Linear IgA bullous dermatosis associated with metastatic renal cell carcinoma

Catherine S. Yang, MD, Leslie Robinson-Bostom, MD, and Shoshana Landow, MD
Providence, Rhode Island

Key words: bullous dermatoses; hematologic malignancy; linear IgA bullous dermatosis; metastasis; paraneoplastic; renal cell carcinoma; solid organ malignancy.

INTRODUCTION

Linear IgA bullous dermatosis (LABD) is a rare disorder characterized by tense bullae arranged annularly on the trunk and extremities. LABD is usually idiopathic or associated with medications, classically vancomycin and nonsteroidal anti-inflammatory drugs. Rarely, LABD has been reported in association with lymphoproliferative disorders, sarcomas, and carcinomas of solid organs, although it is controversial whether this is a causative association.

Abbreviation used:

LABD: Linear IgA bullous dermatosis

CASE REPORT

We report a case of a 64-year-old man with a history of plaque psoriasis, diabetes, coronary artery disease, spinal stenosis, and benign prostatic hypertrophy who presented with 0.2- to 1.0-cm tense vesiculobullae clustered, some annularly, on his trunk and extremities that developed over the course of 1 week (Fig 1). He did not have mucosal involvement. His medications included aspirin, atorvastatin, bupropion, vitamin D, clonazepam, glipizide, hydrocodone/acetaminophen, lisinopril, meloxicam, metformin, mirtazapine, omeprazole, propranolol, tamsulosin, zolpidem, and clobetasol and calcipotriene creams. He denied any new medications.

Pathology results showed a subepidermal split with a predominantly neutrophilic infiltrate in the papillary dermis on hematoxylin-eosin stain (Fig 2) and linear IgA deposition on direct immunofluorescence. Further questioning revealed that he had a known left kidney nodule that had rapidly progressed from 1 to 3 cm in the last 6 months. Biopsies of the nodule soon after his dermatology visit showed clear cell renal carcinoma. Staging workup detected a highly metabolic 1.0-cm nodule in his left lower lung that was too close to his heart to take a biopsy specimen but was presumed to be a metastatic focus.

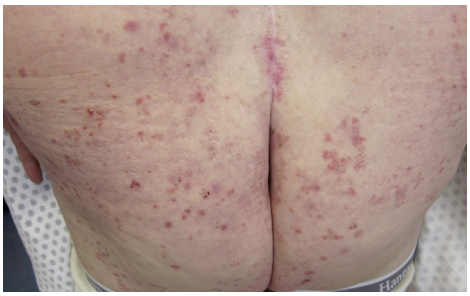

Fig 1. Crusted superficial erosions and vesicles scattered on lower back and buttocks. Note the psoriasiform pink plaque on sacrum inferior to scar.

The patient was started on prednisone, 60 mg daily, tapered slowly over 4 months, and was noted to have occasional, infrequent crops of vesicles. At the time of his admission for left partial nephrectomy, the prednisone was inadvertently abruptly discontinued. Six months since surgery, he has had no recurrence of LABD.

DISCUSSION

To our knowledge, ours is the fifth reported case of LABD in a patient with renal cell carcinoma.[1-4] The relationship between hematologic malignancies and LABD is more established than that of solid organ

From the Department of Dermatology, Warren Alpert Medical School of Brown University.

Funding sources: None.
Conflicts of interest: None declared.

Correspondence to: Catherine S. Yang, MD, Department of Dermatology, Rhode Island Hospital, 593 Eddy Street APC 1018, Providence, RI 02903. E-mail: catherine_yang@brown.edu.

JAAD Case Reports 2015;1:91-2.
2352-5126

http://dx.doi.org/10.1016/j.jdcr.2015.02.001

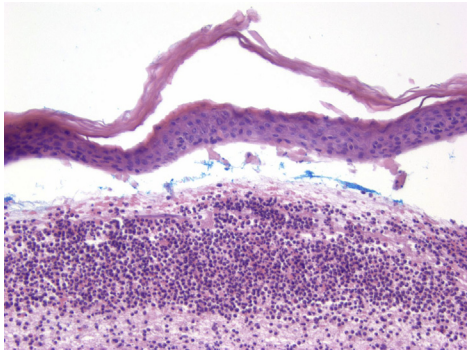

Fig 2. Light microscopy shows a subepidermal split with a neutrophilic infiltrate in the papillary dermis. (Hematoxylin-eosin stain.)

tumors. Although a study in 1990 of 70 British patients with LABD did not show an increased rate of solid organ tumors,[1] subsequent reports have challenged those findings.[2,5] In our patient, the temporal sequence of development of LABD with discovery of his underlying malignancy, the lack of other medication or viral etiologies, and LABD remission after treatment of the malignancy all suggest a causal association between LABD and renal cell carcinoma. Our case, in combination with prior case reports and series noting an association between LABD and malignancy, strengthens the argument that LABD can be a paraneoplastic syndrome of solid organ tumors.

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