Intro: Bullous pemphigoid is an autoimmune subepidermal blistering disease causing lesions on the body oropharynx and esophagus. We present a general anesthetic of a patient with bullous pemphigoid and pericardial effusion necessitating an urgent pericardial window.

Case: 39y M with active bullous pemphigoid as well as latent TB. He presented with cough, dyspnea, and fatigue. Pericardial effusion was diagnosed and the patient was scheduled for urgent pericardial window.

He was hypotensive, tachycardic, and dyspneic upon arrival in pre-op. An A-line was placed and norepinephrine infusion started prior to induction. Laryngoscopy was performed with a Miller 2 blade coated in petroleum jelly. The ETT was coated in petroleum jelly and secured with low adhesive paper tape to avoid epidermal injury. Ointment was placed in the eyes and they were closed with paper tape. A right IJ central line was sutured in place and covered with petroleum jelly. Surgery was well tolerated and norepinephrine was weaned during emergence. He was extubated awake and transferred to the SICU in stable condition.

Care was taken to protect the patient’s skin and oropharynx from development of bulla. Removal of the tape over the eyes did lead to partial thickness erosion of the skin on eyelids bilaterally. He did not develop oropharyngeal bulla, or have any respiratory distress. The central line and arterial line sites showed no signs of skin lesions.

Cultures were negative, and effusions are believed to be rheumatologic in nature, possibly secondary to isoniazid induced systemic lupus erythematosus.

Discussion: Bullous pemphigoid patients may develop oropharyngeal lesions that complicate airway management as well as painful skin lesions. The disease typically has periods of remission and exacerbations. Clinical diagnosis is confirmed with direct immunofluorescence microscopy showing linear deposits of IgG and/or C3 in the epidermal basement membrane. Treatment consists of corticosteroids and immunosuppressive agents (1).

There are few reports of bullous pemphigoid patients in the anesthesia literature. In 1989 Prasad and Chen reported a case using a continuous spinal in a patient with stage IV vulvar carcinoma for radical vulvectomy and lymph node dissection (2). In a letter to the editor of the Canadian Journal of Anesthesia in 1996 Yaniv et al. report a case of general anesthetic in a 75year old man undergoing hemicolecctomy (3). Neither case reported complications.

Recommendations for anesthetic management are derived from the epidermolysis bullosa literature. Recommendations include avoiding shearing forces on the skin or mucosa by minimizing transfers under anesthesia, avoiding tape and suturing lines in place, lubricating the ETT and laryngoscope with petroleum jelly as well as any other device that contacts the skin (4,5).

Bullous pemphigoid can pose a unique challenge to the anesthesiologist, however with proper planning and care to avoid new lesions general anesthesia can be provided in a safe manner to these patients.

References: