Case Report

Escitalopram-induced Bullous Pemphigoid: A Case Report

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ABSTRACT:

Bullous pemphigoid is an autoimmune blistering disorder affecting elderly individuals. Emerging evidence links selective serotonin reuptake inhibitors (SSRIs) to bullous pemphigoid development. A 64-year-old man with hypertension, Type-2 diabetes mellitus, hypothyroidism, developed widespread blisters one week after starting escitalopram 10 mg daily. Histopathology and serology confirmed bullous pemphigoid. Naranjo Adverse Drug Reaction Probability Scale score was 4 (possible adverse reaction), with positive findings for temporal relationship. After stopping escitalopram and initiating melatonin, corticosteroids, doxycycline, & antihistaminergic complete resolution occurred within 6 weeks. Clinicians should remain vigilant for drug-induced bullous pemphigoid in elderly patients on SSRIs presenting with new-onset blistering. Early recognition and drug discontinuation lead to favourable outcomes.

KEY WORDS: Bullous pemphigoid, escitalopram, drug-induced autoimmune disease, Naranjo scale, polypharmacy

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Submitted: 08.08.2025, **Accepted:** 16.11.2025, **Published:** 23.12.2025

INTRODUCTION:

Bullous pemphigoid is the most common autoimmune subepidermal blistering disease, predominantly affecting individuals over 60 years.[1] The condition results from autoantibodies against hemidesmosomal proteins BP180 and BP230, causing basement membrane disruption and blister formation.[2] Recent large-scale studies demonstrate strong associations between neuropsychiatric medications, particularly selective serotonin reuptake inhibitors (SSRIs), and bullous pemphigoid development.[3,4] The pathophysiology remains incompletely understood but likely involves antigen modification, immune dysregulation, and cross-reactive responses between neural and cutaneous antigens.[5,6]

Managing drug-induced bullous pemphigoid in elderly patients with polypharmacy presents unique challenges, as polypharmacy independently increases mortality risk in bullous pemphigoid.[7] We present a case of escitalopram-induced bullous pemphigoid highlighting diagnostic and management considerations.

CASE REPORT:

A 64-year-old male, presented with pruritic, blistering eruption for 1 week starting from dorsal aspect of right hand and gradually spreading over torso, legs, scalp, neck & groin (Figure 1). Patient was referred to psychiatry department for disturbance in sleep from dermatology department, on further

Access this article online

Quick Response Code:

Website: www.pjsr.org

DOI: https://doi.org/10.5281/zenodo.18058250

How to cite this article: Upadhyay A, Shakya A, Tomar G, Dubey V. Escitalopram-induced Bullous Pemphigoid: A Case Report. PJSR. 2025;18(2):49-52.

Figure 1: Shows the trunk of the patient with multiple intact vesicles and bullae, and ruptured bullae with erosions and crusting.

evaluation we found that patient had been started on Escitalopram 10mg & clonazepam 0.5mg 10 days prior of developing cutaneous symptoms by a neurologist for sleep disturbance. His past medical history included hypertension, Type-2 diabetes mellitus, hypothyroidism with history of CVA 1 year ago & disturbance in sleep. His treatment comprised of Tablet telmisartan 40mg, metoprolol 20mg, thyroxine75 mcg, metformin 500mg, aspirin 75mg and atorvastatin 20mg. On examination patient presented with widespread erosions affecting the whole body with tense blisters, serology and biopsy suggestive of bullous pemphigoid. Hamilton depression rating scale score was *6* at day 3rd of admission. On Naranjo Adverse Drug Reaction Probability Scale the score was 4 (Possible adverse drug reaction).

Escitalopram was discontinued as it was identified as a potential trigger, and was prescribed melatonin 5 mg at bedtime and zolpidem 5 mg as needed for sleep management. The endocrinologist-initiated insulin therapy, while the dermatologists managed the patient with dexamethasone, doxycycline, antihistaminergic & topical ointments. After stopping the potential trigger medication, there was a gradual reduction in the formation of new blisters and improvement in sleep. The patient was discharged from hospital after an intensive 6 weeks of treatment. The follw-up was done till 1 year and no recurrence was seen.

DISCUSSION:

This case demonstrates escitalopram-induced Bullous Pemphigoid in an elderly patient with multiple co-morbidities. The Naranjo score of 4 supports probable causality, with clear temporal relationship and resolution after drug discontinuation.

Varpuluoma et al. found significant associations between SSRIs (particularly escitalopram) and bullous pemphigoid in a Finnish registry study.[3] While mechanisms remain unclear, proposed pathways include antigen modification exposing cryptic epitopes, neoantigen formation, and immune dysregulation.[5,8,9]

Bullous pemphigoid patients show higher prevalence of psychiatric disorders (OR 1.77), with anxiety and depression potentially predisposing to bullous pemphigoid development.[10,11] Shared mechanisms include neuroinflammation and cross-reactive immune responses to BP180/BP230, expressed in both neural and cutaneous tissues.[12] Our patient's minimal depression score: 6 suggests even mild psychiatric indications for SSRIs may carry bullous pemphigoid risk in vulnerable populations.

Polypharmacy correlates with increased bullous pemphigoid mortality.[13,14] Systematic medication review is essential when elderly patients develop new symptoms. Managing multiple conditions requires balancing therapeutic needs against adverse reaction risks.

Melatonin effectively regulates circadian rhythms with excellent safety profiles in elderly populations.[15] Combined with PRN zolpidem, this approach addressed insomnia while avoiding SSRI-associated bullous pemphigoid risk.[16,17]

In elderly patients with co-morbidities, systemic corticosteroids carry significant risks including hyperglycemia, hypertension, and infections.[18] Drug-induced BP prognosis is generally favorable with prompt drug withdrawal, though close monitoring remains essential.[19]

CONCLUSION:

This case of escitalopram-induced bullous pemphigoid demonstrates the importance of recognizing SSRIs as potential triggers in elderly patients. The Naranjo score of 4 supports probable

improvement after discontinuation, and objective confirmation.

Maintaining vigilance for cutaneous adverse effects when prescribing SSRIs to elderly patients, considering drug-induced bullous pemphigoid in patients on psychotropic medications with new-onset blistering, conducting systematic medication reviews in polypharmacy contexts, and recognizing that alternative psychiatric treatments can effectively manage symptoms after serious drug reactions.

Early recognition and prompt drug withdrawal with appropriate multidisciplinary management achieved complete resolution. However, the increased morbidity and mortality in elderly BP populations emphasize prevention through judicious prescribing.

Further research is needed to elucidate escitalopram-bullous pemphigoid mechanisms, identify susceptibility markers, and develop evidence-based guidelines for managing psychiatric symptoms in at-risk patients. Enhanced clinical awareness will facilitate earlier diagnosis and improved outcomes.

DECLARATION OF PATIENT CONSENT:

The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient(s)/guardian has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients/guardian understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

Financial Support and Sponsorship
Nil.

Conflicts of Interest

There are no conflicts of interest.

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