

# IgA-Epidermolysis Bullosa Acquisita Associated with Lyme Borreliosis: A Case Report

Daniela R Petermann Smits<sup>1</sup>, Nadia H Shadid<sup>2</sup>, Valère J Goossens<sup>3</sup>, Gilles FH Diercks<sup>4</sup>, Peter M Steijlen<sup>2</sup> and Jan Willem Cohen Tervaert<sup>1\*</sup>

<sup>1</sup>Department of Internal Medicine, Division of Clinical and Experimental Immunology, Maastricht University Medical Center, PO Box 5800, 6202 AZ Maastricht, The Netherlands

<sup>2</sup>Department of Dermatology, Maastricht University Medical Center, PO Box 5800, 6202 AZ Maastricht, The Netherlands, GROW Research Institute for Oncology and Developmental Biology, Maastricht University, Maastricht, The Netherlands

<sup>3</sup>Department of Medical Microbiology, Maastricht University Medical Center, 6202 AZ Maastricht, The Netherlands

<sup>4</sup>Center for Blistering Diseases, Department of Dermatology, University Hospital Groningen, PO Box 30.001, 9700 RB Groningen, The Netherlands

## Introduction

We report a woman who developed IgA-epidermolysis bullosa acquisita (IgA-EBA) after a *Borrelia burgdorferi* infection. IgA-EBA is an autoimmune bullous disease with exclusive IgA deposition along the epidermal basement membrane zone. Cases with an association with drugs, rheumatoid arthritis, Hodgkin's disease and/or hypertension [1] have been described but an association with Lyme borreliosis has never been reported.

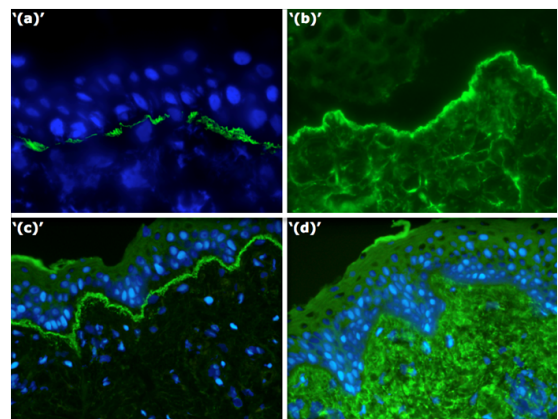
## Case Report

In 2007, a 39-year old Caucasian woman developed an erythematous lesion above her left breast, which evolved into an erythematous, concentric spreading and raised five-centimetre ring, leaving a vesicle filled with clear liquid in the centre. Despite living in an endemic region for ticks and having dealt with the removal of ticks in the past, she had not noticed a tick bite at the site where the lesion developed. During the six months that followed, several vesicular lesions on the left breast and shoulder developed. In 2008, lesions spread to the whole body, except for the face, the palms and the soles. In November 2008, a biopsy of the skin was suggestive for urticarial vasculitis. Treatment with clobetasol propionate cream 0,05% and levocetirizine dihydrochloride was started but was not effective.

We saw the patient in October 2009. Serology for *Borrelia burgdorferi* was strongly positive and these results were confirmed by a positive IgG and IgM blot. She was treated with doxycycline 100 mg twice daily for four weeks with no improvement. Treatment with hydroxychloroquine was started without a beneficial effect. Because of progression of the lesions in the facial area (Figure 1) dapsone 100 mg was started. A biopsy showed a subepidermal blister with a



**Figure 1:** IgA-epidermolysis bullosa acquisita. Development of vesicles and bullae on the previously eruption-free facial area, after treatment with hydroxychloroquine.



**Figure 2:** IgA-epidermolysis bullosa acquisita. Immunofluorescence analysis. (a) Deposition of linear IgA in a u-serrated pattern along the epidermal basement membrane in patient skin. (b) Binding of patient serum IgA autoantibodies to the dermal side of salt-split skin. (c) Patient serum IgA antibodies bind to laminin-332 knockout skin. (d) Patient serum IgA antibodies do not bind to type VII collagen knockout skin.

predominance of neutrophils. Immunofluorescence revealed a linear IgA deposition along the epidermal basement membrane, in a u-serrated pattern [2] (Figure 2). Indirect immunofluorescence on salt-split skin showed binding of IgA to the dermal side of the split. The combination of a linear u-serrated deposition pattern in patient skin and a dermal binding of antibodies on salt-split skin suggest epidermolysis bullosa [3]. Furthermore, knockout skin substrates [4], lacking laminin-332 showed binding of patient's IgA along the basement membrane, whereas her IgA did not bind to the type VII collagen knockout skin.

A diagnosis of IgA-EBA was made. Daily prednisone 25 mg was started and dapsone 100 mg was continued. During follow up

**\*Corresponding author:** Jan Willem Cohen Tervaert, Department of Internal Medicine, Division of Clinical and Experimental Immunology, Maastricht University Medical Center, PO Box 5800, 6202 AZ Maastricht, The Netherlands, E-mail: [jw.cohentervaert@maastrichtuniversity.nl](mailto:jw.cohentervaert@maastrichtuniversity.nl)

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prednisone could not be decreased below 10 mg daily because of recurrence of the dermal lesions.

## Discussion

Lyme borreliosis is an inflammatory disease transmitted by three different tick species of the spirochete *Borrelia burgdorferi* [5]. Despite the fact that *B. burgdorferi* is very susceptible to antibiotics, some patients develop chronic persistent disease after treatment.

We postulate that in our patient chronic Lyme borreliosis may have caused an autoimmune activation, resulting in the development of IgA-EBA. The development of autoimmunity could be mediated directly or indirectly by intracellular persistence of *B. burgdorferi* [6]. Alternatively, there might be a homology between type VII collagen and Borrelia proteins, leading to molecular mimicry [5]. Further studies are needed to evaluate the possibility of *Borrelia burgdorferi* being a causative agent for IgA-EBA.

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