Dermatitis herpetiformis and rheumatoid arthritis

To the Editor

I have read with interest the case report entitled "Dermatitis herpetiformis and rheumatoid arthritis" by Aydog and colleagues,[1] and I would like to add some comments to this interesting case. Actually, it is basic knowledge that direct immunofluorescence should always be positive in dermatitis herpetiformis (DH) and if there is a high degree of clinical suspicion, serial sections and multiple biopsies are necessary to confirm the diagnosis.[2,3] Therefore, immunofluorescence is mandatory to diagnose DH and clinical findings or treatment response is only of less importance. Another important point, the biopsy should be taken from clinically normal skin. In the article, the author did not specify the site of the biopsy. Lastly, any inflammation involving neutrophils should respond to dapsone so improvement was expected even if the case was not DH. I think these are valuable comments for the authors to reconsider in the diagnosis of this condition, and I look forward to their response .

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Reply from the Author

We thank Dr. Bukhari for his interest in our paper and his valuable comments on our article.[1] We agree that DH is usually suspected with its classic skin presentation, but confirmation requires direct immunofluorescence (DIF) staining, particularly with perilesional biopsy specimens. The characteristic pattern of granular IgA dermal papillary tips in perilesional skin is highly specific for DH. More than 90% of patients with DH have granular or fibrillar IgA deposits in the dermal papillae.[4] Although DIF can usually confirm the diagnosis, there are several reported cases of DIF (-) negative DH[5-8] secondary to technical errors and failure of current laboratory methods in detecting cutaneous IgA deposits. However, this may be the nature of some DH patients. Several antibodies have been described in DH, and all correlate with intestinal lesions: antigliadin, antireticulin, antiendomysial, and tissue transglutaminase. Some authors report the importance of these antibodies that support the diagnosis of DH in DIF (-) negative patients.[5,7,8] Although serology provides helpful adjunctive evidence for detection and diagnosis of intestinal involvement, biopsy remains the gold standard of diagnosis.[9] In our patient, intestinal involvement was demonstrated in the jejunal biopsy as a histopathological finding. The distribution of cutaneous lesions, positive jejunal biopsy, positive response for gluten free diet, fast and complete response of dapsone indicated the diagnosis as DH in our patient. Dr. Bukhari is correct; we did not indicate the skin biopsy technique. We obtained 2 skin biopsy specimens, one from the involved skin for routine microscopic examination, and another perilesional area (approximately 1 cm from the lesion). We did not obtain another invasive skin biopsy, because clinical, and intestinal histopathological findings were consistent with DH. We also agree that any inflammation involving neutrophils should respond to dapsone. However, dapsone has no place in the treatment of eczema, scabies, erythema multiforme, neurotic excoriation, Grover's diseases and urticaria. Dapsone can be used in autoimmune bullous diseases. However, in our case we did not diagnose DH with only response for dapsone. As mentioned before, additional clinical findings and intestine involvement supported our diagnosis of DH.

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