Letters to the Editor

Pemphigus foliaceus occurring with adenocarcinoma of prostate

Sir,

A 73-year-old man presented with painful and burning vesiculo-bullous lesions that had developed sequentially over scalp, face, trunk and extremities, eroding after a few days and recurring episodically for the preceding one year despite treatment from private practitioners. Examination revealed multiple crusted erosions intermixed with hyperpigmented patches on these sites with a few intact vesicles and bullae [Figure 1a and b]. General physical and systemic examination were normal.

Histopathological examination revealed a subcorneal bulla containing a few acantholytic cells. A few plasma cells and lymphocytes were present in the dermis [Figure 2a and b]. Direct immunofluorescence of perilesional skin revealed IgG deposition in the intercellular spaces in the upper epidermis [Figure 2c] suggestive of pemphigus foliaceus. Absence of mucosal involvement, lack of vacuolar degeneration at the interface and absence...
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of apoptotic/dyskeratotic keratinocytes ruled out paraneoplastic pemphigus.

The patient responded poorly to daily oral prednisolone, 1 mg/kg given for 1 month. Detailed enquiry revealed that he had hesitancy and dribbling of urine. Urological work-up revealed elevated levels of prostate specific antigen (PSA) at 104.9 ng/mL. Histopathological examination of transurethrally resected prostatic tissue confirmed adenocarcinoma, Gleason score 4 [Figure 2d]. Bilateral orchidectomy was done and the urologist instituted oral leuprolide, a luteinizing hormone-releasing hormone agonist. Administration of exactly the same dosage of steroids as previously now led to prompt response of pemphigus within a fortnight. Steroids were gradually tapered off over 2 months after introducing dapsone as a steroid sparing agent. Follow-up after 6 months revealed normal skin and prostate specific antigen (PSA) levels returned to normal.

The malignancy most commonly reported with pemphigus foliaceus is thymoma.[1] Less commonly, mycosis fungoides, hepatocellular carcinoma, Kaposi sarcoma and non-Hodgkin lymphoma have been reported[3] and in one previous report, adenocarcinoma of prostate.[3] Paraneoplastic pemphigus is a subtype of pemphigus commonly associated with lymphoid neoplasms including non-Hodgkin lymphoma, chronic lymphocytic leukemia and Castleman disease. It is characterized clinically by severe mucosal erosions, polymorphic cutaneous eruptions, particularly on the upper body and palmo-plantar target lesions and serologically by the presence of antibodies to desmoplakin-1, envoplakin, periplakin and plectin and organ antigens.[4]

Of the epidermal and subepidermal immunobullous disorders, concurrent malignancy has been reported least commonly in pemphigus foliaceus.[1] Younus et al., in a study undertaken before paraneoplastic pemphigus was defined, reported 60 cases of malignancies in patients belonging to the pemphigus group; thymic malignancies being equally prevalent among pemphigus foliaceus and pemphigus vulgaris patients.[1] A recent report described 19 neoplasms in patients of pemphigus vulgaris: 12 skin cancers, 2 cervical cancers, 2 prostatic cancers and 1 each of breast, thyroid, and thymic cancers.[5]

The co-occurrence of adenocarcinoma of prostate with pemphigus foliaceus in our patient seems a chance association, as Curth’s criteria are not met. However, the improved response to treatment for pemphigus after surgery for prostatic adenocarcinoma suggests that tumor-induced immune dysregulation may have contributed to the initial recalcitrance of the disease.

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