Involvement variant with blister +PMNs and Eos bullosa
With no reported gender predilection and primarily sites mofetil identical exposure.
diseases (c).

1,500 mg twice daily Solumedrol (EBA) is cleavage in EBA (b). Above right, a depiction of the components of Rituximab 1mg/kg IV on day 1 and day 15 (Rheumatoid Arthritis protocol) et al., Histopathologic differentiation and no evidence of ocular patches, with involvement Upper endoscopy demonstrated acquisita specimen c/w involvement (usually very limited)
IVIG 2gm/kg total dose, given IV over 3 days involvement sign
Clinical differentiation involvement +scarring + blistering involvement.
folds as well (not pictured).

Dermatol blister, +Eos sometimes PMNs, - Hematoxylin Genitour

3 months prior for involvement

CASE PRESENTATION

A 63 year old Jamaican male presented with a 4 month history of a mucocutaneous disease, EBA is affecting

1 per every five reported previous hospitalization

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CASE PRESENTATION

A 63 year old Jamaican male presented with a 4 month history of a severe generalized cutaneous bullous eruption with intraoral lesions, accompanied by pruritus, dysphagia,odynophagia, epistaxis, loss of teeth, and changes in vocal quality. Patient reported previous hospitalization 4 months prior for similar blistering skin rash and was discharged home with a diagnosis of bullous pemphigoid, on a long-term prednisone taper, finishing three days before re-presentation. Patient denied any nausea, vomiting, abdominal pain, or penicillamine exposure. Dermatologic examination revealed multiple tense and ruptured bullae on an erythematous base involving the head, trunk, extremities, and acral surfaces on a background of mottled pink and light-tan hypopigmented patches (Figure 2). Oral examination revealed multiple tense and ruptured bullae of the tongue, gingiva, and buccal mucosa (Figure 3) with ulcerations of the inferior left labial mucosa, not extending past the vermilion border, with positive mucocutaneous nikolsky sign and no evidence of ocular involvement. Laboratory workup for SL-E was negative with comprehensive metabolic panel, and complete blood count negative save for a mild normocytic, normochromic anemia.

PATHOLOGY

Figure 6 (I) Hematoxylin and eosin (H&E) staining of bullosal skin at D3 magnification (I) demonstrated a subepidermal blister with light scanning fibres of dermal epidermis and neutrophils (figure 4, insert, 20x magnification), basophilic dermal papillae, and dermal and peri-vascular fibrosis. Direct immunofluorescence (DF) of peri-lesional skin (I) revealed thick, linear deposition of IgG, with scant linear C3 deposition. Sub-salt demonstrated staining adhering the dermal and sub-epidermal skin (II). Table 1: B) Clinical and histopathologic differentiation of subepidermal autoimmune blister diseases. EBA, mucocutaneous variant (MM), and mechanocutaneous variant (M).