INTRODUCTION

A patient case with ocular mucous membrane pemphigoid (OcMMP) presents with symblepharon and chronic dry eye disease. During the initial visit, the patient felt ill because she was up late in the emergency room the night prior due to an adverse reaction to an increased dosage of mycophenolate mofetil, an immunosuppressant drug to treat her mucous membrane pemphigoid disease. This poster illustrates the patient's OcMMP condition and the changes made for her course of treatment. This patient is co-managed with dermatology for systemic and ocular care.

CASE HISTORY

60 year old WF

Chief Complaint: Fluctuating vision w/ eyelashes aggravating left eye and itching OU. Pt was very tired from being in the ER the previous night d/t dizziness from increased dosage of mycophenolate mofetil.

Medical History: diabetes mellitus, rheumatoid arthritis, chronic venous insufficiency, nonalcoholic steatohepatitis, hypertension, extreme obesity with alveolar hypoventilation, recurrent major depression, osteoarthritis, chronic pain syndrome, hypothyroidism, psychosocial matters

Ocular History:
OD: Type 2 diabetes w/ mild-proliferative diabetic retinopathy and Restrictive strabismus d/t symblepharon
OS: No diabetic retinopathy
OU: Punctal plugs LL

Ocular Meds:
Cyclosporine 0.05% BID OU, Systane ATs, dexamethasone PF QID OU, vigamox QID OD, lubricating ung QHS OU, doxycycline 50 mg qDay PO

Dermatology Prescribed Meds:
mycophenolate mofetil, peridex mouthwash, magic mouthwash, clotobetasol 0.05% gel, dapsone 200mg qDay PO

Other meds:
oxycodone, emapgliflozin, insulin, duloxetine, hydroxyzine, pramipexole, clotobetasol, ketocnoazole shampoo, loratadine, levotyroxine, diclofenac gel, albuterol, budesonide, oxybutynin, lisinopril

Allergies: penicillin, codeine, morphine, pseudoephedrine, bee stings, povidence iodine, ciprofloxacan, shellfish, pork, Bactrim, iodinated contrast media

PERTINENT FINDINGS

Entrance Testing:
VA CC OD: 20/200   PH 20/40
OS: 20/40   PH 20/30

Slit Lamp Exam:
- Lids: OD: Mild MG expression, two symblepharon (one lateral and one medial aspect of RLL to PO. Continue co
- Lids: OS: Lateral fornix foreshortening, RUL, LUL, and LLL plugs
- Cornea: OU mild PEE; OD: no evidence of abrasion from eyelashes due to change of meds.
- Labs: Direct Immunofluorescence (DIF)

DPTENTIAL DIAGNOSIS

- Pseudopemphigoid: Pt tested positive for MMP on conjunctival biopsy and DIF, therefore diagnosis is not pseudopemphigoid
- Stevens-Johnson Syndrome (SJS) or Toxic Epidermal Necrolysis (TENS): Pt tested positive for MMP on DIF and biopsy for OMMP. SJS and TENS are characterized by a severe adverse reaction to medications leading to mucocutaneous blistering and epithelial sloughing with life-threatening conditions.

DIAGNOSIS & DISCUSSION

OcMMP is a mucocutaneous disease characterized by a type 2 hypersensitivity reaction against the basal epithelial membrane of the conjunctiva. This patient’s initial symptoms started OD 5/3/18 & OS 6/12/18 with early signs of inferior symblepharon formed temporally and nasally OD with distichiasis, trichiasis and limbal follicles and edema. DIF biopsies and cultures performed 1/16/19 & 1/18/19 with results consistent with OcMMP. Dermatology also diagnosed oral and skin lesions that are consistent with this disease.

TREATMENT AND MANAGEMENT

INITIAL ENCOUNTER: 7/7/20
The patient presented to the clinic a day after having an adverse reaction to an increased dosage of mycophenolate mofetil prescribed by dermatology. She was hospitalized the night prior due to severe nausea and vomiting. After communicating with dermatology, the mycophenolate mofetil dosage was readjusted accordingly. Ocular lid involvement and evaporative dry eye disease were treated with vigamox QID OD, PF dexamethasone QID OU, ATs PRN OU, lubricating ung QHS OU, dapsone 200 mg qDay PO, cyclosporine 0.05% BID OU and doxycycline 50 mg qDay PO. Continue co-management with dermatology. RTC 1 month for follow-up.

3 MONTH FOLLOW-UP: 9/17/20
- A month after this patient was seen in clinic, dermatology discontinued mycophenolate mofetil due to progression of several oral lesions. She was then started on Imuran which she also could not tolerate, which was later discontinued. Dermatology then prescribed Rituxumab which she started on 9/14/20.
- Our patient missed her 1 month f/u. At her 3 month f/u on 9/17/20, the patient reported the Rituxumab infusion made her feel very tired. Pt c/o ocular discharge, crustling of lids in the morning and soreness of the eyes for the past three weeks.
- Her OcMMP was previously well controlled on the lower dosage mycophenolate mofetil, and dapsone. Dermatology was alerted with this encounter. New onset of ocular symptoms are indicative that there is possible early recurrence of OcMMP due to change of meds.

CONCLUSIONS

OcMMP can be an aggressive and blinding disease. As this case highlights, patients with moderate or worse disease usually require systemic immunosuppressants and benefit from interdisciplinary treatment.

BIBLIOGRAPHY

During the initial visit, f/u. At her this patient was seen in clinic, dermatology discontinued mycophenolate mofetil due to PO. Continue co.

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OD: Mild MG expression, two symblepharon (one lateral and one medial aspect of RLL to OS: Mild MG expression, two symblepharon (one lateral and one medial aspect of RLL to bulbar conjunctiva); no scarring UL, lower punctum scoured over, entropion w/ 5 long lashes rubbing against cornea nasally; 1+ injection inferior conjunctiva

Lids: OS: Lateral fornix foreshortening, RUL, LUL, and LLL plugs

Cornea: OU mild PEE; OD: no evidence of abrasion from eyelashes

Labs: Direct Immunofluorescence (DIF)

Ocular History:
OD: Type 2 diabetes w/ mild non-proliferative diabetic retinopathy and Restricted strabismus d/t symblepharon
OS: No diabetic retinopathy
OU: Punctal plugs LL

Medical History: diabetes mellitus, rheumatoid arthritis, chronic venous insufficiency, nonalcoholic steatohepatitis, hypertension, extreme obesity with alveolar hypoventilation, recurrent major depression, osteoarthritis, chronic pain syndrome, hypothryroidism, psychosocial matters

Ocular History:
OS: 20/40     PH 20/30

Cyclosporine 0.05% BID OU. Systane Atis, dexamethasone PF QID OU, vigamox QID OD, lubricating unq QHS OU, doxycycline 50 mg qDay PO

Other meds: oxycodeone, emapagliflozin, insulin, duloxetine, hydroxyzine, pramipexole, clobetasol, ketoconazole shampoo, loratadine, levotyroxine, diclofenac gel, albutorol, budesonide, oxybutynin, lisonopril

Pertinent Findings:

Entrance Testing:
VA CC OD: 20/200 PH 20/40
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Slit Lamp Exam:
- Lids: OD: Mild MG expression, two symblepharon (one lateral and one medial aspect of RLL to bulbar conjunctiva); no scarring UL, lower punctum scoured over, entropion w/ 5 long lashes rubbing against cornea nasally; 1+ injection inferior conjunctiva
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Differential Diagnosis

- Pseudopemphigoid: Pt tested positive for MMP on conjunctival biopsy and DIF, therefore diagnosis is not pseudopemphigoid.
- Stevens-Johnson Syndrome (SJS) or Toxic Epidermal Necrolysis (TENS): Pt tested positive for MMP on DIF and biopsy for OMMP. SJS and TENS are characterized by a severe adverse reaction to medications leading to mucocutaneous blistering and epithelial sloughing with life-threatening conditions. 3

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Ocular Meds:
cyclosporine 0.05% BID OU
Puritox 10% BID
Dexamethasone 0.1% BID
Doxycycline 50 mg qDay PO
Pseudopemphigoid

Dermatology Prescribed Meds: mycophenolate mofetil, peridex mouthwash, magic mouthwash, clobetasol 0.05% gel, dapsone 200mg qDay PO

Other meds: oxycodone, emapagliflozin, insulin, duloxetine, hydroxyzine, pramipexole, clobetasol, ketoconazole shampoo, loratadine, levotyroxine, diclofenac gel, albutorol, budesonide, oxybutynin, lisonopril

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Treatment and Management

Initial Encounter: 7/7/20
The patient presented to the clinic a day after having an adverse reaction to an increased dosage of mycophenolate mofetil prescribed by dermatology. She was hospitalized the night prior due to severe nausea and vomiting. After communicating with dermatology, the mycophenolate mofetil dosage was readjusted accordingly. Ocular lid involvement and evaporative dry eye disease were treated with vigamox QID OD, PF dexamethasone QID OU, Atis PRN OU, lubricating unq QHS OU, dapsone 200 mg qDay PO, cyclosporine 0.05% BID OU and doxycycline 50 mg qDay PO. Continue co-management with dermatology. RTC 1 month for follow-up.

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