ERYTHEMA MULTIFORME WITH DEPIGMENTATION
(Case report with review of literature)

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Summary

In the present paper, three cases of Erythema Multiforme (EM) with depigmentation are recorded The depigmentation is considered to be extremely rare. Depigmentation appeared after healing of the vesiculo-bullous and maculopapular type of eruption of EM. Repigmentation of the lesion occurred 4-8 months later with corticosteroid therapy. Erythema Multiforme with depigmentation in a Negro girl has been reported by Bleier in 1958[1].

Definition and Review of Literature

Erythema-multiforme (EM) is a distinctive clinical and histological reaction which can be precipitated by many agents. It was first described by Hebra in 1860 in the form of pleomorphic lesions confined to the skin. Later in 1866[2], he reported association of EM with pneumonia. Bazin in 1862[3], was the first to describe association of pleomorphic skin eruption of EM with stomatitis and ophthalmia. Later on confusion was created by a number of terms given by different authors, Fiessenger et al[4] named it "Ectodermosis erosiva Pluriorificialis", Stevens and Johnson[5] as "A new eruptive fever". Baader[6] coined the term "Dermatostomatitis," Behcet[7] suggested "Triple symptom complex", Stanyon[8] used the term "Mucosal respiratory syndrome". Klander[9] reported it as Ectodermosis erosiva pluriorificialis in American literature and now it is considered as a forme fruste of Stevens-Johnson's syndrome. At present Erythema multiforme is the accepted term for this distinct disorder which has a typical history, clinical picture and histological changes.

A clinical picture of EM is divided into three forms according to its severity (i) A papular or simplex form characterised by successive crops of dull red, flat maculopapules with cyanotic or purpuric centre on the backs of the hands, palms, wrists, forearms, feet, elbows, knees, face and neck. Occasionally, there may be bullae or erosion of mucous membrane (ii) A vesiculo-bullous or intermediate variety characterised by erythematous plaques, often with central bullae and marginal rings of vesicles (Herpes Iris of Bateman) their sites and numbers being similar to the first form. Mucous membranes are often severely involved. A severe bullous form known as Stevens Johnson syndrome is characterised by sudden onset, involvements of mucus membrane, bullae or typical maculopapular lesions of EM on skin which appear in crops. In addition, respiratory, renal, otitic and polyarthritic lesions may occur sometimes with a fatal outcome.

The exact aetiology of EM is not known. The vesicles and bullae are

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usually sterile. Cases of EM following viral infections have been reported by many authors[10-13]. March[14] reported EM after trichomonal infection and it has been reported after otherbacterial infections as well. EM has occurred following injection of number of drugs and after vaccinations[15-20]. A hyper sensitivity mechanism due to various factors has been postulated.

Typical histopathological changes in EM are seen in upper dermis and lower epidermis in the form of oedema, vasodilatation and lymphohistiocytic infiltrate in dermo-epidermal junction. Vacuolar degeneration of lower epidermis or necrosis of epidermal cells and subepidermal bullae are characteristic. Histopathology of oral lesion is similar to that of cutaneous lesion but with distinguishing features of liquefaction degeneration in upper epithelium followed by intraepithelial vesicle formation[21].

Case Reports

Case No. 1 :— 20 years old female presented with sudden eruption of EM on the dorsae hands, feet and face. Lesions on healing, left behind depigmentation in a ring like fashion. The patient was treated with 20 mg. of prednisolone per day. The lesions started to get repigmented after a period of one month. Complete repigmentation occurred after six months on a maintenance dose of 10 mg. of prednisolone per day.

Case No. 2 :— 35 years old female attended the Skin O. P. D. with history of recurrent erythematous maculopapular and vesiculo-bullous lesions on the dorsae of hands and feet, extensor surfaces of forearms and face for $2\frac{1}{2}$ years. Lesions on healing would leave behind annular depigmented spots. Patient was put on 10 mg. of prednisolone per day for a period of 8 months during which time complete repigmentation occurred at the sites of post-EM depigmentation.

Case No. 3 :— 18 years old male was admitted in Skin ward in October, 1974 with a sudden eruption of erythematous maculopapular and vesiculobullous lesion of EM present mainly on the dorsal surfaces of hands and feet with few scattered lesions on the trunk. Mucous membrane of the lips was also involved. 2-3 weeks after healing, depigmentation was observed. Patient was treated with 20 mg. of prednisolone orally per day which was tapered off to a maintenance dose of 10 mg. for a period of 4 months during which time complete repigmentation of the patches occurred. (Fig. Page No. 47)

Comments

All the three patients of EM presented here suffered from intermediate (ii) type of EM with vitiliginous depigmentation. The shape of depigmented lesions corresponded to the original lesions of EM and were arranged in a ring like fashion. Depigmentation in EM has been mentioned in the literature[1]. The present study reports the vitiliginous depigmentation following EM which is considered to be a rare, sequelae. In the experience of the authors, repigmentation of depigmented patches could be achieved with prolonged administration of low doses of oral prednisolone.

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Erratum

Volume No. 42, page No. 303, 1976 under ABSTRACTS

Article by Sehgal V.N. in para 1, second line :

" complete improvement was noted in 8.9% and partial improvement was recorded in 59.5% ". instead of "complete improvement was recorded in 59.5%."