RCMOS - Revista Científica Multidisciplinar O Saber.
ISSN: 2675-9128. São Paulo-SP.

Ano VI, v.1 2026 | submissão: 08/02/2026 | aceito: 10/02/2026 | publicação: 12/02/2026

Bullous pemphigoid in an elderly woman: clinical recognition and management in internal medicine

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1. Introduction

Bullous pemphigoid is a chronic autoimmune subepidermal blistering disorder characterized by circulating autoantibodies directed against hemidesmosomal proteins of the basement membrane zone. It predominantly affects elderly individuals and is associated with intense pruritus, tense blister formation, skin fragility, and an increased risk of secondary infection.

Initial manifestations are often nonspecific, commonly presenting as generalized pruritus or eczematous lesions, which may delay diagnosis. Drug exposure has been described as a potential triggering factor in susceptible patients. Given the possibility of systemic complications, internal medicine physicians frequently represent the first point of care, particularly in hospital settings.

2. Theoretical Framework

The pathophysiology of bullous pemphigoid involves autoimmune-mediated injury to BP180 and BP230 antigens, leading to complement activation and recruitment of inflammatory cells. This inflammatory cascade results in subepidermal blister formation and progressive disruption of the skin barrier.

In elderly patients, age-related immune dysregulation, impaired skin integrity, and delayed wound healing increase disease severity and the risk of complications. Rupture of bullae exposes underlying tissue, facilitating bacterial invasion and potentially progressing to severe skin infection and septicemia.

3. Material and Method

This descriptive case report presents an elderly woman evaluated in January 2024 in an internal medicine setting at a tertiary care hospital, the Hospital São Lucas da PUC-RS. Clinical assessment included a comprehensive dermatologic examination, detailed medication history with suspicion of drug-induced hypersensitivity as a triggering factor, evaluation of pruritus severity, and investigation for infectious complications.

Management followed standard clinical protocols. No experimental or investigational interventions were performed.

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4. Results and Discussion

The patient initially presented with intense generalized pruritus temporally associated with recent medication exposure. Within days, she developed multiple tense bullae on erythematous skin, predominantly involving the trunk and extremities. Progressive rupture of the bullae resulted in extensive areas of exposed dermis.

Subsequently, the patient developed secondary bacterial skin infection with systemic inflammatory response, evolving with clinical features consistent with septicemia. Early recognition by the internal medicine team allowed prompt hospitalization and initiation of appropriate treatment.

The suspected triggering medication was discontinued. For disease control, systemic corticosteroid therapy was initiated with intravenous methylprednisolone (0.5–1 mg/kg/day), aiming at rapid suppression of autoimmune activity. After clinical stabilization, therapy was transitioned to oral prednisone with a gradual tapering schedule.

Due to secondary infection and systemic involvement, empirical broad-spectrum antibiotic therapy with intravenous piperacillin–tazobactam was started, with later adjustment according to microbiological findings. Supportive measures included fluid resuscitation, sterile non-adherent wound dressings, strict skin care, infection control, and close laboratory monitoring.

Following adequate clinical management, the patient showed progressive improvement, with resolution of systemic infection, stabilization of skin lesions, and reduction of inflammatory activity. Interdisciplinary coordination and timely dermatology referral contributed to favorable clinical outcomes.

Final Considerations

Bullous pemphigoid is a potentially severe condition in elderly patients, particularly when associated with blister rupture and secondary infection. Drug exposure may act as a triggering factor and should always be considered during evaluation.

This case underscores the essential role of internal medicine physicians in early recognition, acute management, and interdisciplinary coordination. Prompt initiation of systemic corticosteroids, appropriate antimicrobial therapy, and comprehensive supportive care were decisive for clinical recovery and complication prevention.

References

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Bullous Pemphigoid in an Elderly Woman.

Relatório técnico publicado no repositório científico internacional Zenodo, 2026.
DOI: 10.5281/zenodo.xxxxxxx.

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