Abstract N°: ID-533

Topic: Autoimmune disorders

A Case of Bullous Pemphigoid associated with Pembrolizumab Treatmentin a Patient with Bladder Cancer

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Introduction
N/A

Materials and Methods
N/A

Results

A 66-year-old man with a history of bladder cancer presented to the emergency department with multiple tense bullae and erosive ulcers involving the trunk and upper extremities. His medical history included type 2 diabetes mellitus, for which he had been treated with linagliptin for five years. In addition, he had been receiving pembrolizumab every three weeks for bladder cancer for the preceding 15 months. Several months before presentation, he had attended our clinic complaining of generalized pruritus and erythematous skin lesions without blister formation. Two weeks prior to the visit, he experienced worsening pruritus followed by the abrupt development of tense bullae, which rapidly evolved into painful, widespread erosions.

Bullous pemphigoid and toxic epidermal necrolysis were initially considered in the differential diagnosis. A 4-mm punch biopsy and direct immunofluorescence (DIF) study were therefore performed. Histopathologic evaluation demonstrated subepidermal blister formation accompanied by a dense eosinophilic infiltrate. DIF revealed linear deposition of IgG and C3 along the dermo-epidermal junction, confirming the diagnosis of bullous pemphigoid. The patient was treated with intravenous methylprednisolone at a dose of 80 mg daily for two weeks, followed by gradual tapering.

Drug-induced bullous pemphigoid is clinically and histologically indistinguishable from idiopathic disease, which often complicates diagnosis. Furthermore, symptom onset may be delayed for several months or even more than a year after exposure to the causative medication. Although more than 50 drugs have been reported as potential triggers of bullous pemphigoid, most evidence derives from isolated case reports. Recent case-control studies, however, have demonstrated a strong association with dipeptidyl peptidase-4 (DPP-4) inhibitors and immune checkpoint inhibitors, including pembrolizumab. In the present case, the patient had been exposed to both agents, and whether their concurrent use increases the risk of bullous pemphigoid remains to be determined.

Conclusions
N/A