Dermatology Practical & Conceptual

Pemphigus Foliaceus in Skin of Color: A Challenging Clinical-Pathological Correlation

Veronica Melchionda[1], Nicholas McEntyre[2], Leila Izadi Firouzabadi[1]

1 Department of Dermatology, Churchill Hospital, Oxford University Hospitals NHS Foundation Trust, Oxford
2 Department of Cellular Pathology, John Radcliffe Hospital, Oxford University Hospitals NHS Foundation Trust, Oxford

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Corresponding Author: Veronica Melchionda BSc MSc MBBS PGCert Med Edu MRCP (UK), Department of Dermatology, Churchill Hospital, Oxford University Hospitals NHS Foundation Trust, Oxford. E-mail: veronica.melchionda2@nhs.net

Case Presentation

A 51-year-old male with Fitzpatrick skin type 5, originally from the Indian subcontinent, presented with a 1-year history of pruritic erosions and violaceous patches and plaques, initially involving the back. This progressed to the scalp, face, wrists, and arms. Four months later, he also developed small tense bullae around the medial aspect of the hands. Lesions left post-inflammatory hyperpigmentation with no scarring (Figure 1). There was no preceding trigger. Investigations revealed an ANA titer of 1:160 with a speckled pattern and a marginally raised C4 at 48mg/dL. Following two non-specific skin biopsies of patches and plaques involved, a third biopsy when blisters appeared revealed vesicle formation at the level of the upper stratum spinosum and stratum granulosum with strong expression of IgG, weaker C3 in an intercellular pattern, and weak basement membrane staining on immunofluorescence. ELISA showed a high level of Dsg1 autoantibodies. This clinched the diagnosis of pemphigus foliaceus.

Teaching Point

The under-representation of skin of color images in dermatology, and immunobullous disorders in particular, has been recognized in the literature [1,2]. We provide a case of pemphigus foliaceus with features mimicking lichen planus pigmentosus and lupus erythematosus in a patient with skin of color, highlighting the importance of documenting clinical images in this group. The striking extent of post-inflammatory pigmentation is noteworthy in skin of color. In pemphigus foliaceus, blisters can resolve quickly into erosive or scaly patches, posing a diagnostic challenge particularly if biopsies are taken without capturing the blistering stage.

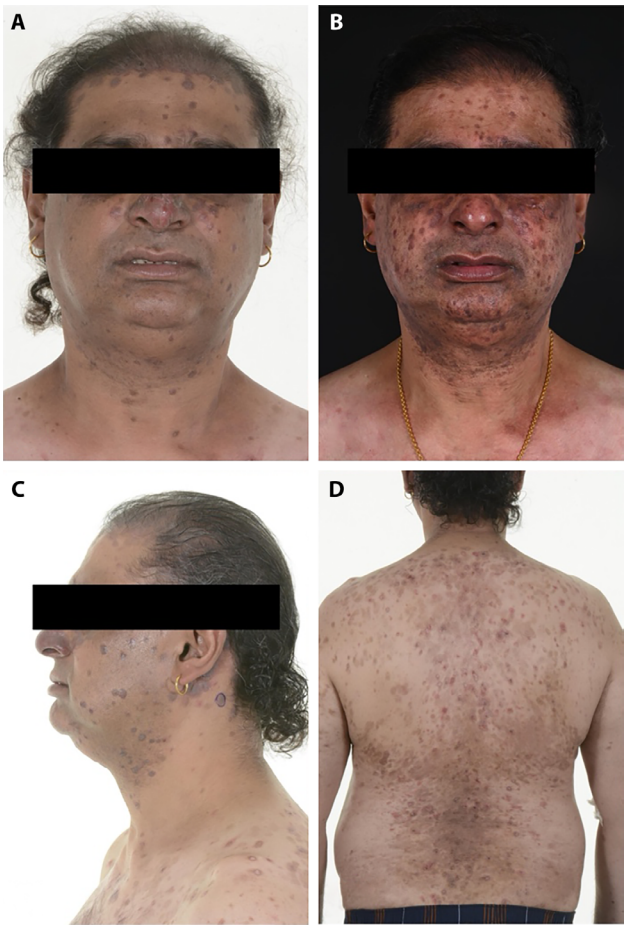

Figure 1. (A) Erosions on the nose and darkly pigmented patches and nodules on the head and neck. (B) Widespread post-inflammatory macules of the same head and neck area, following the initiation of treatment, namely, oral prednisolone and mycophenolate mofetil. (C) Tense hyperpigmented brown-purplish nodules on the head and neck. (D) Multiple widespread pink-purple patches on the trunk with several erosions and occasional vesicles. Post-inflammatory hyperpigmentation from previous flares is evident.

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