Letters to the Editor

Carbamazepine-induced bullous eruption or bullous pemphigoid?

Sir,

We read with great interest the paper of Godden and McPhie which was published recently in the *Postgraduate Medical Journal* (Godden and McPhie, 1983) describing a patient who developed a bullous skin eruption which they associated with coma induced by carbamazepine overdose.

We strongly believe that one has to rule out the diagnosis of bullous pemphigoid in such a patient, which, unfortunately, the authors failed to do. The age of the patient, the clinical picture of vesicles and bulla up to 3 cm in diameter, and the histology of subepidermal vesicle favour the diagnosis of bullous pemphigoid. Direct immunofluorescence study was not carried out. Negative indirect immunofluorescence does not rule out the diagnosis of bullous pemphigoid since it may be negative in about 20% of patients with bullous pemphigoid (Maize and Provost, 1983; Lazaro-Medina *et al.*, 1983). The histological description does not provide sufficient information as to which kind of inflammatory cells were predominant in the dermis and vesicle cavity.

Our conclusion is that this patient may have had bullous pemphigoid, and that it was unrelated to the coma induced by carbamazepine.

Yours faithfully,
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References

- GODDEN, D.J. & MCPHIE, J.L. (1983) Bullous skin eruption with carbamazepine overdose. *Postgraduate Medical Journal*, **59**, 336.
LAZARO-MEDINA, A., ROBBINS, T.O., BYSTRYN, J.L. & ACKERMAN, A.B. (1983) Limitation in the diagnosis of vesiculobullous diseases. *American Journal of Dermatology*, **5**, 7.
MAIZE, J.C.L. & PROVOST, T.T. (1983) Value of immunofluorescent techniques in the study of bullous disease. *American Journal of Dermatology*, **5**, 67.

The above letter was sent to Drs McPhie and Godden who replied as follows:

Sir,

The diagnosis of bullous pemphigoid was indeed considered in this patient. However, at a histological level, the early total necrosis of the epithelium roofing the bulla and the vascular changes in the dermis with perivascular acute inflammatory cell infiltration were in keeping with a severe erythema multiforme. To further clarify the diagnosis of this biopsy, direct immunofluorescence (Mera, Young and Bradfield, 1980), and also immunoperoxidase study (Turbitt *et al.*, 1982), were carried out on paraffin sections of the biopsy with negative results. Both techniques could reasonably be expected to show positive staining patterns in bullous pemphigoid. I do agree, however, that negative indirect immunofluorescence may be misleading in bullous pemphigoid.

Yours faithfully,
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References

- MERA, S.L., YOUNG, E.W. & BRADFIELD, J.W.B. (1980) Direct immunofluorescence of skin using formalin-fixed paraffin-embedded sections. *Journal of Clinical Pathology*, **33**, 365.
TURBITT, M.L., MACKIE, R.M., YOUNG, H. & CAMPBELL, I. (1982) The use of paraffin-processed tissue and the immunoperoxidase technique in the diagnosis of bullous diseases, lupus erythematosus and vasculitis. *British Journal of Dermatology*, **106**, 411.

Drs McPhie and Godden originally submitted a photomicrograph of the lesion which was not published. Editor.