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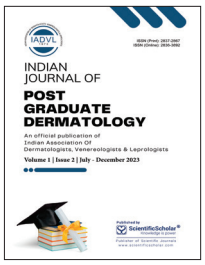

Correspondence

Angina Bullosa Haemorrhagica: A Presenting Feature of Dengue Haemorrhagic Fever

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Dear Editor,

A 30-year-old male presented to skin OPD with the sudden haemorrhagic blistering on the left buccal mucosa for 1 day. The lesion was asymptomatic. The patient gave a history of malaise and fever 4 days before the blister. Fever subsided with antipyretics. On examination of the oral cavity, there was a haemorrhagic blister of size 2 × 2 cm present in the left buccal mucosa above the left second molar [Figure 1]. Rest of the mucosa was uninvolved. A provisional diagnosis of angina bullosa haemorrhagica (ABH) was made. The patient developed multiple asymptomatic pinpoint purpuric macules over bilateral upper extremities and the trunk next day [Figure 2]. There was thrombocytopenia, relative lymphocytosis with a total platelet count of 41,000/uL. He was then advised a dengue serology. The patient tested positive for immunoglobulin M and immunoglobulin G antibody against dengue antigen. The haemorrhagic blister ruptured spontaneously and healed in 3 days without any scarring.

ABH presents clinically with blisters filled with blood mostly on the soft palate. They generally reach a size of 2–3 cm.[1] They tend to rupture spontaneously, leaving a ragged ulcer which might be painful that heals without scarring. Approximately 30% of patients may have a recurrence.[2] The incidence in male is 48% and in female is 52%.[2]

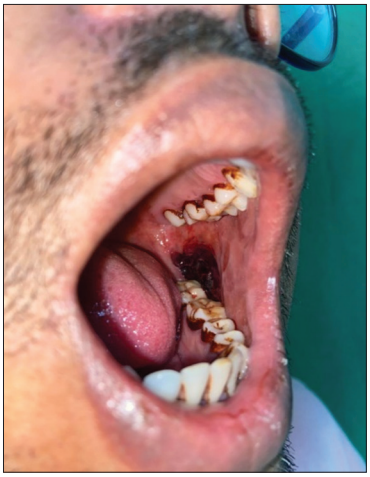

Figure 1: Haemorrhagic blister of size 2 × 2 cm present in the left buccal mucosa just above the second molar tooth.

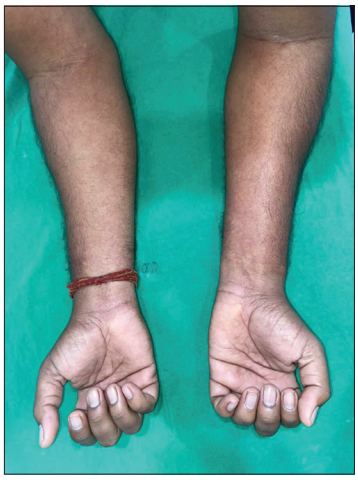

Figure 2: Multiple asymptomatic pinpoint purpuric macules over bilateral upper extremities and the trunk.

Its etiologic remains unknown. Laboratory evaluation usually fails to show any underlying illness. Stephenson *et al*. presented a series of 30 patients, in which no clear precipitating factor was found in 47% of the cases.[1] The commonly described factors are: Trauma by a sharp cusp or edge of an adjacent tooth or metal crown, injury due to mastication, hot drinks, steroids use as well as minor surgical procedure.[3] Badham[4] reported association between ABH and systemic conditions, such as diabetes mellitus and hypertension including menstruation in some female patients. Moreover, several cases of chronic kidney failure associated ABM have been described in various literature.[5,6]

Dengue fever generally presents with high-grade fever, arthralgia, myalgia, headache, sore throat and maculopapular rash with islands of sparing. Some atypical manifestations include disseminated intravascular coagulation, acute lung injury and acute respiratory distress syndrome.[7]

After an extensive search of literature, we could not find the association between dengue and ABH which is highly misdiagnosed and under-reported. Although ABH is commonly not associated with any underlying disease, the index case highlights that it may be the earliest cutaneous manifestations of a viral haemorrhagic fever like dengue.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent.

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Nil.

Conflicts of interest

There are no conflicts of interest.

REFERENCES

1. Stephenson P, Lamey PJ, Scully C, Prime SS. Angina bullosa haemorrhagica: Clinical and laboratory features of 30 patients. Oral Surg Oral Med Oral Pathol 1987;63:560-5.
2. Grinspan D, Abulafia J, Lanfranchi H. Angina bullosa hemorrhagica. Int J Dermatol 1999;38:525-8.
3. Edwards S, Wilkinson JD, Wojnarowska F. Angina bullosa haemorrhagica: A report of three cases and review of the literature. Clin Exp Dermatol 1990;15:422-4.
4. Badham NJ. Blood blisters and the oesophageal cast. J Laryngol Otol 1967;81:791-803.
5. Yamamoto K, Fujimoto M, Inoue M, Maeda M, Yamakawa N, Kirita T. Angina bullosa hemorrhagica of the soft palate: Report of 11 cases and literature review. J Oral Maxillofac Surg 2006;64:1433-6.
6. Pahl C, Yarrow S, Steventon N, Saeed NR, Dyar O. Angina bullosa haemorrhagica presenting as acute upper airway obstruction. Br J Anaesth 2004;92:283-6.
7. Nimmagadda SS, Mahabala C, Boloor A, Raghuram PM, Nayak AU. Atypical manifestations of dengue fever (DF)-where do we stand today? J Clin Diagn Res 2014;8:71-3.

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