

SHORT COMMUNICATIONS

A female with thick intertriginous vegetative plaques

Brandon T. Beal, MD¹; Hannah Cundall BS²; Anthony P. Fernandez, MD, PhD³

¹Department of Dermatology, Cleveland Clinic, Cleveland, OH

²School of Medicine, Case Western Reserve University, Cleveland, OH

³Department of Dermatology, Cleveland Clinic, Cleveland, OH

CASE REPORT

A woman in her 80's presented with exudative, malodorous, and vegetative plaques in the bilateral axillary vault, groin, and right inframammary fold for 18 months (Figure 1). Her past medical history was significant for a remote history of breast cancer treated with unilateral left mastectomy without recurrence. She denied history of inflammatory bowel disease (IBD) and gastrointestinal symptoms. Oral and ocular examinations were unremarkable. Work-up was notable for a peripheral eosinophilia (24.1%). Indirect immunofluorescence (IF) for IgG and IgG4 antibodies and enzyme-linked immunosorbent assay (ELISA) for desmoglein (Dsg) 1 and 3 antibodies were negative. A 4-mm punch biopsy was obtained (Figure 2). Direct immunofluorescence (DIF) to evaluate for pemphigus vegetans revealed weak granular deposition of complement C3 at the basement membrane zone.

DISCUSSION

Pyodermatitis vegetans (PDV) is a rare cutaneous inflammatory disease characterized by thick intertriginous vegetative plaques and peripheral

eosinophilia (1). Pyostomatitis vegetans is characterized by pustular and vegetative plaques of the oral mucosa, and is considered to be the oral equivalent of PDV. Pyodermatitis-pyostomatitis vegetans is often associated with IBD, in particular ulcerative colitis (2,3).

PDV can be difficult to distinguish from pemphigus vegetans, a rare autoimmune bullous disease, since the two disorders share many clinical and histologic features.



Figure 1: Plaques present in the inframammary fold.

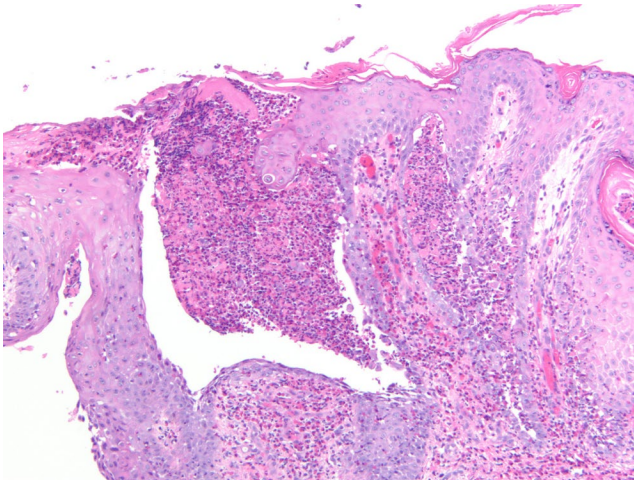


Figure 2: Lesional hematoxylin-eosin staining demonstrated mild spongiosis with abundant eosinophils, prominent epidermal acanthosis, intraepidermal microabscesses with eosinophils, and a dense perivascular and interstitial inflammatory infiltrates with eosinophils and neutrophils.

Common histologic findings in PDV include intraepidermal eosinophilic microabscesses, eosinophilic and neutrophilic infiltrates, and acanthosis (1,4). Unlike PDV, pemphigus vegetans is not associated with IBD (5). DIF and IF are crucial to distinguish between these disorders (4). Pemphigus vegetans DIF demonstrates IgG and C3 epidermal deposits and IF or ELISA reveals IgG antibodies against Dsg 3 (4).

In summary, we present a case of PDV without mucosal involvement and not associated with IBD. This case highlights a rare disease entity whose clinical and histologic features are important for dermatologists and dermatopathologists to be knowledgeable about.

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Corresponding Author:

Brandon T. Beal, MD
 Department of Dermatology, Cleveland Clinic
 Cleveland, OH
bealb@ccf.org

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