

BULLOUS PEMPHIGOID MASQUERADING AS DESQUAMATIVE GINGIVITIS IN TWO ELDERLY PATIENTS: A RARE CASE REPORT

¹*Dr. Manali Shashikant Waghmare, ²Dr. Smita Malbhage, ³Dr. Yadnya Shashikant Waghmare, ⁴Dr. Gurudev Swami

¹MDS Periodontology and Oral Implantology, Department of Periodontology, VYWS Dental College and Hospital, Amravati, Maharashtra.

²MDS Periodontology and Oral Implantology, Department of Periodontology, MIDSR Dental College and Hospital, Latur, Maharashtra, India.

³BHMS, SJMES, College of Homeopathy, Kolhapur, Maharashtra.

⁴MD Pathologist, BKL Walawalkar Medical College and Hospital, Chiplun, Maharashtra.



*Corresponding Author: Dr. Manali Shashikant Waghmare

MDS Periodontology and Oral Implantology, Department of Periodontology, VYWS Dental College and Hospital, Amravati, Maharashtra. DOI: <https://doi.org/10.5281/zenodo.23275680>



How to cite this Article: ¹*Dr. Manali Shashikant Waghmare, ²Dr. Smita Malbhage, ³Dr. Yadnya Shashikant Waghmare, ⁴Dr. Gurudev Swami (2026). Bullous Pemphigoid Masquerading As Desquamative Gingivitis In Two Elderly Patients: A Rare Case Report. European Journal of Pharmaceutical and Medical Research, 13(10), 479-483.
This work is licensed under Creative Commons Attribution 4.0 International license.

Article Received on 15/09/2026

Article Revised on 05/10/2026

Article Published on 10/10/2026

ABSTRACT

Background: Bullous pemphigoid (BP) is a chronic autoimmune subepithelial blistering disease of older adults that only uncommonly involves the oral mucosa, where it may mimic ordinary periodontal disease. **Case Presentation:** Two elderly patients presented with painful desquamative gingivitis (DG). A 65-year-old woman had 6 months of oral burning unresponsive to routine care, with an intact tense bulla at the maxillary left canine (tooth 23); biopsy confirmed BP, and corticosteroids produced marked improvement within 3 weeks. A 72-year-old man on multiple medications, with psychological stress and tobacco use, showed gingival changes consistent with DG. **Discussion:** The differential diagnosis of DG includes mucous membrane pemphigoid, BP, pemphigus vulgaris, and erosive lichen planus; these overlap clinically, so perilesional biopsy with direct immunofluorescence is essential. **Conclusion:** BP should be considered in persistent DG in the elderly, as timely biopsy and corticosteroid therapy expedite diagnosis and restore oral health.

INTRODUCTION

Bullous pemphigoid (BP) is a chronic autoimmune subepithelial blistering disease caused by autoantibodies against the hemidesmosomal proteins BP180 and BP230, and it predominantly affects older adults.^[1,2] Oral involvement is uncommon and is often mistaken for ordinary inflammatory periodontal disease, delaying diagnosis. Desquamative gingivitis (DG) is a descriptive term for erythematous, friable, peeling gingiva that may be the oral manifestation of several mucocutaneous disorders, including mucous membrane pemphigoid, BP, pemphigus vulgaris, and erosive lichen planus.^[3-5] Because these entities require different investigation and treatment, DG should never be managed with empirical periodontal therapy alone.^[4] We report two elderly patients in whom DG was the presenting feature of autoimmune and drug-associated blistering disease. This report follows the CARE guideline.^[8]

Case Presentation 1

A 65-year-old woman presented with a 6-month history of oral burning aggravated by spicy food, which disturbed her oral hygiene and food intake. She had been treated by a private dental practitioner without improvement. Her medical history was non-contributory, she took no long-term medication, and she had no tobacco or alcohol history. Extraoral examination was normal. Intraorally, diffuse erythema and desquamation affected the maxillary anterior attached gingiva, with an intact tense bulla related to the maxillary left canine (tooth 23). Gentle lateral pressure on clinically normal gingiva produced sheet-like epithelial sloughing, indicating tissue fragility (**Fig. 1 to Fig. 6**). A provisional diagnosis of an autoimmune vesiculobullous disorder presenting as DG was made, with mucous membrane pemphigoid, pemphigus vulgaris, erosive lichen planus, and BP as differentials.^[4,6] Routine haematology and

biochemistry were normal. Incisional perilesional biopsy showed a subepithelial split with a chronic inflammatory infiltrate, confirming BP. Direct immunofluorescence was unavailable at our centre.^[7,9] She received topical clobetasol propionate 0.05% with a short tapering course

of systemic corticosteroids, vitamin A and E supplementation, and oral hygiene instruction. At 3 weeks she reported marked relief of burning, with healing of the gingiva, resolution of the bulla, and reduced erythema (**Fig. 7 to Fig. 10**). She remains on periodic follow-up.



Fig. 1: Frontal view.



Fig. 2: Left Lateral View.



Fig. 3: Right Lateral view.



Fig. 4: Maxillary Occlusal view.



Fig. 5: Mandibular Occlusal view.



Fig. 6: Bullous Lesion on Buccal Mucosa.



Fig. 7: Follow-up after 21 days.



Fig. 8: Mandibular Occlusal view.



Fig. 9 Right Lateral view.



Fig. 10 Left Lateral view.

Case Presentation 2

A 72-year-old man presented with oral burning and throat discomfort, with a history of psychological stress and tobacco chewing. On clinical examination sloughing of gingival epithelial surface was seen with prominent redness of the gingiva (**Fig. 11 and Fig. 12**). In phase I therapy Oral hygiene instructions were given, patient counselling for stoppage of habit was followed. Thorough scaling was done. Later patient was asked to take tablet betamethasone, B-complex vitamins, a chlorhexidine-metronidazole gel, a topical corticosteroid gel, and Multifibro tablets. Several of these agents—particularly systemic and topical corticosteroids—may modify an inflammatory or immune-mediated gingival lesion, and some systemic drugs are recognised triggers of drug-induced BP.^[10] But after 14 days and so patient

did not show any signs of improvement. Examination showed erythematous, desquamative gingival changes consistent with DG. So, modification of medications was done which included Vitamin C 500mg, Tablet Rabeprazole 20mg, Tablet Domperidone 30mg, B-complex Vitamins and Zinc, Capsule Amoxicillin 500mg + Capsule Clavulanic Acid 125mg, Tablet Linezolid 600 mg, Gel choline+ Salicylate+ Lignocaine + Benzalkonium Chloride.

These medications showed drastic improvement in gingival color, contour, consistency after 21 days (**Fig. 13 to Fig. 15**). Also, the burning sensation was completely stopped and patient was able to eat properly. He remains on periodic follow-up.



Fig. 12: Right lateral View



Fig. 11: Left lateral View



Fig. 13: Follow-up after 21 days Left Lateral View.



Fig. 14: Follow-up after 21 days Right Lateral View.



Fig. 15. Follow-up after 21 days Frontal View

DISCUSSION

These cases illustrate a common and costly trap: in an older adult, chronic gingival burning and peeling is attributed to periodontal irritation and treated empirically, while autoimmune subepithelial blistering smoulders beneath. BP arises from autoantibodies against BP180 and BP230, producing a split at the epithelial-connective tissue junction.^[1] Although cutaneous disease is the classic hallmark, isolated or predominantly oral disease occurs, and DG is among its most common oral presentations.^[4,5] The differential diagnosis of DG is dominated by mucous membrane pemphigoid, BP, pemphigus vulgaris, and erosive lichen planus.^[3-6] Because these overlap clinically, examination alone is unreliable; the recommended pathway rests on perilesional incisional biopsy with direct immunofluorescence as the reference standard.^[6,7,9] In our first patient, a characteristic clinical picture, positive tissue fragility, and confirmatory histopathology established the diagnosis despite the absence of direct immunofluorescence. Treatment is stepwise: high-potency topical corticosteroids—clobetasol propionate most widely used—are the mainstay for localised disease, with systemic corticosteroids reserved for extensive or refractory involvement, supported by

meticulous oral hygiene and correction of nutritional deficiencies.^[2,9] Our first patient improved substantially within 3 weeks. The second patient adds the dimension of polypharmacy: corticosteroids can partly suppress an immune-mediated lesion, and some systemic drugs trigger drug-induced BP,^[10] reinforcing the value of a thorough medication review and unbiased biopsy rather than a reflex diagnosis of ordinary gingivitis. Proper Multidrug treatment was able to make second patient within 21 days. Persistent gingival burning, erythema, and peeling in an elderly patient that fails conventional therapy should prompt a search for blistering disease, with examination for intact bullae and tissue fragility and prompt biopsy.^[4,5]

CONCLUSION

BP should be considered in chronic DG, particularly in elderly patients with persistent burning and tissue fragility unresponsive to routine care. Histopathological confirmation is essential, with direct immunofluorescence as the gold standard where available. Early corticosteroid therapy with supportive oral care can rapidly control oral lesions and improve quality of life.

Figure Legends

Fig. 1 Frontal view.

Fig. 2 Left Lateral View Fig. 3 Right Lateral view.

Fig. 4 Maxillary Occlusal view Fig. 5 Mandibular Occlusal View.

Fig. 6 Bullous Pemphigoid on buccal Mucosa.

Fig. 7 Follow-up after 21 days Fig. 8 Mandibular Occlusal view Fig. 9 Right Lateral view.

Fig. 10. Left Lateral view Fig. 11 Left lateral View Fig. 12 Right lateral View.

Fig. 13. Follow-up after 21 days Left Lateral View Fig.

14. Follow-up after 21 days Right Lateral View Fig. 15. Follow-up after 21 days Frontal View.

Ethics and Consent Statement

Written informed consent for the diagnostic procedures and for publication of these case details and clinical images was obtained from both patients.

Data Availability Statement

All data supporting this report are contained within the manuscript. [AUTHOR TO CONFIRM].

Conflict of Interest

The authors declare no conflict of interest.

Funding

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

REFERENCES

- Schmidt E, Zillikens D. Pemphigoid diseases. *Lancet*, 2013; 381(9863): 320-332.
- Persson MSM, Harman KE, Vinogradova Y, Langan SM, Hippisley-Cox J, Thomas KS. Incidence, prevalence and mortality of bullous pemphigoid in England 1998-2017: a population-based cohort study. *Br J Dermatol*, 2021; 184(1): 68-77.
- Scully C, Porter SR. The clinical spectrum of desquamative gingivitis. *Semin Cutan Med Surg*, 1997; 16(4): 308-313.
- Robinson NA, Wray D. Desquamative gingivitis: a sign of mucocutaneous disorders-a review. *Aust Dent J*, 2003; 48(4): 206-211.
- Tofan EC, Parlatescu I, Tovar S, Nicolae C, Preda AS, Funieru C. Desquamative gingivitis - a clinicopathological review. *Curr Health Sci J*, 2018; 44(4): 331-336.
- Rashid H, Lamberts A, Diercks GFH, Pas HH, Meijer JM, Bolling MC, et al. Oral lesions in autoimmune bullous diseases: an overview of clinical characteristics and diagnostic algorithm. *Am J Clin Dermatol*, 2019; 20(6): 847-861.
- Leuci S, Ruoppo E, Adamo D, Calabria E, Mignogna MD. Oral autoimmune vesicobullous diseases: classification, clinical presentations, molecular mechanisms, diagnostic algorithms, and management. *Periodontol*, 2000, 2019; 80(1): 77-88.
- Gagnier JJ, Kienle G, Altman DG, Moher D, Sox H,

Riley D. The CARE guidelines: consensus-based clinical case reporting guideline development. *Glob Adv Health Med*, 2013; 2(5): 38-43.

- Chan LS, Ahmed AR, Anhalt GJ, et al. The first international consensus on mucous membrane pemphigoid: definition, diagnostic criteria, pathogenic factors, medical treatment, and prognostic indicators. *Arch Dermatol*, 2002; 138(3): 370-379.
- Rashid H, Meijer JM, Diercks GFH, Sieben NE, et al. Assessment of diagnostic strategy for mucous membrane pemphigoid. *JAMA Dermatol*, 2021; 157(7): 780-787.