Treatment of Generalized Bullous Pemphigoid with Topical Corticosteroids

Sir,

In an open prospective study, the efficacy of topical corticosteroid cream as first-choice therapy in generalized bullous pemphigoid (BP) was evaluated in 6 patients.

Although many studies have been performed in order to find a good alternative or adjuvant therapy to minimize the use of oral corticosteroids in the treatment of generalized BP (1–8), the mainstay of therapy is still high-dosage systemic steroids, in general associated with another immunosuppressive drug (9). This treatment can cause severe side-effects (10–11), especially in elderly patients who often have (pre-existing) medical problems.

Six consecutive patients (3 men and 3 women, ranging in age from 47 to 80 years), who were admitted to the hospital from May 1991 to August 1992 with generalized BP, were included in this study. The diagnosis was confirmed by direct immunofluorescence performed on perilesional skin.

They were treated with topical steroids according to the following tapering protocol. After the top of the blisters had been removed, clobetasol propionate cream 0.05% was applied twice daily on the defects and erythematous lesions with a margin of 10 cm. After re-epithelialization of the skin, treatment was continued with less potent steroid creams: betamethasone dipropionate 0.05% and later triamcinolone acetonide 0.1% on the remaining erythematous lesions and, depending on the general condition of the patient, continued on an outpatient basis. If an exacerbation of the BP occurred (two or more new blisters) clobetasol propionate was reintroduced. During this topical corticosteroid treatment no other form of therapy was used for BP. Drugs which might be causative agents for BP (12) were, if possible, stopped or replaced by others.

As Westerhof described earlier in 10 other topically treated patients (13), a good initial response to clobetasol propionate could be obtained. After 5 to 7 days no new blisters developed and re-epithelialization started. Complete re-epithelialization of the affected skin was achieved in 7 to 17 days, with a mean of 11 days. In 5 patients, BP was completely controlled with topical steroids, although in 4 patients clobetasol propionate cream had to be restarted more than once. In one patient systemic treatment was added to the topical treatment, because of frequent recurrences.

The total duration of therapy in 5 patients who finally experienced remission was 2,5 to 5,5 months.

For this treatment intensive and qualitatively high nursing care is needed. Apart from localized atrophy and telangiectasia in 3 patients, no secondary infections or severe side-effects were seen.

At the time of this report 3 of the 6 patients are still in remission. In the follow-up period (2–26 months), the other 3 patients (including the patient with systemic treatment) died of causes unrelated to the BP or topical treatment.

In conclusion, topical corticosteroids are an effective and safe treatment for generalized BP and should be considered in elderly patients who often have relative contraindications for systemic corticosteroids.

On the basis of these results, it would be interesting to compare systemic therapy for BP with topical corticosteroid therapy in a prospective randomized controlled study.

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