Pruritus with pemphigoid autoantibodies is the tip of an iceberg.

Pruritus with pemphigoid autoantibodies is the tip of an iceberg

To the Editor: I read with interest the recent study in which Lamberts et al1 describe the clinical features and disease course of a cohort of patients with nonbullous pemphigoid (NBP). Consistent with previous reports, they found that there is significant variability in the cutaneous manifestations of NBP, ranging from papules and nodules to urticarial plaques and eczematous lesions. They also confirmed the low rate of progression to blister formation, adding further weight to the view that NBP represents a distinct entity rather than a prodrome of bullous pemphigoid as was once thought.2

Although many cases of NBP present with skin lesions, Lamberts et al1 identified a significant minority of patients who had pruritus without rash, a condition that could be referred to as pruritus with pemphigoid autoantibodies (PPA). Lamberts et al found that this group had substantial diagnostic delays, and they suggest testing for pemphigoid autoantibodies, particularly in elderly patients with chronic itch.

Testing for antiebasement membrane zone anti-bodies in patients with pruritus without rash is not a universal practice, and guidelines from the British Association of Dermatologists3 and the European Academy of Dermatology and Venerology4 do not recommend this as a first-line investigation (Table I). However, these autoantibodies are rare in the general population, and they are as likely to have diagnostic relevance in patients with pruritus as they do in patients with skin lesions of NBP.

It is not clear if Lamberts et al1 routinely test their patients with chronic pruritus for pemphigoid autoantibodies, but the prevalence of PPA would almostcertainlybehigherif systematiccasefinding was undertaken. These patients may benefit from therapies known to be effective in NBP, such as methotrexate and whole-body application of superpotent topical corticosteroids. That being said, the question of whether this testing is cost effective must be asked, given that these treatments are already used in the empirical management of chronic refractory pruritus without regard to autoantibody status.5

Table I. Guidelines for the evaluation of pruritus

Guideline	First-line investigations
British (BAD)[3]	FBC, ESR or CRP, urea and electrolytes, liver function tests, ferritin, and chest radiography*
European (EADV and EDF)[4]	FBC and differential, ESR, urea and creatinine, liver enzymes and LDH, TSH, glucose, ferritin, CRP, chest radiography, and stool occult blood if age over 40 years†

ALP, Alkaline phosphatase; *BAD*, British Association of Dermatologists; *CRP*, C-reactive protein; *EADV*, European Academy of Dermatology and Venereology; *EDF*, European Dermatology Forum; *ESR*, erythrocyte sedimentation rate; *FBC*, full blood count; *LDH*, lactate dehydrogenase; *TSH*, thyroid-stimulating hormone.

∗Biopsy and indirect immunofluorescence are suggested to be considered in some cases.

†Biopsy with direct immunofluorescence is listed as a second-line investigation.

Lachlan A. Byth, MD

FromIpswich Hospital and Griffith University School of Medicine, Southport, Queensland, Australia.

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Correspondence to: Lachlan Byth, MD, Ipswich Hospital, Chelmsford Ave, Ipswich, Queensland 4305, Australia

E-mail: lachbyth@gmail.com

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