Cicatricial pemphigoid (CP) or Mucous Membrane Pemphigoid (MMP)

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Condition for which IVIg has an emerging therapeutic role.

Specific Conditions	• Cicatricial pemphigoid/ mucous membrane pemphigoid
Indication for IVIg Use	• CP resistant to glucocorticoid and immunosuppressive therapy, or when corticosteroid and immunosuppressant therapy is contraindicated.
Level of Evidence	Evidence of probable benefit – more research needed (Category 2a)
Description and Diagnostic Criteria	Cicatricial pemphigoid (CP) or Mucous Membrane Pemphigoid (MMP) is a rare, acquired subepithelial blistering disease characterised by erosive lesions of mucous membranes and skin. It is associated with autoantibodies to antigenic proteins in the epidermal basement membrane. Serious complications may occur due to erosions and scarring of affected tissues. Nasopharyngeal or laryngeal involvement may cause hoarseness, pain, tissue loss and even upper airway destruction, and oesophageal and urogenital lesions may lead to stenosis or strictures. CP is usually a chronic, progressive disorder. The aim of long-term treatment is cessation of the autoimmune process. Failure to do so results in invariable progression of the disease, culminating in progressive scarring. Permanent remission is usually possible if the disease is diagnosed early and treated sufficiently for one to five years. For the 70% of patients who have eye involvement, the disease progresses to conjunctival scarring and shrinkage, but may take 10–20 years to reach the end stage of bilateral blindness.
Justification for Evidence Category	Prolonged clinical remission and reduction in side effects was demonstrated in one small case series (15 cases) of patients with CP/MMP unresponsive to systemic corticosteroids and immunosuppressant agents or presenting with multiple side effects of therapy (Biotext 2004). A small non-randomised, non-blinded trial (16 patients) showed significant improvement in the mean time for clinical control, recurrence, disease progression and drug-related side effects among patients receiving intravenous immunoglobulin (IVIg) compared to conventional immunosuppressant therapy (Frommer and Madronio 2006). The (2003) consensus statement from the Harvard Medical School Department of Dermatology identified a study of 10 MMP patients who had progressive ocular involvement and did not respond to corticosteroids or immunosuppressants. IVIg administration as monotherapy arrested the progression and vision was maintained after IVIg was discontinued. The authors cited two other studies of oral pemphigoid, in 15 and 7 patients respectively, who could not be treated with dapsone; IVIg was compared to immunosuppressants. IVIg led to early and long-term remission and no disease progression.
Diagnosis Requirements	A diagnosis must be made by a Dermatologist or an Ophthalmologist.

Qualifying Criteria for IVIg Therapy	• Moderate to severe CP/MMP disease. AND • Corticosteroids or immunosuppressive agents are contraindicated. OR • Unresponsive to corticosteroids and immunosupressive agents. OR • Presenting with severe side effects of therapy.
Review Criteria for Assessing the Effectiveness of IVIg Use	Review is required every six months by a Dermatologist, Clinical Immunologist or Opthamologist and response must be demonstrated for continuation of supply. Clinical response may be demonstrated by a reduction in disease recurrence or relapse and increased duration of clinical remission, ability to reduce dose or discontinue other therapies, resolution of conjunctival inflammation or reduction of drug-related side effects. Consideration should be given to a trial-off immunoglobulin (Ig) therapy once the patient has achieved stabilised disease or clinical remission. The minimal effective dose should be prescribed. **On review of the initial authorisation period** Clinical effectiveness of Ig therapy may be demonstrated by: • Reduced severity of disease. **On review of a continuing authorisation period** Clinical effectiveness of Ig therapy may be demonstrated by: • Reduced severity, or stablisation of disease compared to the previous review.
Dose	• **Maintenance Dose** - efficacy demonstrated with doses of at least 2 g/kg per monthly treatment cycle. **The aim should be to use the lowest dose possible that achieves the appropriate clinical outcome for each patient.** **Dosing above 1 g/kg per day is contraindicated for some IVIg products.** **Refer to the current product information sheet for further information.**

Bibliography

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