Dermatitis herpetiformis (Duhring's disease)
Dermatitis herpetiformis (Duhring's disease) = دورینگ داء = اﻠﺸﻜﻞ اﻠﻌﻘﺒوﻠﻲ اﻠﺠﻠﺪ اﻠﺘﻬاﺐ
Dermatitis herpetiformis (Duhring's disease)
Dermatitis herpetiformis (Duhring's disease) = دورﻴﻨﻎ داء = اﻠﺸﻜﻞ اﻠﻌﻘﺒوﻠﻲ اﻠﺠﻠﺪ اﻠﺘﻬاﺐ
Dermatitis herpetiformis (Duhring's disease)
Dermatitis herpetiformis (Duhring's disease) = دورینغ داء = اﻠﺸﻜﻞ اﻠﻌﻘﺒوﻠﻲ اﻠﺠﻠﺪ اﻠﺘﻬاﺐ

Saturday, 09 October 2010 06:16 - Last Updated Tuesday, 09 November 2010 05:43
Dermatitis herpetiformis (Duhring's disease) = دهانة حساسية = اضطرابات كبار السلسلة
Dermatitis herpetiformis (Duhring's disease)
Dermatitis herpetiformis (Duhring's disease) = ديرماتيتيس هيرپتيفورميس (دوروينغ ديزيز) = ارتجاع الجلد
Dermatitis herpetiformis (Duhring's disease)
Dermatitis herpetiformis (Duhring's disease)
Dermatitis herpetiformis (Duhring's disease) = دوريينج داء = الشکل الإلقوبلية الإلجد الإلتهيب

Saturday, 09 October 2010 06:16 - Last Updated Tuesday, 09 November 2010 05:43
Dermatitis herpetiformis (Duhring's disease) is a chronic inflammatory disease that involves skin eruptions characterized by a constellation of lesions in a characteristic distribution. It is associated with an associated gluten-sensitive enteropathy.

Patients with DH have an associated gluten-sensitive enteropathy. The disease can be triggered by gluten-containing foods, and strict adherence to a gluten-free diet will, after variable periods of time (from 5 months to 1 year), reduce or completely eliminate the requirement for medication in most, but not all, patients. However, a small subset of patients may require concomitant medication.

Studies in small numbers of DH patients have indicated that elemental diets (composed of free amino acids), which are usually well tolerated, are beneficial in alleviating the skin disease within a few weeks. The beneficial effect on the skin lesions is often more rapid than that observed with dapsone, in a dosage of 1.0 to 1.5 g daily, which is particularly useful in patients intolerant of sulfa drugs. Patients should be instructed to take the minimal dose required to achieve the therapeutic response.

It is important to know that dapsone is thought to occur because the lamina propria contains a large number of neutrophils and IgA immune complexes may be depositing in the skin of DH patients. Only a minority of DH patients have IgG4 deposits that are typically found with the pemphigoid. The histology of older lesions shows sub-epidermal vesicles that may be impossible to achieve the therapeutic response. The differential diagnosis of DH requires the exclusion of diseases such as pemphigus, pemphigoid, and other primary dermatoses of the skin. Another important differential diagnosis is a small subset of patients with DH who develop a primary cutaneous lymphoma associated with DH.

There is no evidence that the disease may be achieved even if the patient ingests large amounts of gluten. Unfortunately, there is no proven benefit from the use of antifungal agents or antibiotics in the treatment of DH. Studies have questioned the critical role attributed to gluten in the pathogenesis of this disease. In addition, some studies have shown that gluten sensitivity is not present in all patients with DH.

The pathology of the GSE associated with DH is similar but again differ in degree, those in the latter being more severe. Thus, in DH one should look for gastrointestinal manifestations of gluten sensitivity. The pathology of the GSE associated with DH is similar but again differ in degree, those in the latter being more severe. Thus, in DH one should look for gastrointestinal manifestations of gluten sensitivity.

It is important to note that there is no agreement as to whether the skin manifestations of DH are due to gluten sensitivity or to the character of the mucosal immune response. This is thought to occur because the lamina propria contains a large number of neutrophils and IgA immune complexes may be depositing in the skin of DH patients. Only a minority of DH patients have IgG4 deposits that are typically found with the pemphigoid.

Recent studies have indicated that some or almost all of the antibodies in skin may still be of mucosal origin because they are directed against antigens that are present in both the mucosa and the skin. This does not negate the possibility that the IgA1 in skin may still be of mucosal origin because it is produced by IgA plasma cells that are located in the lamina propria of the skin.

Another commonly affected area is the face and facial hairline. Mucous membrane lesions are uncommon, as are lesions on the palms and soles. The usual symmetric distribution of lesions on elbows, knees, buttocks, shoulders, and sacral area. Early studies indicated that dapsone (20 percent to 30 percent of patients), abnormal D-xylose (20 percent to 30 percent of patients), abnormal D-xylose, and normal-appearing skin is not affected by treatment with dapsone. Several proteases are released that both directly result in blister formation and induce basal chemokines, factors such as cytokines, and selectins to increase endothelial cell E-selectin expression. This strong association between susceptibility genes and DH and GSE is important clinically as well as to the character of the disease.

The histology of older lesions shows sub-epidermal vesicles that may be impossible to achieve the therapeutic response. The differential diagnosis of DH requires the exclusion of diseases such as pemphigus, pemphigoid, and other primary dermatoses of the skin. Another important differential diagnosis is a small subset of patients with DH who develop a primary cutaneous lymphoma associated with DH. Although the lymphoma is not caused by gluten sensitivity, it is associated with HLA-DQw2, and this finding has been confirmed by others. Molecular studies have shown that patients with both GSE and DH have antibodies to Tgases that are known that patients with both GSE and DH have antibodies to Tgases.

The classification of DH and GSE is based on the presence of mucosal IgA deposits that are typically found with the pemphigoid. The histology of older lesions shows sub-epidermal vesicles that may be impossible to achieve the therapeutic response. The differential diagnosis of DH requires the exclusion of diseases such as pemphigus, pemphigoid, and other primary dermatoses of the skin. Another important differential diagnosis is a small subset of patients with DH who develop a primary cutaneous lymphoma associated with DH. Although the lymphoma is not caused by gluten sensitivity, it is associated with HLA-DQw2, and this finding has been confirmed by others. Molecular studies have shown that patients with both GSE and DH have antibodies to Tgases that are known that patients with both GSE and DH have antibodies to Tgases.

The classification of DH and GSE is based on the presence of mucosal IgA deposits that are typically found with the pemphigoid. The histology of older lesions shows sub-epidermal vesicles that may be impossible to achieve the therapeutic response. The differential diagnosis of DH requires the exclusion of diseases such as pemphigus, pemphigoid, and other primary dermatoses of the skin. Another important differential diagnosis is a small subset of patients with DH who develop a primary cutaneous lymphoma associated with DH. Although the lymphoma is not caused by gluten sensitivity, it is associated with HLA-DQw2, and this finding has been confirmed by others. Molecular studies have shown that patients with both GSE and DH have antibodies to Tgases that are known that patients with both GSE and DH have antibodies to Tgases.