Linear IgA Dermatosis

Introduction

Synonym: linear IgA bullous dermatosis

Linear immunoglobulin A (IgA) dermatosis (LAD) is an autoimmune condition in which there is a linear deposition of IgA at the basement membrane zone (BMZ). The disease affects both children and adults. It may be drug-related or non-drug-related. In the non-drug-related category the cause is mostly unidentified. However, several cases have been reported following an episode of infection (eg, typhoid, brucella, tuberculosis, varicella, herpes zoster, gynaecological infections, upper respiratory infections). In children, the condition has been known historically as chronic bullous dermatosis of childhood.

Histopathology[1]

LAD is an autoimmune disease histopathologically characterised by the linear deposition of IgA at the BMZ. One function of the BMZ is to maintain the contiguity of the dermal-epidermal junction; antibody deposition causes complement fixation and neutrophil chemotaxis (rapid migration of neutrophils to sites of inflammation), eventually resulting in blister formation. It has recently been found that IgA autoantibodies from patients with LAD induce granulocyte-dependent dermal-epidermal separation in cryosections of human skin.

At the molecular level, various antigens have been identified, some of which are also seen in patients with bullous pemphigoid. Various types of dermal proteins have been identified as antigens. It is increasingly acknowledged that LAD can be divided into various subtypes depending on antigen targets and histopathology.

The immune pathology appears to be identical in adults and children.

Epidemiology[2]

This is a rare condition with an incidence in Western Europe of 0.5 per million. There are no figures for the incidence in children. Some studies have reported a slight preponderance of women.

The distribution of the age of onset seems to follow a bimodal pattern. In children, the age range is from 6 months to 10 years, with a mean of 3.3-4.5 years. In adults, the range is from 14-83 years with a mean of 52 years. Drug-induced disease is more prevalent in older people, probably because they are most likely to be on medication.

Presentation[3]

History

Before the appearance of the rash, there may be chronic pruritus or acute itching or burning. Patients developing ocular lesions may initially note pain, grittiness or discharge.

As with any patient presenting with a rash, a detailed medication history should be taken. The rate of spread of the blisters is variable. They tend to appear quickly in drug-induced cases. In vancomycin-induced cases the onset ranges from 1-13 days after the first dose.

Examination

Several skin presentations may occur:

- Clear round or oval blisters on normal underlying skin.
- Small blisters (vesicles) or large ones (bullae), often target-shaped, surmounting an erythematous area of skin which is flat or raised.
- New vesicles developing in a ring around an old one (the ‘string of beads’ sign).
- A crop of vesicles developing close together (‘cluster of jewels’ sign).
- Crusts, scratch marks, sores and ulcers.
- Lesions which mimic erythema multiforme, bullous pemphigoid and dermatitis herpetiformis.
- 50% of patients have blisters and ulcers around the mouth and lips.
- Ophthalmological findings may include subconjunctival fibrosis and shrinkage of the fornices.

The distribution of the skin lesions varies between children and adults. Children tend to get them on the lower abdomen, anogenital areas, perineum, hands, feet and face. In adults, lesions tend more commonly to develop on the trunk and limbs. In both age groups the distribution may be symmetrical or asymmetrical.

Differential diagnosis

A number of skin conditions have an almost identical appearance. These include:
Bullous pemphigoid
Dermatitis herpetiformis
Lupus erythematosus
Epidermolysis bullosa acquisita

Investigations\cite{2}

- Histopathology of a skin biopsy shows subepidermal blistering, differentiating the condition from diseases in which blistering occurs within the epidermis (eg, pemphigus).
- Direct immunofluorescence reveals IgA deposition along the basement membrane.
- Serum IgA levels may be raised but this occurs more often in the childhood version.
- Techniques to identify individual antigens within the BMZ are available but these are more research tools than diagnostic investigations.

Associated diseases\cite{4,5}

- Chronic kidney disease
- Immune complex glomerulonephritis
- Lymphocytic colitis
- Lymphoma
- Other malignant tumours
- Psoriasis
- Rheumatoid arthritis
- Sarcoidosis
- Ulcerative colitis

Associated drugs\cite{6,7}

Vancomycin is the most common drug involved. Other drugs implicated include:

- Amiodarone
- Atorvastatin
- Captopril
- Cefamandole
- Ceftriaxone
- Furosemide
- Glibenclamide
- Interleukin-25
- Lithium carbonate
- Metronidazole
- Non-steroidal anti-inflammatory drugs
- Penicillin
- Phenytoin
- Somatostatin
- Trimethoprim-sulfamethoxazole

Management\cite{4}

Ruptured lesions and erosions may require sterile dressings. Large bullae do not require any particular treatment if intact. Infection lesions should be treated with topical mupirocin and sterile dressings twice-daily.

Dapsone is the treatment of choice for non-drug-related dermatitis. Sulfapyridine causes fewer adverse effects but is not as effective.

Other treatments which have been reported to help some patients include:

- Corticosteroids (prednisone or prednisolone)
- Tetracycline antibiotics
- Erythromycin
- Colchicine
- Mycophenolate mofetil
- Intravenous immunoglobulins

In drug-related disease, removal of the offending drug usually results in resolution, although this can take up to two weeks. Corticosteroids have been required to hasten resolution in severe cases.

Hospital referral

- Dermatological referral will be required for the initial diagnosis.
- An ophthalmological opinion will be required once diagnosis has been made, irrespective of whether the patient has any eye symptoms, as changes may be detected on examination (eg, subconjunctival fibrosis) before complications arise.
Complications

Complications are usually the result of scarring. Lesions on the gums can result in desquamative gingivitis resulting to damage to the teeth. Ocular linear IgA may mimic cicatricial pemphigoid and lead to blindness. There have been reports of involvement of the pharynx, larynx, nose, rectum and oesophagus.

Prognosis

In children, most idiopathic cases resolve within two years. In adults the disease can be more protracted and in some cases can be refractory.

LDA may improve during pregnancy. No fetal damage occurs as a result of the treatment (dapsone) or the disease.

Further reading & references

- Cunliffe T; Linear IgA Disease, Primary Care Dermatology Society, 2014
- Sakka N et al; Intertriginous Linear IgA Bullous Dermatosis Treated with Colchicine, SciMedCentral, 2015
- Braun-Falco O et al; Cicatricial pemphigoid, Dermatology, 2012

Disclaimer: This article is for information only and should not be used for the diagnosis or treatment of medical conditions. Patient Platform Limited has used all reasonable care in compiling the information but makes no warranty as to its accuracy. Consult a doctor or other healthcare professional for diagnosis and treatment of medical conditions. For details see our conditions.

Author: Dr Laurence Knott
Peer Reviewer: Prof Cathy Jackson

Document ID: 12487 (v3)
Last Checked: 23/06/2015
Next Review: 21/06/2020

View this article online at: patient.info/doctor/linear-iga-dermatosis
Discuss Linear IgA Dermatosis and find more trusted resources at Patient.