Tinea Imbricate- like Pemphigus erythematosus (Senear-Usher syndrome)!

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We present a 65-year-old man with a complaint of redness and ulceration on the scalp, as well as on the face, body and armpits, accompanied by burning and itching (fig. 1-4). Complaints date back to 9 months, gradually progressing, and the patient observed worsening in exposure to the sun. He has been treated topically with corticosteroids and emollients without effect. In the course of the dermatological examination, we found the presence of exfoliative erythrodermal and confluent plaques, in places with moist eroded surface, diffusively engaging the skin of the head, face, neck, trunk, back, both axillae and extensor surface of the both arms (fig. 1-4). Additionally, redness and secretion of whitish fluid

is observed. In the differential diagnostic aspect it was thought of lupus erythematosus, psoriasis, mycosis, seborrheic dermatitis, pemphigus foliaceus / erythematosus. A biopsy was taken for histological examination and direct immunofluorescence. Direct immunofluorescence results revealed intercellular deposition of IgG (+++) in the epidermis, as the finding corresponding to pemphigus foliaceus. Histological examination revealed data on diffuse hyperkeratosis, smoothing of the dermo-epidermal border, focal hydropic degeneration of the basal cells and possible lupus erythematosus. ANA screening (1: 320) was performed. In consultation with an ophthalmologist and dentist, acute

Figure. 1-4: Presence of tinea imbricate- like exfoliative erythrodermal and confluent plaques, in places with moist eroded surface, diffusively engaging the skin of the head, face, neck, trunk (1-2,4), back (3), both axillae and extensor surface of the both arms (1,4).

conjunctivitis, focal infection of dental origin, and bimetalism in the oral cavity were determined. Consultation with a cardiologist and echocardiography revealed the presence of an ascending aortic aneurysm with a recommendation for a CAT, which excluded the presence of dissection and a direction was given for hospitalization in the cardiac surgery unit for surgical treatment. On the basis of the clinical examination, invasive studies and ANA screening, the diagnosis of pemphigus erythematosus was accepted. Systemic treatment with Ceftriaxone 2 g / day i.v was performed for 7 days, with methylprednisolone aceponate 0.1% and moisturizing cream applied locally. Following exclusion of hepatitis B infection and tuberculosis, Methylprednisolone i.v therapy was initiated with an initial dose of 60 mg / daily followed by 40 mg / per day ambulatory with a dose reduction of 10% per week. At the same time, therapy with Azathioprine 2x50mg / per day was added on an outpatient basis. During the dehospitalization, guidelines were given for treatment of the dental infection.

Differentiation of pemphigus erythematosus (PE) from pemphigus foliaceus (PF) is usually done on the basis of clinical and histopathological data [1]. PE is considered to combine signs of PF and lupus erythematosus, with a more favorable course than PF [1]. Pemphigus erythematosus is also known in the literature as the so-called Senear-Usher syndrome [2]. According to the majority of authors, PE is a localized form of pemphigus foliaceus, mainly affecting the face and upper trunk [3]. In PE, blisters are rarely observed, as the skin involvement is usually in the form of erosions and crusts, which often need to be differentiated from impetigo, eczema or seborrheic dermatitis [4]. The histologic picture of PE and PF is similar, usually showing evidence of acantholysis and loss of intercellular adhesion between keratinocytes in the granular and subcorneal layers of the epidermis [4]. Direct immunofluorescence reveals intercellular deposition of IgG in the epidermis in both PF and PE [4,5]. An interesting form of PF is the endemic pemphigus foliaceus or fogo selvagem (FS), which has historically been

described as tinea imbricata – "tokelau", in 1903 [6]. It is a superficial mycosis, which is clinically characterized by the appearance of red-brown papules, gradually forming annular, concentric circles, and serpiginous or polycyclic squamous plaques, in which case we presented an interesting patient with Tinea imbricate-like pemphigus erythematosus [7]. The standard therapy for pemphigus foliaceus / erythematosus include systemic corticosteroid and immunosuppressive treatment, as the therapy with Methylprednisolone 0.5-1.0mg / kg and Azathioprine 50/2x50mg is considered to have good therapeutic effect [3,4].

We have presented an interesting case of tinea imbricate-like pemphigus erythematosus, also known in the literature as Senear-Usher syndrome.

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