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Vesicular Bullous Pemphigoid in a 23-Year-Old Male

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Dear Editor:

Bullous pemphigoid (BP) is an autoimmune subepidermal blistering disease that commonly affects elderly people. BP is characterized by erythematous tense bullae; however, clinical presentations of BP can occur polymorphically. A variety of atypical variants have been reported that have unusual clinical features, but histological and immunofluorescence (IF) findings indicative of BP[1-3]. Vesicular BP is a rare variant first described by Bean et al.[3] in 1976. Unlike typical BP with large, tense, serous or hemorrhagic bullae, the vesicular variant presents with multiple small tense vesicles with a symmetric distribution, which is clinically similar to dermatitis herpetiformis (DH). Here we report a case of vesicular BP in a young male patient.

A 23-year-old male presented with a 2-month history of multiple grouped vesicles and excoriations with severe pruritus over the whole body including face (Fig. 1A). Most lesions were erosions with crusts, but intact vesicles with several millimetres in diameter were also found. The lesions were symmetric, involving the extensor surfaces more severely. The mucous membranes, palms and soles were spared. Skin biopsy showed subepidermal bullae with neutrophil and occasional eosinophil infiltration (Fig. 1B, C). Indirect IF using salt-split skin showed linear immunoglobulin (Ig)G deposition on the epidermal side (Fig. 1D). Direct IF revealed linear IgG, IgA and complement 3 depositions along the basement membrane zone (Fig. 1E). Based on these clinical and immunopathological findings, the patient was diagnosed with vesicular BP. The skin lesions were effectively controlled with oral methylprednisolone (12 mg/d) and dapsone (50 mg/d), which were tapered without relapse. The patient remains in complete remission off therapy two years after treatment.

Vesicular BP is a BP variant primarily reported in the elderly[1,3], but it sometimes appears in children as well[2]. Blistering of the skin occurs; however, the lesions are smaller and distributed symmetrically, as seen in DH. The diagnosis of the present case was challenging considering the young age of the patient and the atypical clinical findings. The onset of DH is younger than BP[4] and the patient's clinical symptoms were similar to DH. Diagnostic confirmation was obtained via histologic and IF studies. Histologic findings of subepidermal separation with eosinophil infiltration, direct IF findings of linear IgG deposition along the basement membrane zone, and indirect IF

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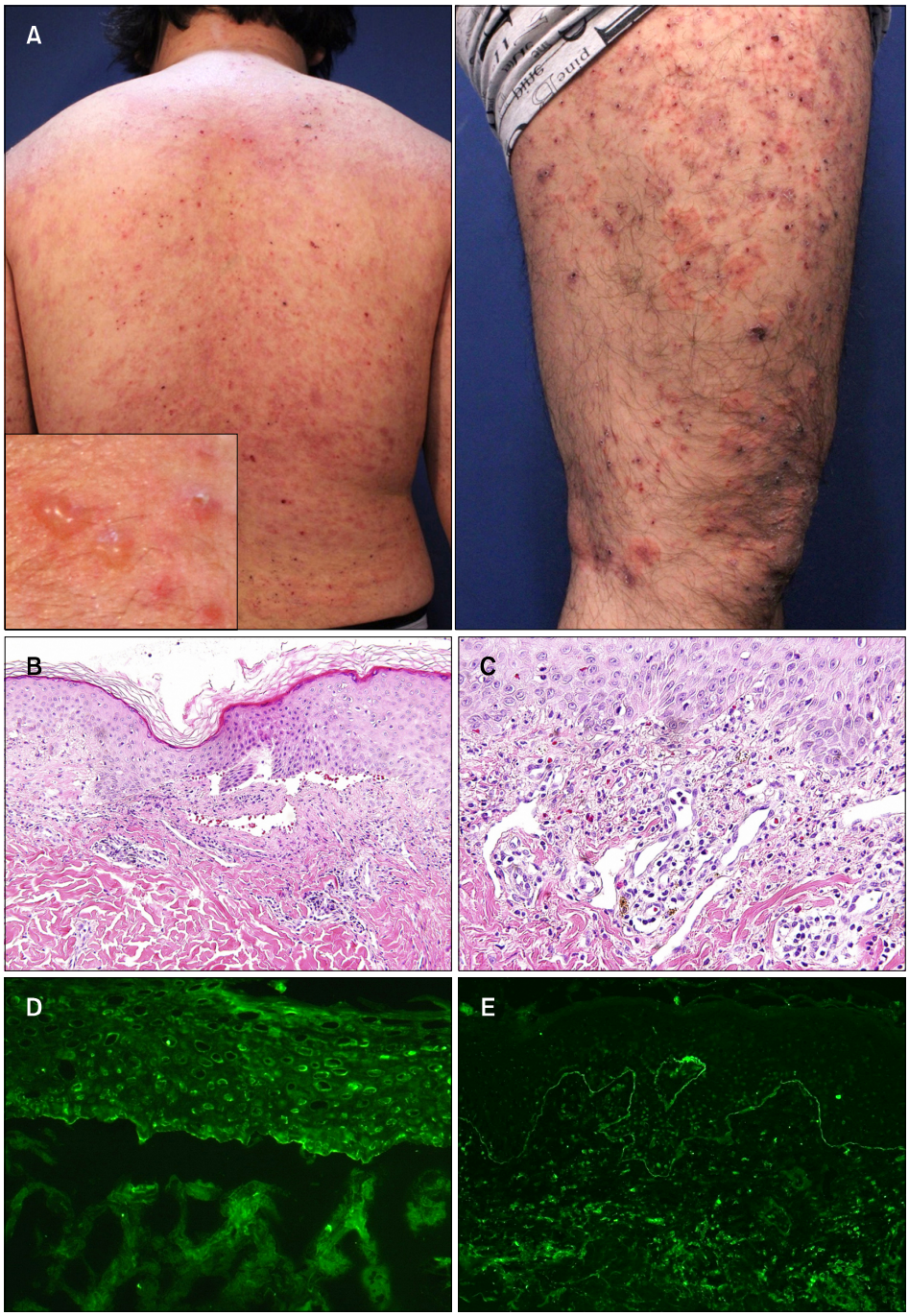

Fig. 1. (A) Clinical findings. Multiple, grouped, symmetric vesicles and excoriations over the whole body. (B, C) Histopathologic findings. Subepidermal bullae with neutrophil and occasional eosinophil infiltration (H&E; B: ×200, C: ×400), Immunofluorescence (IF) findings. (D) Indirect IF using salt-split skin shows immunoglobulin (Ig)G deposition on the epidermal side. (E) Direct IF shows linear IgG deposition along the basement membrane zone.

findings of IgG deposition on the epidermal side of salt-split skin supported a diagnosis of vesicular BP. In this patient, neutrophil infiltration was more prominent than eosinophil, which is uncommon in typical BP. Less is revealed about inflammatory cell composition of vesicular BP, and further investigation is needed.

Vesicular BP has a milder course than typical BP[5], but systemic corticosteroid treatment is needed in some cases. The efficacy of methotrexate or minocycline for vesicular BP has been reported previously[1,2]. In this case, the patient responded well to low-dose corticosteroids and dapsone. BP can present with extremely polymorphic features, and diagnosis can be challenging. A thorough evaluation with histologic and IF examination is needed for accurate diagnosis and appropriate treatment of these atypical clinical BP variants.

CONFLICTS OF INTEREST

The authors have nothing to disclose.

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A Case of Acquired Mucinous Nevus in Nevus Lipomatosus Cutaneous Superficialis

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Dear Editor:

Nevus lipomatosus cutaneous superficialis (NLCS) is a rare form of connective tissue disease, in which mature adipocytes are present ectopically in the dermis[1]. In general, lipomas and other tumors originating from the mesenchyme are known to be accompanied by mucin deposition. However, it is rare to observe mucin deposition in NLCS, and mucinous nevus in NLCS has not been reported yet[2].

A 41-year-old man presented to our department with skin lesions on his buttock. The history and physical examination revealed localized yellowish plaques in clusters and 0.3×0.3 cm pedunculated skin-colored papule on his buttocks (Fig. 1). Without symptoms and trauma history, the plaques were found incidentally about 10 years prior, and the papule that had gradually increased in size over time was found several years ago.

A skin biopsy specimen taken from one of the plaques showed hyperkeratosis and acanthosis of the epidermis, and groups of mature adipose tissues among collagen fibers was observed in the middle and lower part of the dermis, connecting to the subcutaneous fat (Fig. 2A～C). Biopsy results of the pedunculated papule revealed hyperkeratosis, mild acanthosis, and mucin deposition limited to the papillary dermis (Fig. 2D). And mucin was positive for Alcian blue stain at pH 2.5 (Fig. 2E).

Mucinous nevus is a rare form of connective tissue nevus and was first reported by Redondo Bellón et al.[3] in 1993. The term mucinous nevus was used because histological and clinical findings showed a nevoid appearance, with deposition of mucin in the papillary dermis. On histological examination, it shows a ribbon of mucin deposition in the upper dermis. It can be accompanied by acan-

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