Induration</td>
<td>0 to 4</td>
<td>0 to 4</td>
<td>0 to 4</td>
<td>0 to 4</td>
</tr>
<tr>
<td>Scaling</td>
<td>0 to 4</td>
<td>0 to 4</td>
<td>0 to 4</td>
<td>0 to 4</td>
</tr>
<tr>
<td>Total score</td>
<td>Sum of the above</td>
<td>Sum of the above</td>
<td>Sum of the above</td>
<td>Sum of the above</td>
</tr>
</tbody>
</table>

#### Area of psoriatic involvement

[0, none; 1, <10%; 2, 10 to <30%; 3, 30 to <50%; 4, 50 to <70%; 5, 70 to <90%; 6, 90–100%]

<table>
<thead>
<tr>
<th></th>
<th>Head</th>
<th>Trunk</th>
<th>Upper limbs</th>
<th>Lower limbs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree of involvement</td>
<td>0 to 6</td>
<td>0 to 6</td>
<td>0 to 6</td>
<td>0 to 6</td>
</tr>
<tr>
<td>Multiply 1 × 2</td>
<td>1 × 2</td>
<td>1 × 2</td>
<td>1 × 2</td>
<td>1 × 2</td>
</tr>
<tr>
<td>Correction factor for area of involvement</td>
<td>0.10</td>
<td>0.30</td>
<td>0.20</td>
<td>0.40</td>
</tr>
<tr>
<td>1 × 2 × 3</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
</tr>
<tr>
<td>( A + B + C + D )</td>
<td>total PASI</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:**

- \( 1 \) represents the total score of severity.
- \( 2 \) represents the degree of involvement.
- \( 3 \) represents the correction factor for area of involvement.

**Formula:**

\( \text{total PASI} = A + B + C + D \)
Modifying Factors

- **OBESITY**: more likely to present with severe psoriasis (>20% BSA)
- **SMOKING**: twofold increase risk of severe psoriasis and have role in onset of psoriasis
- **INFECTION**:
  - Streptococcal throat infection → guttate psoriasis and exacerbation of chronic plaque type
  - Progression of HIV infection → exacerbation of psoriasis
- **DRUGS**:
  - Antimalarials, beta blockers, lithium, NSAIDs, IFNs-α and -γ, imiquimod, ACEI, and gemfibrozil → exacerbation of psoriasis
  - TNF inhibitor therapy → drug induced psoriasis
Association with internal diseases (including comorbidities)

- **Metabolic syndrome:** obesity
- **Cardiovascular diseases:** myocardial infarctions (three fold in severe psoriasis), peripheral arterial disease, cerebrovascular accidents
- **Dyslipidemia**
- **Venous thromboembolism**
- **Non-alcoholic steatohepatitis**
- **Crohn disease, ulcerative colitis:** share an association with sacroiliitis and HLA-B27 positivity
- **Emotional difficulties:** concerns about appearance, resulting in lowered self-esteem, social rejection, guilt, embarrassment, emptiness, sexual problems, and impairment of professional ability
# Treatment

## Topical treatment
- Corticosteroids
- vitamin D3 analogues
- Anthralin
- Topical retinoids
- Coal tar
- Salicylic acid
- Calcineurin inhibitors

## Systemic Medications
- Methotrexate
- Cyclosporine
- Systemic retinoids: Acitretin
- Targeted immunomodulators (“biologic” therapies)

## Phototherapy
- UVB
- PUVA
PITYRIASIS LICHENOIDES CHRONICA (PLC) AND
PITYRIASIS LICHENOIDES ET VARIOLIFORMIS ACUTA (PLEVA)
Pityriasis lichenoides

- **Epidermiology**:  
  - All race, all geographic regions.  
  - more common in children and young adults  
  - PLC is 3-6 times more common than PLEVA  

- **Etiology**: actually unknown  
  - Associated with Infectious agents:  
    - Toxoplasma gondii, EBV, CMV, Parvovirus B19, HIV  
  - Chemotherapeutic drugs  
  - Estrogen-progestrogen therapy

- **Pathogenesis**: clonal T cell lymphoproliferative disorder
Clinical features

- Erythematous to purpuric papules
- Location: trunk and proximal extremities
- **PLEVA:**
  - Crusts, ulcers, vesicles, pustules, erosions
  - Resolve within weeks
  - Heal with varioliform (smallpox-like) scars
- **PLC:**
  - Erythematous to red-brown, scaly papules
  - Regress over weeks to months (chronic relapsing course)
  - Heal with hypopigmented macules (rarely scar)
Differential diagnosis

PLEVA

- Arthropod bites, stings, infestations
- Leukocytoclastic vasculitis
- Viral exanthem (e.g., varicella-zoster, herpes simplex)

PLC

- Pityriasis rosea
- Drug eruption
- Guttate psoriasis
Treatment

- Topical corticosteroids (2)
- Topical coal tar products (3)
- Oral erythromycin (2)
- Oral tetracyclines (2)
- Oral azithromycin (3)

- Sunlight (2)
- Ultraviolet B (UVB) phototherapy – broadband or narrowband (2)
- PUVA (psoralen plus UVA) phototherapy (2)
- Methotrexate (2)
- Cyclosporine (3)

- Special treatments (3):
  - Antihistamines
  - Systemic antibiotics
  - Systemic corticosteroids

(1) prospective controlled trial
(2) retrospective study or large case series
(3) small case series or individual case reports
PITYRIASIS ROSEA
Epidermiology and etiology

- A self-limited papulosquamous eruption
- Incidence ~ 0.16%
- Most commonly occurs at age 10-35 yr
- Female:male = 2:1
- Etiology → viral exanthem associated with reactivation of HHV6 and HHV7
- Location: trunk and proximal extremities
- Typical lesions last 6-8 wk
Clinical features

- Primary lesion: Herald patch
- Pink- to salmon- to pink-brown-colored patch or plaque with a slightly raised advancing margin and fine collarette of scale ⇒ trunk, neck, and proximal extremities
- Flu-like symptoms (5%)
Clinical features

- **Secondary lesion**: typically occur within 2 wks after primary lesion
  - Symmetrically distributed, localize mainly to trunk (chest wall, abdomen) proximal extremities
  
  - Aligned with their long axes along lines of cleavage and distributed in a *Christmas tree pattern*
  
  - Gradually increase in number and spread peripherally => spare face, palms, and soles
FIGURE 41-4 Schematic diagram of the primary plaque (herald patch) and the typical distribution of secondary plaques along the lines of cleavage on the trunk in a Christmas tree pattern.
Atypical Pityriasis rosea

- ~20% of patients
- **Morphology**: papular, vesicular, urticarial, pustular, purpuric, EM-like, and lack of scale
- **Distribution**: PR inversus (face, axilla, groin), shoulder-girdle type
- **Size** of lesions: various
- **Atypical course** of the eruption
- **Drug-induced**: PR-like rashes
Differential diagnosis

- Secondary syphilis
- Tinea corporis
- Nummular dermatitis
- Guttate psoriasis
- Pityriasis lichenoides chronica
- PR-like drug eruption
Treatment

- Asymptomatic and self-limited => patient education and reassurance
- Antipruritic lotions
- Low- to medium- strength topical corticosteroids
- Short course systemic corticosteroids
- Oral acyclovir: faster resolution of lesions and fewer new lesion
- Erythromycin
- Severe case: Narrowband UVB, natural sunlight exposure, and antihistamine
LICHEN PLANUS
Lichen planus

- Worldwide occurrence: less than 1%
- 2/3 occur between 30-60 years of age
- Lesions: symmetric, grouped, erythematous to violaceous, flat-topped, polygonal papules
- The 4 Ps—purple, polygonal, pruritic, papule
- Affects the skin, mucous membranes, nails, and hair
- Distribution: widespread, predilection for flexural aspects of arms and legs
Classic LP

- Faintly erythematous to violaceous, flat-topped, polygonal papule, sometimes showing a small central umbilication
- Papules are grouped and tend to coalesce
- A thin, transparent, and adherent scale on top
- Fine, whitish puncta or reticulated networks referred to as Wick-ham striae
- Prognosis: unpredictable, typically persist for 1-2yr but maybe chronic, relapsing course
Variants of lichen planus

CONFIGURATION OF LESIONS
- Annular LP
- Linear LP

MORPHOLOGY OF LESIONS
- Hypertrophic LP
- Atrophic LP
- Vesiculobullous LP
- Erosive and ulcerative LP
- Lichen planus pigmentosus
- Actinic LP
Variants of lichen planus

**CONFIGURATION OF LESIONS**
- Annular LP
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Variants of lichen planus

SITE OF INVOLVEMENT

- LP of the scalp:
  1. classic lichen planopilaris
  2. frontal fibrosing alopecia,
  3. Lassueur–Graham–Little–Piccardi
- Mucosal LP
- Nail LP
- Palmoplantar LP
Variants of lichen planus

SITE OF INVOLVEMENT

- LP of the scalp:
  1. classic LPP
  2. frontal fibrosing alopecia,
  3. Lassueur–Graham–Little–Piccardi
- Mucosal LP
- Nail LP
- Palmoplantar LP
**Prognosis and clinical course**

- **Duration of disease**: Generalized < Cutaneous < Cutaneous + mucous membrane < mucous membrane < hypertrophic = lichen planopilaris

- Relapse occurs in 15-20%

- Spontaneous regression is rare in oral LP
  - SCC < 1% in persistent oral LP
  - Risk factor: long standing disease
    erosive or atrophic type
    smoking
    esophageal involvement
Treatment

- Topical/Intralesional corticosteroids
- Topical tacrolimus, pimecrolimus
- Systemic corticosteroid: in severe, acute LP
- Retinoids: Acitretin, Isotretinoin
- Photochemotherapy: PUVA, UVA-1, UVB
- Immunosuppressive agent: cyclosporine, azathioprine
- Others: dapsone, antimalaria, IFN, thalidomide
Lichen nitidus

- Unknown etiology
- Small, glistening, flesh-colored to pink or reddish-brown papules
- Koebner phenomenon
- Location: the flexural surfaces of the arms and the wrists, lower abdomen, breasts, the glans and shaft of the penis, and other areas of the genital region
- There is no associated systemic disease
- Prognosis is good
Pityriasis rubra pilaris

- Follicular papules with an erythematous base are a characteristic finding, including on the proximal dorsal fingers.
- There is a coalescence of orange-red plaques, but with obvious islands of sparing.
- An orange-red waxy keratoderma of the palms and soles is often seen.
VESICULOBULLOUS DISEASE
Vesicle
- Elevated, circumscribed
- <1 cm in diameter
- Filled with fluid – clear, serous, or hemorrhagic
- May become pustular, umbilicated or an erosion

Herpes zoster
- Herpes simplex
- Varicella or zoster
- Dermatitis herpetiformis
- Dyshidrotic eczema
Bulla
- Elevated, circumscribed
- >1 cm in diameter
- Filled with fluid – clear, serous, or hemorrhagic
- May become an erosion

Bullous pemphigoid

- Friction blister
- Bullous pemphigoid
- Linear IgA bullous dermatosis
- Bullous fixed drug eruption
- Corna bullae
- Edema bullae
Bullae

- Inherited
- Acquired
- Flaccid bullae erosion
- Tense bullae
- With autoAb
- Without autoAb
PEMPHIGUS
Pemphigus

- Group of autoimmune blistering diseases of the skin and mucous membranes

- Histology: intraepidermal blisters due to the loss of cell-cell adhesion of keratinocytes

- Immunopathology: circulating IgG autoantibodies directed against the cell surface of keratinocytes
Autoantibodies to desmoglein
Pemphigus

- Group of autoimmune blistering diseases of the skin and mucous membranes
- Histology: intraepidermal blisters due to the loss of cell–cell adhesion of keratinocytes

Flaccid bullae and erosions
Pemphigus group

- **Pemphigus vulgaris**
  - Pemphigus vegetans
- **Pemphigus foliaceus**
  - Pemphigus erythematous: localized
  - Fogo selvagem: endemic
- Herpetiform pemphigus
- Drug-induced pemphigus
- Paraneoplastic pemphigus
- IgA pemphigus
Pemphigus vulgaris

- **Flaccid blister** occur anywhere on the skin surface, but typically not the palms and soles
- Erosions on mucous membranes and skin
- Nikolsky sign +
- Exposure to ultraviolet radiation may **exacerbate** disease activity
Pemphigus foliaceus

- Scaly, crusted erosions, often on an erythematous base
- In early disease: well demarcated lesions and scattered in a seborrheic distribution, including the face, scalp, and upper trunk
- Rarely to involve mucous membrane
- Pain and burning
- Exacerbated by ultraviolet radiation
## Differential diagnosis

<table>
<thead>
<tr>
<th>Oral lesions</th>
<th>Cutaneous lesions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acute herpetic stomatitis</td>
<td>• Other forms of pemphigus</td>
</tr>
<tr>
<td>• Aphthous stomatitis</td>
<td>• Bullous pemphigoid</td>
</tr>
<tr>
<td>• Erythema multiforme major</td>
<td>• Linear IgA bullous dermatosis</td>
</tr>
<tr>
<td>• Stevens–Johnson syndrome</td>
<td>• Erythema multiforme</td>
</tr>
<tr>
<td>• Lichen planus</td>
<td>• Hailey–Hailey disease</td>
</tr>
<tr>
<td>• Systemic LE</td>
<td>• Grover disease</td>
</tr>
<tr>
<td>• Mucous membrane pemphigoid</td>
<td></td>
</tr>
</tbody>
</table>
Thiol containing food

- Garlic
- Leeks
- Onion

- กระเทียม
- ต้นกระเทียม
- หัวหอม
- ดอกกระหล่ำ
- กระหล่ำปลี
- มะม่วง
- พริกไทยดำ
- มันสำปะหลัง
- พริกแดง
- ชำ
- ชา
Associated disease

- Myasthenia gravis
- Thymoma
### Prognosis

- Associated with a significant morbidity and mortality
- Due to severe blistering of the skin and mucous membranes leading to malnutrition, dehydration, and sepsis
- In one study
  - 17% after 18 months of therapy, went into a complete and long-lasting remission
  - 37% achieved remission but relapsed at times after therapy was stopped
Treatment

Standard treatment

- Oral prednisone 1 mg/kg/day as an initial dose (usually 60 mg/day) (1)

Topical treatment

- Topical corticosteroids (1), especially Class I to localized persistent sites
- Topical antibiotics (2)
- Topical immunomodulators (e.g. cyclosporine, tacrolimus) (3)

Intralesional therapy

- Corticosteroids (3)
- Rituximab (5 mg/cm2) (3)

Aggressive treatment

- Azathioprine (1)
- Mycophenolate mofetil (2)
- Cyclophosphamide (2)
- Cyclosporine (2)
- Pulse methylprednisolone (2)
- Methotrexate (3)
- Plasmapheresis (2)
- High-dose IVIg (1)
- Rituximab (2)
- Extracorporeal photopheresis (3)
Autoantibodies to basement membrane
BULLOUS PEMPHIGOID
Bullous pemphigoid

- The most common autoimmune subepidermal blistering disease
- Onset after 60 years of age
- Urticarial lesions, tense bullae on normal or erythematous skin
- Symmetry, predominate on the flexural aspects of the limbs, lower trunk and abdomen
- Marked pruritus
Bullous pemphigoid

- 10% of patients involve mucous membrane-buccal mucosa
- 50% elevate serum IgE/peripheral blood eosinophilia
- Triggered by ultraviolet (UV) light, UVB or PUVA and radiation therapy
- Childhood bullous pemphigoid often presents as localized disease with acral distribution being common
Differential diagnosis

- Others pemphigoid group: EBA, LABD, CP
- Bullous arthropod bites
- Allergic contact dermatitis
- Stevens–Johnson syndrome
- Bullous drug eruptions
- Dyshidrotic eczema
- Pseudoporphyria
- Porphyria cutanea tarda
**Associated disease**

- Neurological disease (esp. age over 80 years)
- Acquired hemophilia due to acquired Factor VIII inhibitor
Prognosis

- Waxing and waning course
  - 30% of BP patients have a relapse during their first year of treatment
  - After cessation of therapy, ~50% of patients experience a relapse, most often within the first 3 months

- Occasional spontaneous remission in the absence of treatment

- Poor prognosis: old age, poor general health, and the presence of anti-BP180 antibodies
# Treatment

<table>
<thead>
<tr>
<th>First-line</th>
<th>Second-line, or as adjunctive therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Superpotent topical corticosteroids (1*)</td>
<td>- Azathioprine (2)</td>
</tr>
<tr>
<td><strong>Second-line</strong></td>
<td>- Mycophenolate mofetil (2)</td>
</tr>
<tr>
<td>- Oral corticosteroids (1)</td>
<td>- Methotrexate§ (2)</td>
</tr>
<tr>
<td>- Minocycline, doxycycline or tetracycline, (1)</td>
<td>- Chlorambucil (3)</td>
</tr>
<tr>
<td>- Erythromycin, penicillins (3)</td>
<td>- Cyclophosphamide (3)</td>
</tr>
<tr>
<td>- Dapsone, sulfonamides (3)</td>
<td>- IVIg (3)</td>
</tr>
<tr>
<td>- Topical immunomodulators (e.g. tacrolimus)</td>
<td>- Plasma exchange (2)</td>
</tr>
<tr>
<td>(3)</td>
<td>- Rituximab (3)</td>
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<td></td>
<td>- Omalizumab (3)</td>
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<tr>
<td></td>
<td>- Immunoadsorption (3)</td>
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</tbody>
</table>
OTHERS PEMPHIGOID
Pemphigoid gestationis

- Associated with pregnancy (2nd trimester), postpartum, and trophoblastic tumor
- Abrupt onset of intensely pruritic urticarial lesions
- First onset on the abdomen, often within or immediately adjacent to the umbilicus
- Sparing only the face, mucous membranes, palms, and soles is the rule
- Flare during labor and delivery, subsequent use of oral contraceptives
Pemphigoid gestationis

- No significant maternal morbidity or mortality
- Increased risk for the subsequent development of *Graves disease*
- Associated with a slight increase in premature and small-for-gestational-age births
Linear IgA bullous dermatosis

- Onset after 40 yrs
- Pruritic papules, vesicles or bullae distributed symmetrically on extensor surfaces
- Annular crust
- 70% mucosal involvement
- Drug induced LABD: vancomycin
Chronic bullous disease of childhood

- Preschool children < 5 yr
- Annular erythema and blisters (cluster of jewels)
- Perineum and perioral region
- Self limit within 2 years
- Good prognosis
Dermatitis herpetiformis

- Occur in any age but common in 20-40 years
- Erythematous papulovesicular eruption in herpetiform grouping, distributed symmetrically on extensor surfaces
- Mucosal lesions are uncommon
- Severe itching
- Most patients have associated gluten-sensitive enteropathy (90%)
QUIZ
Papulosquamous disease

- Sharply defined, erythematous, scaly plaques with Auspitz sign, salmon patch and oil drop on nail
- Herald patch with fine collarette scales, christmas tree distribution
- Erythematous to purpuric papules locate on trunk and proximal extremities, healed with hypopigmented macules
- Symmetric, grouped, erythematous to violaceous, flat-topped, polygonal papules with wickham striae

- Psoriasis
- Pityriasis rosea
- Pityriasis lichenoides chronica
- Lichen planus
# Nail psoriasis

## Nail Changes in Psoriasis

<table>
<thead>
<tr>
<th>Nail Segment Involved</th>
<th>Clinical Sign</th>
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<tbody>
<tr>
<td>Proximal matrix</td>
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<td>Intermediate matrix</td>
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<td>Distal matrix</td>
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<td>Nail bed</td>
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<td>Hyponychium</td>
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<td>Nail plate</td>
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<td>Proximal and lateral nail folds</td>
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</table>
Vesiculobullous disease

- Urticarial lesions, tense bullae predominant on flexural area, old age
- Flaccid blisters and erosions on mucous membranes and skin, Nikolsky’s sign positive
- Scaly, crusted erosions, often on an erythematous base, Predominant on seborrheic area
- Thymoma, myasthenia gravis

- Bullous pemphigoid
- Pemphigus vulgaris
- Pemphigus foliaceus
- Pemphigus vulgaris
THANK YOU FOR YOUR ATTENTION