Gynecology & Obstetrics
ISSN: 2161-0932

Sahli et al., Gynecol Obstet (Sunnyvale) 2016, 6:9
DOI: 10.4172/2161-0932.1000398

Case Report Open Access

Pemphigoid Gestationis: A Case Report and Review of Literature

Sana Salhi*, Arij Bouzid, Mahassen Ben Abdallah and Anis Haddad

Department of Obstetrics and Gynecology, Maternity and Neonatology Center, University Hospital of Monastir, Monastir, Tunisia

***Corresponding author:** Sana Sahli, Department of Obstetrics and Gynecology, Maternity and Neonatology Center, University Hospital of Monastir, Monastir, Tunisia, Tel: 0021625986115; E-mail: snsalhi3@gmail.com

Received Date: Aug 02, 2016; **Accepted Date:** Sep 21, 2016; **Published Date:** Sep 27, 2016

Abstract

Pemphigoid gestationis is a rare autoimmune blistering disease specific to pregnancy. It is characterized by pruritic, urticarial plaques with development of tense vesicles and bullae within the lesions. Recurrence with subsequent pregnancies are often more severe and may be associated with miscarriages, prematurity, low birth weight and rarely fetal death. We report this case of pemphigoid gestationis in view of the importance of early diagnosis and treatment for prevention of fetal risk.

Keywords: Pemphigoid; Pregnancy; Fetus; Skin

Introduction

Gestational (pemphigoid gestationis, PG) is an uncommon immune system skin issue that happens amid pregnancy.

PG has a place with the pemphigoid gathering of immune system skin sicknesses that cause rankling of the skin and mucosal films [1].

It is an uncommon sickness with an occurrence of 1 in 50,000 pregnancies. PG ordinarily shows amid the second or third trimester with repeat in consequent pregnancies. It can be analyzed by histopathology and direct immunofluorescence which is corroborative. Systemic steroids are the backbone of treatment.

Case Report

A 23 year old normotensive, non-diabetic female, gravid 1, nulliparous, with 30 weeks incubation gave severly pruritic emission on appendages and trunk of 2 weeks length. The emission began with extreme pruritus once again trunk and appendages took after two days by raised ruddy sores respectively on trunk and both upper and lower appendages over a time of 2-3 days (Figure 1).

The patient had not taken any treatment that time with the exception of some topical arrangements. She didn't utilize oral contraceptives and did not report a flare with her menses.

There was no noteworthy family or medication history.

Her haemogram, liver capacity tests, kidney capacity tests and stomach ultrasonography was typical.

The analysis of PG was made by a dermatologist.

The patient was dealt with by oral prednisolone 40 mg day by day for 1 week and decreasing 5 mg at regular intervals until a support measurements of 20 mg day by day was accomplished. The patient was likewise given chlorpheniramine 25 mg thrice every day and topical mupirocin salve for the crusted regions.

The patient was on customary development and support measurements of 20 mg day by day till she delivered and postpartum for 1 month. She delivered, vaginally at term, a healthy child.

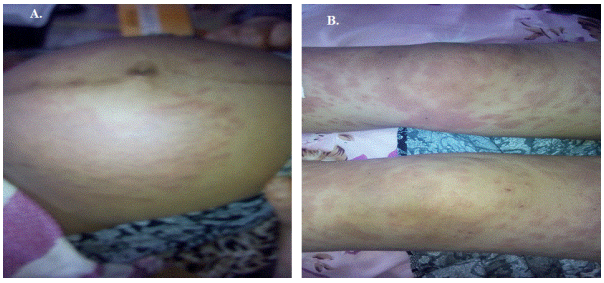

Figure 1: Physical examination uncovered respectively circulated erythematous papules and plaques with a couple target injuries, diffuse vesicular plaques over entire trunk including neck and different erythematous papules on the thighs. Palms, soles and mucous layers were not included.

Discussion

PG is evaluated to happen in one out of around 40,000-50,000 pregnancies [1]. PG may show up whenever amid pregnancy or puerperium, however the most well-known time of side effect onset is amid the second and third trimester. Extreme stomach tingling for the most part starts around the navel, with changed red papules, urticarial plaques or annular target sores (erythema multiforme - like) showing up in the bothersome zones, trailed by rankling following a couple of weeks. Bullous injuries shift from little vesicles to extensive rankles with a thick rooftop; nonetheless, some PG patients have no rankles by any means.

The manifestations of PG typically mitigate a couple of weeks before conveyance, however the sickness is re actuated in 75% of the patients at the season of conveyance. The dispatching, backsliding course of the illness has been thought to be connected with progestin, which has immunosuppressive properties, and with changes in progestin levels: an expansion in late pregnancy took after by a sharp fall amid conveyance [1,2]. The pathogenesis of PG stays obscure.

A biopsy for histopathology is not required; the determination depends on clinical picture, direct immunofluorescence microscopy and serology.

On the off chance that PG is suspected, estimation of serum BP180 neutralizer level is suggested, as it associates with the level of malady seriousness and encourages evaluation of treatment reaction [3,4].

Patients with PG ought to be distinguished as a high-hazard pregnancy and be taken after as needs be. Fetal dangers incorporate unnatural birth cycles, rashness, low birth weight and infrequently fetal passing. Five to 10% of neonates have a transient sub-epidermal rankling that determines all alone with no sequelae [5]. Systemic corticosteroids remain the backbone of treatment in the low dose of 20-60 mg day by day yet higher doses up to 180 mg day by day have been accounted for [2]. Upkeep treatment, by and large at a lower dose, might be required all through incubation and baby blues.

Repeat of PG in consequent pregnancies is likely, and indications are typically more extreme, with prior onset. In patients with a prior PG scene the probability of pregnancy without any indications is evaluated to be 5-8%, however the explanation behind the absence of side effects is obscure [2,6].

At the baby blues examination, moms with PG ought to be helped to remember the likelihood of backslide amid feminine cycle and/or regarding hormonal preventative use. Defenselessness for repeat may endure for quite a long time [7].

Conclusion

Gestational pemphigoid is an uncommon skin issue in pregnancy. The extreme tingling and rankling brought about by the infection can be very crippling. The analysis of PG is made in a specific consideration setting at a dermatology division.

Since PG is connected with a danger of rashness and fetal development limitation, pregnancy checking by an obstetrician is prescribed. Moms with PG ought to be educated of the characteristic course of the malady, great fetal guess, the likelihood of backslides after conveyance, and the danger of backslides in ensuing pregnancies and with hormonal contraception.

References

1. Semkova K, Black M (2009) Pemphigoid gestationis: current insights into pathogenesis and treatment. Eur J Obstet Gynecol Reprod Biol 145: 138-144.
2. Jenkins RE, Hern S, Black MM (1999) Clinical features and management of 87 patients with pemphigoid gestationis. Clin Exp Dermatol 24: 255-259.
3. Sitaru C, Powell J, Messer G, Brocker EB, Wojnarowska F, et al. (2004) Immunoblotting and enzyme-linked immunosorbent assay for the diagnosis of pemphigoid gestationis. Obstet Gynecol 103: 757-763.
4. Sitaru C, Dahnrich C, Probst C, Komorowski L, Blocker I, et al. (2007) Enzyme-linked immunosorbent assay using multimers of the 16th non-collagenous domain of the BP180 antigen for sensitive and specific detection of pemphigoid autoantibodies. Exp Dermatol 16: 770-777.
5. Shornick JK, Black MM (1992) Fetal risks in Herpes gestationis. J Am Acad Dermatol 26: 63-68.
6. Holmes RC, Black MM, Jurecka W, Dann J, James DC, et al. (1983) Clues to the aetiology and pathogenesis of herpes gestationis. Br J Dermatol 109: 131-139.
7. Kroumpouzos G, Cohen LM (2003) Specific dermatoses of pregnancy: an evidence-based systematic review. Am J Obstet Gynecol 188: 1083-1092.