

Clinical Images

Drug-induced bullous pemphigoid

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A previously healthy 28-year-old man presented with a rash for 1 month. He had taken griseofulvin for a week prior to rash onset. He had visited two ERs and was given minocycline and valacyclovir, followed by acyclovir, hydroxyzine and low-dose oral

steroids, with no improvement. On presentation to our clinic, he had vesicular lesions and large bullae over his forearms and thighs (Figs. 1 and 2). No mucosal lesions were present. Lab test results demonstrated WBC 10.2 K/cmm with 8.4% eosinophils. Perilesional skin biopsy showed spongiotic dermatitis with eosinophils, with direct immunofluorescence positive for sub-epidermal IgG and C3 depositions consistent with bullous pemphigoid. He was treated with oral prednisone and clobetasol ointment, with improvement.¹

Over 50 agents have been implicated as a cause of drug-induced bullous pemphigoid (DIBP), including diuretics, ACE inhibitors, and antibiotics.^{2–5} Unlike classic bullous pemphigoid, DIBP occurs in younger patients, and relapses are rare.³ Eosinophilia is often seen on lab tests, and symptoms may persist for up to 3 months after drug exposure. In our patient, griseofulvin was suspected as the trigger. Vesicular lesions are often misdiagnosed as herpetic infection, which may delay diagnosis and management. DIBP should

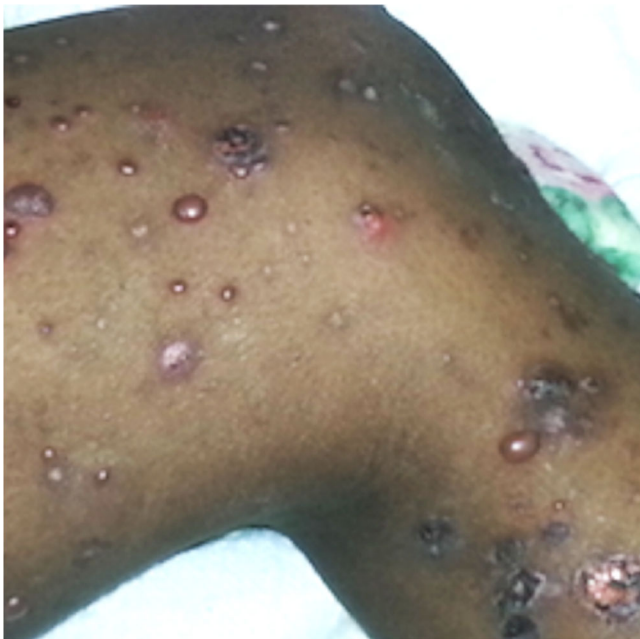


Figure 1 Vesicular lesions on the leg of a 28-year-old man following griseofulvin exposure.



Figure 2 Tense bullae on the forearm with negative Nikolsky sign.

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be considered in young patients presenting with bullous lesions with recent exposure to a new medication.

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Compliance with Ethical Standards:

Conflict of Interest: The authors declare that they do not have a conflict of interest.

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