Posters

THE DIAGNOSTIC COMPLEXITY OF PERSISTENT ERYTHEMA MULTIFORME: A REPORT OF TWO CLINICAL CASES

S. Visinoni, V. Rubino, S. Colabrese, L. Cerchiai, M. E. Baffa, C. Pipitò, R. Maglie, E. Antiga

Dermatology, University of Florence, Italy

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Introduction. Erythema Multiforme (EM) is an acute condition often triggered by infections, primarily Herpes Simplex Virus (HSV). Alongside this classic form, a much rarer chronic variant exists: Persistent Erythema Multiforme (pEM). pEM follows a chronic or remitting-relapsing path that can persist for years, representing a formidable diagnostic and therapeutic challenge. We report two cases of multi-mucosal pEM.

Materials and Methods. We conducted a retrospective review of the clinical history of two patients presenting with chronic, extensive vesiculobullous eruptions and multisite mucosal involvement. To establish a differential diagnosis with autoimmune bullous diseases, both underwent a workup including: histopathology, Direct/Indirect Immunofluorescence (DIF/IIF), ELISA (anti-dsg1/dsg3, anti-BP180/230), systemic screening for infectious triggers (HSV-1/2 PCR, HBV, HCV), and anamnesis for pharmacological triggers.

Results. Case 1: a 20-year-old female presented with recurrent bullous lesions on the palms and soles and severe oro-genital mucosal erosions, which appeared after an antibiotic regimen for H. pylori eradication. While DIF, ELISA, and PCR were negative, biopsy revealed subepidermal blistering with satellite cell necrosis, consistent with an EM-like drug eruption. Some flares coincided with NSAIDs intake, while others occurred independently. After failing colchicine, dapsone, and methotrexate due to adverse events, she was transitioned to azathioprine and remains under close observation. Case 2: a 49-year-old female reported a 3-year history of nasal, oral, and genital erosions. Mucous membrane pemphigoid was ruled out by negative DIF/IIF. Histology confirmed interface dermatitis typical of EM. Blood screening identified a chronic HBV infection as the likely persistent trigger. Clinical stability was optimized with hydroxychloroquine and methotrexate, reducing mucosal relapses and systemic steroid use.

Conclusions. The differential diagnosis of pEM from autoimmune bullous diseases is a challenge due to the frequent absence of classic "target" lesions and the predominance of mucosal erosions. Diagnosis is often one of exclusion and relies on specific histological patterns. Underlying triggers can be both infective or pharmacological, acting as persistent drivers of the T-cell mediated immune response. A personalized immunosoppressive approach using steroid-sparing agents is essential to achieve clinical stability.

References

1. Lerch M, Mainetti C, Terziroli Beretta-Piccoli B, Harr T. Current Perspectives on Erythema Multiforme. Clinical Reviews in Allergy & Immunology. 2018;54(1):177-184.
2. Trayes KP, Love G, Studdiford JS. Erythema Multiforme: Recognition and Management. American Family Physician. 2020;102(2):107-114.
3. Chang DG et al. Chronic and persistent erythema multiforme: A diagnostic and therapeutic challenge. Journal of Dermatology. 2021;48(9):e432-e433.
4. Salgado-Boquete L, et al. Management of Persistent Erythema Multiforme: A Systematic Review. Actas Dermo-Sifiliográficas. 2022;113(4):385-395.
5. Zoghaib S, Kechichian E, Souaid K, Tomb R, Helou J. Triggers and Management of Persistent Erythema Multiforme: A Recent Update. Journal of Clinical Medicine. 2024;13(3):742.