Short Communication

Post-pemphigus acanthomata

Sir, a 19-year-old male presented with multiple erosions and verrucous lesions distributed all over the body. He developed flaccid blisters over the head and neck region 4 months back, which ruptured to form erosions. Gradually, they increased in number and size to involve the trunk and extremities. He had consulted a general physician and was clinically diagnosed as "pemphigus". He was prescribed oral prednisolone in a dose of 20mg/day. Unfortunately, the disease continued to progress and new lesions developed. Older lesions healed with verrucous prominences (**Figure 1a**, **1b** and **1c**). Then, he presented to us with increasing discomfort and significant deterioration in the quality of life. Tzanck smear from erosion showed acantholytic cells (**Figure 2**). Histopathology of the verrucous lesion from lateral aspect of chest showed hyperkeratosis, acanthosis, and papillomatosis (**Figure 3**). Direct immunofluorescence microscopy showed intercellular deposition of IgG and C3. With this background, a diagnosis of pemphigus vulgaris with post-pemphigus acanthomata was made. Routine laboratory investigations did not reveal any abnormality. The patient was treated with intravenous corticosteroid and oral azathioprine. On initiation of therapy, new lesions stopped appearing and old lesions healed with post-inflammatory hyperpigmentation (**Figure 1d**).

Pemphigus refers to a group of intraepidermal vesiculobullous disorders, wherein the flaccid blisters appear spontaneously and heal with hyper- or hypopigmentation.[1] However, a few cases heal with hyperpigmented, verrucous plaques and these plaques are known as "post-pemphigus acanthomata". Clinically, they resemble seborrhoeic keratoses, post-eczema

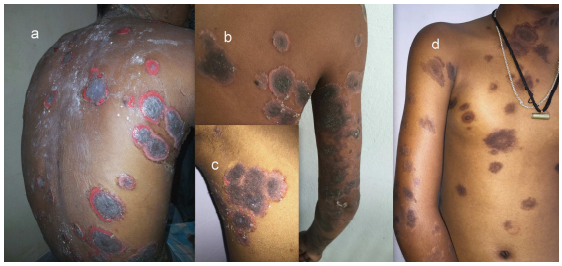

Figure 1: Moist hyperpigmented, verrucous plaques surrounded by erosions (a). 3 weeks post treatment, erosions are healing and verrucous plaques are becoming dry (b). Close-up of verrucous plaques (c). 8 weeks post treatment, lesions have healed with hyperpigmentation. (d)

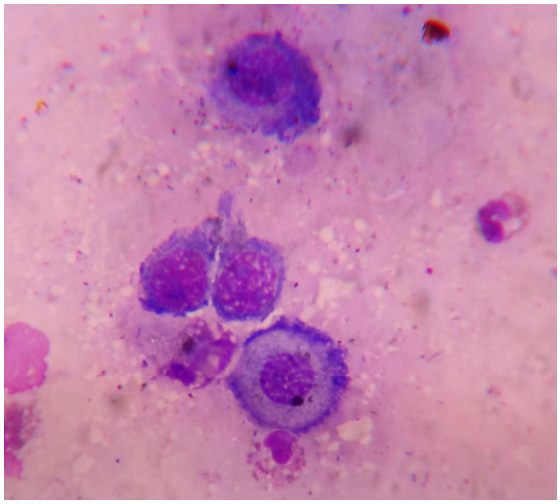

Figure 2: Tzanck smear from erosion showing acantholytic cells (Giemsa stain x 1000)

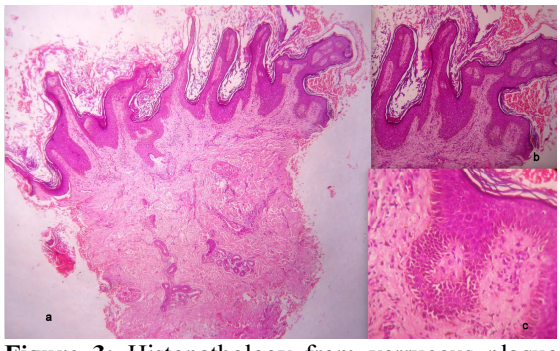

Figure 3: Histopathology from verrucous plaque showing hyperkeratosis, papillomatosis, and mild perivascular infiltration (a, H&E x 40). Higher magnification (b, H&E x 100 and c, H&E x 100)

acanthomata and acantholytic acanthoma. The lesions of post-pemphigus acanthomata usually develop during the remission phase of disease and undergo spontaneous involution with treatment. Histologically, it is

characterised by intraepidermal cleft, hyperkeratosis, acanthosis and papillomatosis. On direct immunofluorescence (DIF), there is a fishnet pattern of deposition of C3 and IgG in the intercellular spaces of epidermis. DIF positivity is a predictor of disease activity and is a marker of possible relapse of the disease in near future.[2-4] Thus, the presence of acanthomata lesions is an indirect clue for the dermatologist, that the disease is still active and the therapy must be continued.

References

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