Coexistence of Psoriasis vulgaris and Pemphigus foliaceus

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Sir:

A number of combined cases of psoriasis and autoimmune diseases such as myasthenia gravis, Crohn's disease, ulcerative colitis, and systemic lupus erythematosus have been reported [1, 2]. Recently, there have been many reported cases of psoriasis associated with bullous pemphigoid [3]. However, the coexistence of psoriasis and pemphigus is a very rare event. Here we describe a patient with both psoriasis vulgaris and pemphigus foliaceus.

Report of a Case. A 51-year-old Japanese male developed brownish red papules and plaques on his lower legs in August 1986. The lesions were sharply demarcated and covered with layers of silver scales. He was treated with topical corticosteroids by his local physician under the diagnosis of psoriasis vulgaris. In April 1987, bullous and erosive lesions appeared on his neck and axilla, these later spread to the trunk and extremities. The patient was then referred to our outpatient department. On physical examination, the lesions were confluent, with various-sized flaccid bullae, erosions, scales and crusts being present (fig. 1). Nikolsky's sign was positive. He did not have any oral lesions. Biopsy studies were performed. Epidermis showed extensive acantholysis, subcorneal fissure and bulla (fig. 2). These findings tended to confirm the clinical diagnosis of pemphigus foliaceus. Direct immunofluorescent studies showed intercellular deposits of IgG and C3. By indirect immunofluorescence serum was positive, demonstrating circulating intercellular antibodies at a titer of 1:256. There were slight elevations of ESR, CRP and complement levels. Other serological studies and routine hematological tests were all within normal limits or were negative. Treatment with 60 mg of prednisolone daily was started. With time, the eruptions improved and we were gradually able to decrease the dose of prednisolone. For 6 months, neither bullous nor psoriatic lesions were observed. However, when the dose of prednisolone was reduced to 15 mg daily, erythema with white scales appeared on his trunk. Biopsy of these eruptions revealed acanthosis of epidermal rete ridges, parakeratosis, and absence of the granular layer. These eruptions confirmed the diagnosis of psoriasis vulgaris.

Comment. It has been known that psoriasis coexists with autoimmune diseases such as myasthenia gravis, Crohn's disease, ulcerative colitis, systemic lupus erythematosus, and bullous pemphigoid [1–3]. Pemphigus also coexists with other autoimmune disorders such as thymoma, myasthenia gravis, systemic lupus erythematosus, and bullous pemphigoid [4, 5]. However, the coexistence of psoriasis and pemphigus has only been very rarely reported. In the English literature, only 6 cases have been reported to our knowledge [6–9]. It is not easily determined

whether the association between psoriasis and pemphigus is a random event or not. However, we believe the association is more than a coincidence.

Sauder et al. [10] described a significant decrease in suppressor activity in psoriasis patients compared with normal individuals, and such lack of suppression of the humoral immune system could lead to autoantibody production against skin antigens. Grunwald et al. [9] suggested that the concurrence of psoriasis and pemphigus might be basically a result of immunological reactions not necessarily connected with the antipsoriatic treatment.

Furthermore, it is well known that plasminogen activator is increased in clinically psoriatic lesions [11]. Plasminogen activator also has an important role in the induction of acantholysis in pemphigus [12], and may have a bearing on the concurrence of psoriasis and pemphigus.

Fig. 1. The face was confluent with bullae, erosions, scales and crusts.

Fig. 2. Intraepidermal bulla with few acantholytic cells. Hematoxylin-eosin. x 200.

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In Reply. Nuchal Nevus flammeus

In one of the last issues of *Dermatologica* we proposed that nuchal nevus flammeus (NNF) might be a valuable marker indicating a more severe course of alopecia areata (AA) [1].

We would like to thank Prof. Manzke for his interest in our article [2]. His explanation about NNF is that in patients with AA it is rather a sign of epidermal atrophy visualizing the ectasia of subpapillary vessels in the nape than a concomitant skin abnormality.

Prof. Manzke's opinion needs in vivo measurements on epidermal thickness for further confirmation. However, in NNF biopsies from 5 AA patients we observed a moderate vasodilatation and no signs of epidermal atrophy (flattening of dermoepidermal grooves, thinning of epidermis, etc.) [1].

This view does not change the value of NNF as skin marker in AA prognosis , because , no matter whether it is due to epidermal thinning or not, this clinical sign (NNF) is observed with a high incidence in severe forms of AA [1].

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