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ERYTHEMA MULTIFORME CLINICALLY MIMICKING LICHEN PLANUS PEMPHIGOIDES-A RARE CASE REPORT

Dermatology

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ABSTRACT

Erythema multiforme (EMF) is an acute, self-limiting, usually mild skin disease which clinically starts as papular, urticarial or classical target lesions commonly over the lower limbs. Here we report a 40-year-old male who was clinically thought to be lichen planus pemphigoides and histologically diagnosed as erythema multiforme.

KEYWORDS

erythema multiforme, lichen planus pemphigoides, eosinophils

INTRODUCTION:

Erythema multiforme is an acute, self-limiting, usually mild skin disease which clinically starts as papular, urticarial or classical target lesions commonly over the lower limbs. Erythema multiforme can occur in any age group but uncommon in children[1,2]. Most common causative organism is found to be HSV-1 and HSV-2[3]. Histopathology of EMF will show intraepidermal vesicle in early stages and satellite cell necrosis. On the other hand, lichen planus pemphigoides is a rare variant of bullous pemphigoid which clinically manifests as blisters over violaceous papules and plaques and also over uninvolved skin.

CASE REPORT:

A 40-year-old male came to our skin OPD with complaints of fluid filled blisters over the lower limb which is present for the past 1 week with mild itching. History of drug intake 20days back for light colored skin lesions over bilateral arms details of which are unknown. No history of photosensitivity or constitutional symptoms. On examination there were multiple violaceous patches with few tense blisters noted over bilateral legs mainly over the anterior aspect. Bilateral forearms showed scaly patches suggestive of pityriasis rosea. Oral cavity was normal. Systemic examination was normal.

Patient was clinically diagnosed as lichen planus pemphigoides and a biopsy was taken. Low dose of systemic steroids was started preemptively. Three days later some of the bullae settled leaving behind characteristic target lesion. Histopathology showed basal cell vacuolar degeneration with plenty of eosinophils in the dermis. Based on the above-mentioned findings a diagnosis of erythema multiforme was made.

DISCUSSION:

Erythema multiforme is an acute, self-limiting skin disease which clinically present with classical target lesion in addition to papular or urticarial lesion, commonly seen over the lower limbs but can also occur over other parts of body. Erythema multiforme can occur in any age group but relatively rare in children[1,2]. The commonest causative organisms are found to be HSV-1 and HSV-2[3]. Histoplasmosis and Orf are also found to be associated with EMF. Few drugs are thought to cause EMF like sulfonamides, barbiturates, penicillin, and carbamazepine. Histopathology of EMF will show intraepidermal vesicle in early stages and satellite cell necrosis. On the other hand, lichen planus pemphigoides is a rare variant of bullous pemphigoid which clinically manifests as blisters over violaceous papules and plaques and also over uninvolved skin. Drugs triggering LPP are ACE inhibitors, cinnarizine, anti-tuberculous drugs, etc[4]. There are IgG autoantibodies directed against Bullous Pemphigoid Ag1 and 2, which play a vital role in causing the disease. Histopathology will show classical features of lichen planus with subepidermal blister formation and polymorph infiltrates.

Treatment of EMF mainly focuses on symptomatic relief since it's a self-limiting disease. Antibiotics are given in case of secondary bacterial infection. The use of systemic corticosteroids is controversial, whereas LPP can be treated with a short course of systemic corticosteroids, later followed by dapsone therapy.

CONCLUSION:

A diagnosis of erythema multiforme should be borne in mind despite the lack of target lesion in the initial stages when the patient gives a positive history of drug intake, as in our patient was clinically diagnosed as lichen planus pemphigoides.

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CONFLICT OF INTEREST: The authors declare that they have no conflict of interest.

LEGENDS TO IMAGES



FIGURE 1- a) bullous lesions over violaceous as well as normal skin b) picture taken three days later showing target lesion

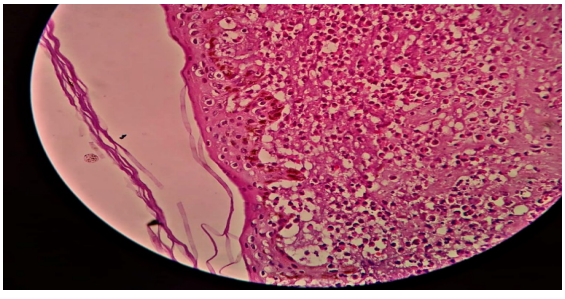


FIGURE 2- high power showing basal cell vacuolar degeneration with abundant eosinophils

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