

## NOTES &amp; COMMENTS

**Response to “Linear IgA bullous dermatosis protracted by vancomycin-loaded bone cement”**

*To the Editor:* We read with great interest the case report by Nartker et al<sup>1</sup> on linear IgA bullous disease (LABD) associated with vancomycin-loaded bone cement. We report a similar case to further highlight this entity, as we suspect it is underreported and likely to be an increasing issue given our aging population.

A 64-year-old man was admitted for a revision of a left total knee replacement. He went on to have widespread bullae and erosions over the trunk (Fig 1), limbs, scalp and mucosa 7 days postprocedure. Interestingly, there was a linear distribution of blisters around the dressing sites (Fig 2) suspicious of a contact allergy. He had been fitted with a vancomycin-impregnated cement spacer (VICS) and was receiving intravenous vancomycin postoperatively. Bacterial and virology swabs from the blister lesions were negative. Skin biopsy found subepidermal blistering with eosinophil and neutrophil-rich inflammation. Direct immunofluorescence illustrated linear IgA deposition indicating LABD.

Vancomycin was switched to teicoplanin given the possibility of a drug-related blistering disorder. Prednisolone (40 mg once daily) was commenced with application of clobetasol propionate 0.05% ointment and regular emollients. Significant improvement of the skin was observed, and he was subsequently discharged and seen in dermatology outpatient clinic 3 weeks later. He continued to have new blisters; therefore, oral dapsone (100 mg once daily) was introduced alongside prednisolone. Dapsone was later increased to 125 mg and prednisolone gradually tapered.

At 3 months there was marked improvement with clear skin and no new blister formation; thus, prednisolone was withdrawn successfully. Patch testing was performed to exclude a possibility of contact allergy to the dressings given the initial blister development around the left knee dressing site. Standard and dressing series in concordance to the British Contact Dermatitis Society were applied,



**Fig 1.** Erosions and bullae on the trunk.

which revealed negative results. After 12 months, dapsone and topical steroids were all discontinued, as satisfactory disease control was achieved. In the interim, the patient had another revision procedure of the left knee without vancomycin with no dermatologic complications.

This is another case reporting LABD with VICS. The patient did initially respond well to the oral corticosteroids and cessation of intravenous vancomycin. However, the formation of new blisters would support vancomycin being absorbed systemically from the cement spacer. It is noted that there is an increasing use of antibiotic-impregnated cement spacer to minimize periprosthetic infection in joint replacement surgery. Concurrently, there have been growing reports of linear IgA bullous dermatosis associated with VICS.<sup>2,3</sup> Recognition of this potential link is crucial in any presentation of blistering disorder seen in those who have received parenteral vancomycin and VICS, as we may see more cases in the future. Lastly, LABD associated with vancomycin has been reported to exhibit isomorphic phenomenon which can mimic a contact dermatitis as in our case.<sup>4</sup> This finding is clinically important for dressing use and mobilization postprocedure, as this could



**Fig 2.** Isomorphic reaction around the dressing site.

stimulate bullae formation; thus, patients need effective counselling prior to discharge.

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