



Linear IgA Bullous Dermatitis in Association With Crohn Disease

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A man in his 50s with a 3-year history of Crohn disease presented with a 1-week history of pruritic blistering on the trunk and extremities. Examination revealed tense vesicles arranged in annular pattern on the nape, upper back, and extensor side of the upper arms (Figure 1). No new medications were initiated in the past 3 months, including antibiotics, angiotensin-converting enzyme (ACE) inhibitors, and nonsteroidal anti-inflammatory drugs (NSAIDs). A skin biopsy from the right upper arm showed a subepidermal blister with neutrophilic infiltrates at the basement membrane and papillary dermis. Direct immunofluorescence study revealed linear immunoglobulin A (IgA) deposition along the basement membrane (Figure 2). Clinicopathologic correlation led to a diagnosis of linear IgA bullous

dermatitis (LABD). Skin lesions resolved a month later following treatment with oral prednisolone (0.4 mg/kg per day) and topical corticosteroids. The activity of Crohn disease remained stable throughout the course of LABD.

An autoimmune bullous disease, LABD is characterized by annular or polycyclic, tense blisters typically on the extensor extremities, trunk, buttocks, and face with linear deposition of IgA at the basement membrane; LABD can be idiopathic or associated with drug exposure (eg, vancomycin, ACE inhibitors, NSAIDs), inflammatory bowel disease

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FIGURE 1. Tense vesicles arranged in annular configuration on the extensor side of the upper arms, with a characteristic “strings of pearls” sign.

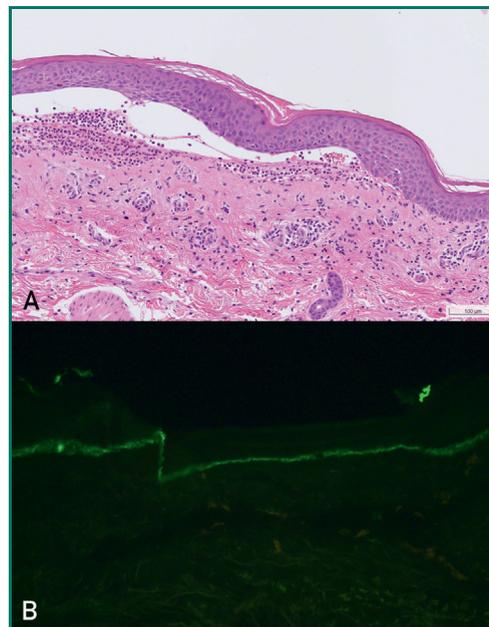


FIGURE 2. Histopathologic features. A, A subepidermal blister with neutrophilic infiltrates at the basement membrane and papillary dermis (hematoxylin and eosin stain). B, Linear immunoglobulin A deposition along the basement membrane in direct immunofluorescence examination.

(IBD), systemic lupus erythematosus, and malignancies.¹ In cases of IBD associated with LABD, ulcerative colitis is more frequently reported than Crohn disease.² LABD usually follows IBD and may occur during flare-ups of IBD.³ The mainstays of treatment for LABD are dapsone, sulfapyridine, and colchicine. Treating IBD may result in resolution of LABD, and vice versa.^{2,3} Patients presenting with gastrointestinal symptoms and otherwise unexplained LABD should be screened for IBD.

POTENTIAL COMPETING INTERESTS

The authors report no competing interests.

All authors substantially contributed to the collecting of data and drafting of this manuscript and approved the final version. The authors have obtained patient consent.

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