Bullous Pemphigoid and Amyotrophic Lateral Sclerosis

A New Clue for Understanding the Bullous Disease?

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Background: Bullous pemphigoid (BP) occurs in many patients with multiple sclerosis. Isolated cases of BP in patients with other neurological disorders further support a pathogenetic association between cutaneous and neurological diseases. Any description of BP in patients with amyotrophic lateral sclerosis is lacking.

Observations: We studied a French population of 168 patients with typical amyotrophic lateral sclerosis. Among these, 3 had clinical and histological features of BP. The mean age of the patients was 54 years. None was known to have autoimmune disorders. Results of immunoblot analysis disclosed both anti-BP antigen 1 and anti-BP antigen 2 antibodies.

Conclusions: Bullous pemphigoid seems to be unexpectedly associated with amyotrophic lateral sclerosis. On the basis of the cases presented herein, we discuss the epidemiological significance of the association and the possible interrelation between BP antigen 1 and neurofilaments in the pathogenesis of both disorders.

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present (1/10) with antibodies binding to the roof of the salt-split skin. Immunoblot analysis results disclosed both anti-BPAG1 and anti-BPAG2 antibodies. Treatment was begun with 1 mg/kg per day (100 mg/d) of prednisone with antiseptic care and classic adjuvant corticosteroid therapy. Neither the study medication nor baclofen therapy was discontinued. The outcome was favorable, and the corticosteroid treatments were discontinued after 5 months. The patient died of respiratory failure 7 months after the onset of BP.

CASE 2

A 47-year-old woman, affected by ALS for at least 9 years, was enrolled in the riluzole group (100 mg/d). She had been treated for more than 3 years with dantrolene, dihydroergotamine mesylate, temazepam, amitriptyline hydrochloride, theophylline, and oral contraceptives. Because of acne, she had undergone 6 months of minocycline treatment. She had begun treatment with 30 mg/d of baclofen 10 months prior the onset of BP. The patient had severe functional disability with complete paralysis of the forelimbs, dysphonia and dysphagia, and stiffness and fasciculations of the tongue. Nine months after enrollment, she developed papulous lesions of the elbows diagnosed as prurigo. She also had dyshidrotic lesions on the palms and soles. After a week, she had extensive crusted and bullous lesions of the axillas and the flexor forearms, and she was hospitalized. She presented with a vesicular and bullous, annular, crusted, and surinfected dermatitis localized to the anterior chest, axillas, pubis, lower legs, and arms (Figure 3). Her mucous membranes were normal. She had hypereosinophilia (630/mm³) and hypogammaglobulinemia (7.8 g/L), and BP was confirmed by the presence of subepidermal blisters associated with linear deposits of C3 and IgG along the basal membrane zone. Circulating antiepidermal antibodies were not found. Immunoblot analysis disclosed both anti-BPAG1 and anti-BPAG2 antibodies. Treatment was begun with 1 mg/kg per day (45 mg/d) of prednisone, antiseptic care, and classic adjuvant corticosteroid therapy. Neither the study medication nor baclofen treatment was discontinued. The outcome was dramatically favorable, and the prednisone dose was slowly decreased. The corticosteroid treatments were stopped after 14 months. A relapse occurred 9 months later, and treatment with oral prednisone was resumed with a good response. The patient was still alive at the end of the study.
A 68-year-old man, affected by ALS for at least 3 years, was enrolled in the placebo group. For more than 6 months, the patient received treatment with baclofen (40 mg/d), fluoxetine hydrochloride, vitamins B1, B2, B3, B4, and B5, thiamine hydrochloride, riboflavin, pyridoxine hydrochloride, tetrazenam (25 mg/d), and hydroxyzine hydrochloride (25 mg/d). The patient had severe functional disability with paralysis of the lower limbs, swallowing difficulties, and dysphonia. He was hospitalized in a long-term unit when, 1 month after enrollment, pruritus, generalized eczema, and pseudo-urticarial lesions occurred. The lesions were localized on the anterior part of the trunk and the proximal part of the lower limbs. He had hyperesoinophilia (1562/mm³), and BP was confirmed by the presence of subepidermal blisters associated with linear deposits of C3 and IgG along the basal membrane zone. Dosing of circulating anti-epidermal antibodies was not performed. Results of immunoblot analysis disclosed both anti-BPAG1 and anti-BPAG2 antibodies. Treatment was begun with 20 mg/d of prednisolone and vitamins, but baclofen therapy was still given during the following 4 weeks. Nineteen days later, dermatological lesions had disappeared, and eosinophils had returned to normal count. Treatment with the corticosteroids was stopped after 4 months of treatment. The patient died of respiratory failure 12 months after the onset of BP.

**COMMENT**

All 3 of the reported patients had advanced ALS of long standing, which is a progressive and fatal neurodegenerative disorder (incidence of 1 to 2 per 100,000 per year in the United States). Also, in all 3 patients, a bullous disease developed. The clinical course, results of laboratory data, including immunoblot analysis, and prompt response to oral corticosteroids were consistent with BP. Moreover, 2 patients presented with dyshidrosiform pemphigoid, now recognized as a possible form of BP. The mean age of the 3 patients at the onset of BP was 52 years, which is substantially lower than the average age of onset of BP. The 3 patients belong to a French study population of 168 patients with ALS, giving a theoretical BP prevalence of 1.8% during the 11 months of the trial. As a result of laboratory data, including immunoblot analysis, and prompt response to oral corticosteroids, the association between BP and ALS is more than coincidental.

As a matter of fact, various chronic neurological disorders have been reported in association with BP, eg, multiple sclerosis, posttraumatic (Jean-Claude Roujeau, MD, personal communication, 1991) or ischemic paresia, and Shy-Drager syndrome, suggesting that these diseases share a feature able to induce the bullous disease. The role of drugs should be considered. The experimental drug riluzole, given to our ALS population, cannot be considered an inducer because 2 of the 3 patients received the placebo. Baclofen, a muscle relaxant, could be a good candidate because it is quite commonly prescribed for patients with paralytic neurological disorders, but if baclofen were an inducer, the prevalence of BP in such patients would have been much higher. Moreover, baclofen had been taken for weeks to years by our patients with ALS, and that treatment was not discontinued even after clearing of BP under specific therapy. Also, BP has occurred in patients with multiple sclerosis not treated with baclofen, and baclofen was not found to be a risk factor of BP in a recent case-control study. The high BP risk factor in these chronic neurological paralytic disorders could be the bedridden and/or parietic state. The occurrence of BP on only the paretic side of a hemiplegic patient would seem to support this clinical hypothesis. Moreover, we looked for the neurological status of the patients reported in the literature with both multiple sclerosis and BP. When it was specified (in at least 14 of 18 patients), all had long-standing, advanced multiple sclerosis with chronic definitive paresia. Lastly, our patients with BP had limb function that was much more altered than that in the total ALS population.

Neurologically, various pathogenic hypotheses have been forwarded for the causes of ALS, including immunological factors or increased susceptibility to gluteamate toxic effects in critical parts of the nervous system. Cutaneously, light and electron microscopic alterations of skin connective tissue have recently been described in 7 patients with ALS, with a cutaneous deposition of β-amyloid protein. Moreover, 1 study showed a decreased type IV collagen immunoreactivity of the basement membrane of the skin, which was even more substantial in patients with disease of longer duration. The cutaneous consequences of these findings are not yet known. What could be the biological link between neurological and skin disorders? Interestingly, there are 2 isoforms of BPAG1, an epithelial one and a neuronal-specific one (BPAG1-n). Mice that are BPAG1 null have developed severe neurodegeneration and dystonia typical of dystonia muscularum mice. The candidate dystonia muscularum gene, dystonin, encodes cytoskeletal linker proteins capable of anchoring neuronal intermediate filaments to actin cytoskeleton. Massive neurofilament conglomeration in motor neurons has occurred in...
a transgenic mouse model of motoneuron disease and in the early stages of ALS.\textsuperscript{12,25} It could be postulated that the accumulation of intermediate filaments could favor an immune-specific response, including a cross-reaction between the 2 isoforms (nervous system and skin) of BPAG1. 

Surely, extrapolation of the concept should include neurological evaluation, eg, clinical, biochemical, or immunological, in the classic population of patients with BP. However, in a mouse superoxide dismutase 1–mediated form of ALS, neither initiation nor progression of pathology required an axonal neurofilament cytoskeleton.\textsuperscript{26} Moreover, many sorts of mutations occur in ALS,\textsuperscript{27} which raises the question of the mechanisms of the motor neuron death in patients with ALS with mutations of neurofilament-heavy genes.

In conclusion, more studies are warranted to explain why BP is sometimes associated with some chronic neurological paralytic disorders. These studies might also explain why BP is so strongly linked with old age.

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REFERENCES


