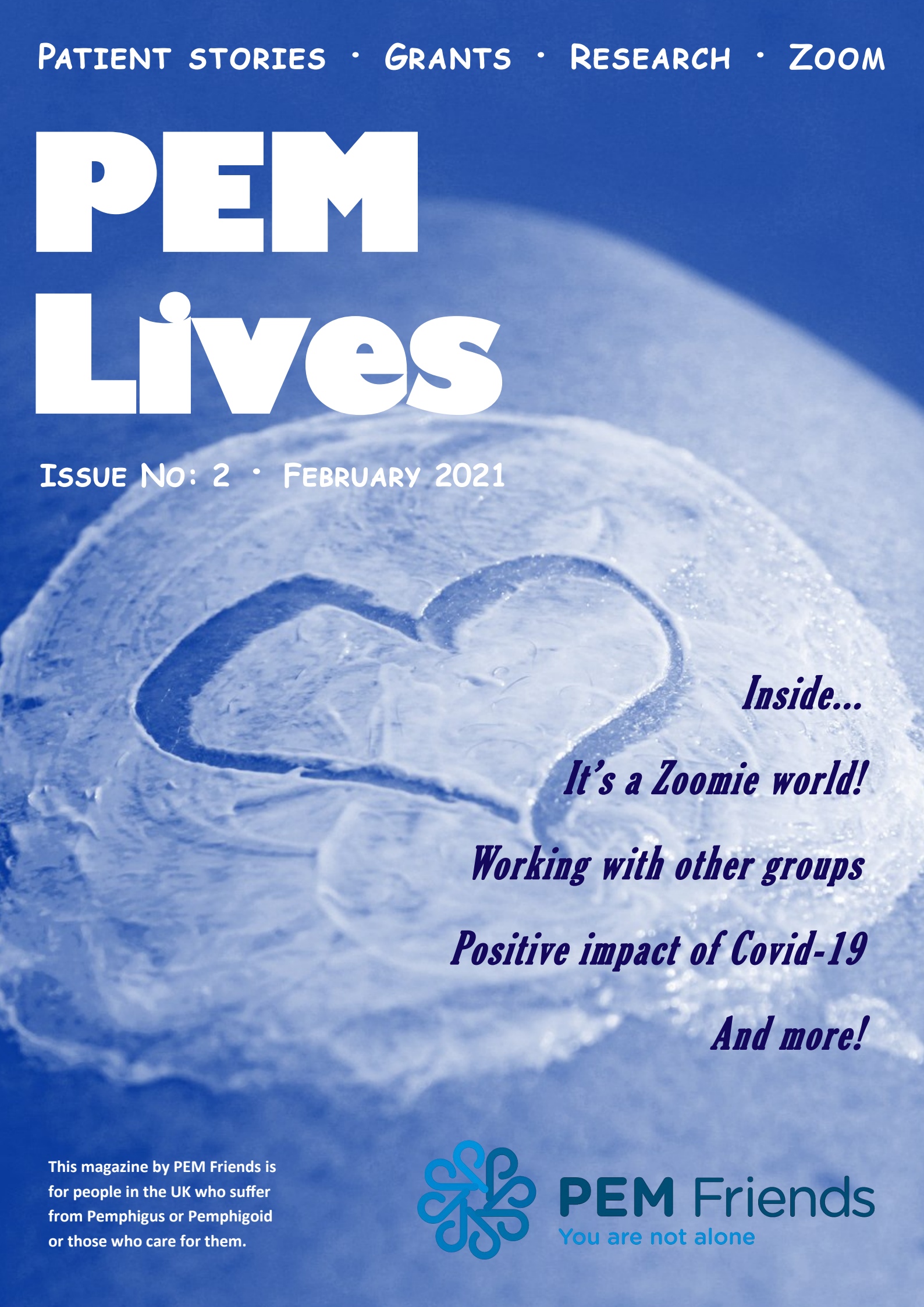
Patient stories · Grants · Research · Zoom

PEM Lives

Issue No: 2 · February 2021



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This magazine by PEM Friends is for people in the UK who suffer from Pemphigus or Pemphigoid or those who care for them.

PEM Friends
You are not alone

ISSUE NO:2
FEBRUARY 2021

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PEM Friends

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PEM Friends is for people in the UK who suffer from Pemphigus or Pemphigoid or those who care for them.

Who are we?

A warm welcome to the PEM Friends magazine. We hope it provides a summary of some of our recent activity but do go and visit the new website which is packed with much more information. www.pemfriendsuk.co.uk

PEM Friends is a support group for people in the UK who have been diagnosed with either Pemphigus or Pemphigoid, or those who care for them.

We have very little funding and most of our work is done by people who care and who are willing to offer their time and energy to support others. But there are many more people in the UK who have pemphigus and pemphigoid who don't know we are here and that we need to tell about us. And many clinicians and other medical professionals who may not be aware of these awful and rare diseases or the help that PEM Friends can offer. We would like to talk to anyone who is interested in these autoimmune bullous diseases

We try to keep up-to-date on any research or medical advances related to the diseases and increasingly participate as patient representatives, but we do this on an ad hoc basis.

Most support is via our closed and private Facebook group who are very active and extremely helpful. We also have set up weekly Zoom calls for anyone to attend and share any relevant topic. Or simply chat. Many members however, are on e-mail only or, occasionally only receive information via the post.

However people contact us, we will ty to help. If you would like to know more, do get in touch via the website.

Some PEM Friends at a recent Zoom meeting

A Year in the life of PEM Friends

By Isobel Davies

It's few months since the last edition in April 2020. We were then reeling from the changes to our lives as a consequence of Covid-19. And it has certainly been a year of many developments – a lot bad, but not entirely awful.

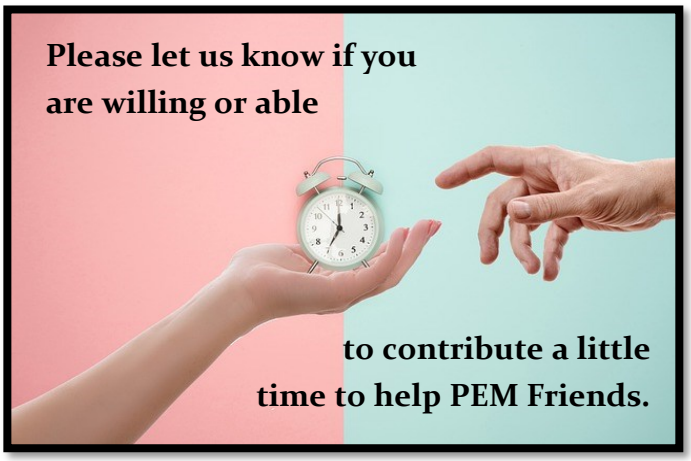
In April, we were pleased to mention the launch of the study into Bullous Pemphigoid by the Centre of Evidence Based Dermatology. This resulted in a lot of communication including videos featuring our own Ingrid and Jag. They have the potential to change how we treat Bullous Pemphigoid and the need for building more awareness about what seems to be less rare than we thought.

The Priority Setting Partnership for the treatment of blistering diseases is also still rolling on, but slowly. We are still refining the questions all the participants asked in order to re-examine the main priorities raised by patients and professionals.

Before the last Newsletter, we started to develop a brand new website. This launched prematurely because of the Covid-19 crisis and has provided an essential source of information. It continues to develop and was launched officially in October www.pemfriendsuk.co.uk.

We also set up weekly Zoom calls for those who simply wanted to check in and chat. These work well and we have extended these to include sessions with Professor Setterfield, an update on the research being done by Professor Dart at Moorfields and Ms Rauz at Birmingham and more to come. This latter discussion led to PEM Friends being invited to a session on Covid-19 and the implications to eye disease run by PINGU – the Uveitis Group that meet at Birmingham.

SCAN TO GO TO WEBSITE



Collaboration with and membership of other groups continues. So we have attended a number of virtual conferences and webinars. One of these, run by Findacure, initiated an application to the National Lottery Community Fund – sponsoring groups affected by Covid-19. And we were provided with a small and welcome grant. This gave us the confidence to apply for a small grant from GlobalSkin – an organisation we also belong to.

We want to do as much as possible to keep our information about our diseases, Covid-19 and the effects of the vaccine up to date and available for all.

In the middle of all of this, we have tried to build awareness amongst patients and clinical professionals. Our public Facebook page has been advertised to Dermatologists, GPs and Dentists and we are about to advertise again. The more clinicians that are aware of our diseases, the faster the diagnosis and the better the understanding of treatment options.

We are still working on the roll out of the project plans for the grants. Further information on these and the activity above can either be obtained from the website, or from anyone mentioned in this newsletter. And we are looking for anyone who can help. Please let us know if you are willing or able to contribute a little time to help PEM Friends.

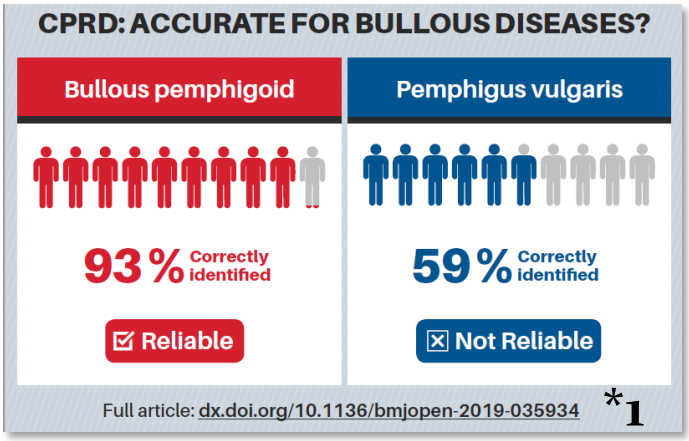
Study into Bullous Pemphigoid in the UK

By Dr Monica SM Persson

I do not need to start off by telling you what pemphigus and pemphigoid are, what their impact is, or why we need more research into these devastating diseases. It seems sufficient to start by saying that we agree – more research is needed. And that is exactly what we have been doing over the last year and a half at the Centre of Evidence Based Dermatology, University of Nottingham. Working closely with experts from the University of Oxford and the London School of Hygiene, and patient partners from PEM Friends UK, we have embarked on a journey aiming to improve our understanding of these diseases in the UK. I am delighted to the share the results of our research with you.

Faced with the inherent difficulties of studying a rare disease, we decided that the best approach would be to use electronic health records. When a person goes to visit their general practitioner in the UK, the information about the consultation is recorded electronically. For a subset of practices in the UK, encompassing approximately 17 million people, the anonymised version of that information is available for research purposes in the form of the Clinical Practice Research Datalink (CPRD).(***1**) Within it, we find all sorts of useful information – diagnoses, prescriptions, vaccinations, and basic personal information (e.g., age, gender). Such a rich resource is invaluable for examining rare diseases, but only if the diseases in question can be accurately identified from a person's health records.

We first set out to investigate whether we could accurately identify people with Bullous Pemphigoid (BP) and Pemphigus Vulgaris (PV) from their general practice records.(***2**) To do so, we compared the diagnosis each person had recorded in their general practice records to any blistering disease diagnosis they may have received whilst hospitalised. Now not everyone with BP or PV had been hospitalised, but we were able to compare the diagnoses for 797 people with BP and 85 with PV. We found that for every 100 people with a record for BP, approximately 93 had the disease according to hospital records. This was excellent news – we could use the CPRD to examine BP! Unfortunately, we could not say the same for



PV. For every 100 people with a record for PV, only 59 had PV. The other 40 had another blistering disease diagnosis, of which 25 had BP. Here we identified an inherent flaw in using electronic health records – it seemed that, too often, not enough care was taken when entering the diagnosis into the patient records. Disappointing, but perhaps not surprising. The diagnosis of BP or PV is made in dermatology departments and consequently fed back to the general practitioners where it is manually entered into the patients' electronic records. It seemed that the term pemphigus was used interchangeably with other terms, likely because of a lack of awareness of the differences between these similar-sounding diseases. The devastating bottom line – we could not use electronic health records in the UK to conduct much-needed research into PV. And so we turned our focus to BP.

The next step was to understand how many people were diagnosed with BP for the first time each year, how many people were living with it, and what the consequence of a diagnosis was in terms of mortality.(3) Between 1998 and 2017, we found for every 100,000 people approximately 7-8 per were diagnosed with BP for the first time each year in England. This is the highest reported incidence in the world and had increased by approximately 1%

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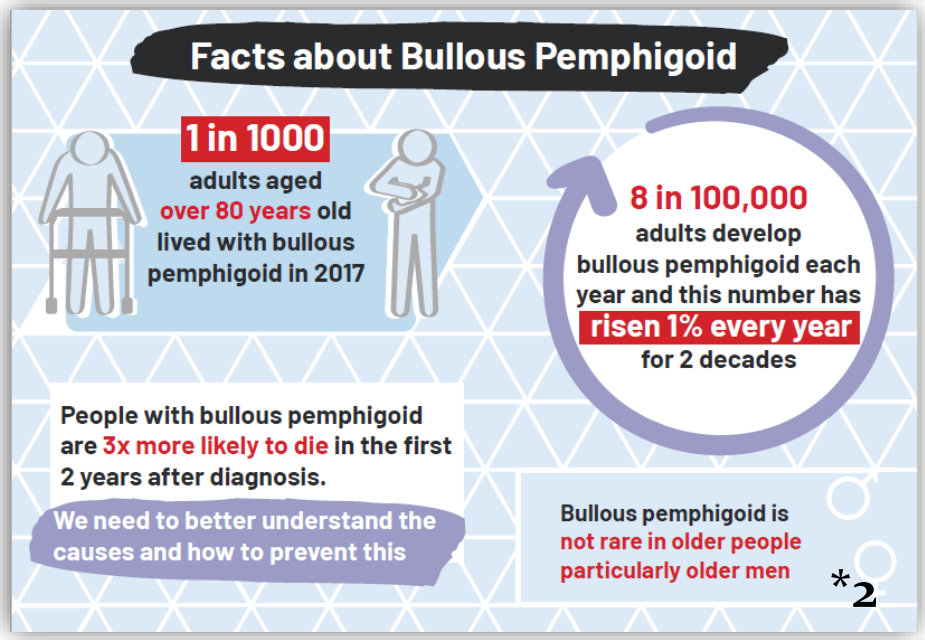


each year. We found that BP increased dramatically at older ages, and that older men, in particular, were most likely to be affected. Our most recent estimate (in 2017) was that about 48 in every 100,000 adults were living with BP. Focusing on the older age groups, about 141 in every 100,000 adults aged over 60 were living with BP, whilst 375 per 100,000 adults aged over 80 were affected. For reference, the European definition of a rare disease is a one affecting less than 50 per 100,000 people. As such, we argue that BP should not be considered “rare” in older age groups. Finally, what happened after the diagnosis? We found that in the two years after being diagnosed, those with bullous pemphigoid were approximately three times more likely to die than their peers. Even after this initial period, they remained at about 50% higher risk of death. A startling number to hear and should be followed by a caveat – because of the type of information we have, we could not specifically attribute the increased risk of death to the disease alone. Our finding may be influenced by factors such as differences in who gets BP (perhaps BP affects those that are already at higher risk of dying because of other health conditions) and the effects of the treatment for BP (for example, oral prednisolone). We call for greater awareness of the diseases, improved recording of blistering diseases in health records, and further research into the causes and prevention of excess deaths from the disease.

As a final word – we wanted to take our research one step further and provide information that might help researchers and clinicians plan trials of new treatments. Oral prednisolone has long been the mainstay of treatment for BP, but is often regarded as a double-edged sword. We therefore sought to understand the extent of the problem, so to speak. How many are prescribed oral prednisolone, at what doses, and how long for? In order to replace oral prednisolone with safer alternatives, trials of new treatments are required. We wanted to understand how many people might be eligible to take part in such trials in the UK and provide information that could be used when designing this trial. Sound interesting? As I write this, our work is being reviewed for publication to the scientific community. Stay tuned for an update, once the work is finalised. In the meantime, a little teaser – the extent of prednisolone prescribing for BP is worrisome, but it looks like we might have enough people in the UK to conduct trials of new treatments.

On behalf of the full study team: Dr Sonia Gran (principal investigator), Dr Karen Harman, Dr Yana Vinogradova, Professor Sinead M Langan, Professor Julia Hippisley-Cox, and Professor Kim Thomas.

References:

1. Herrett E, Gallagher AM, Bhaskaran K, Forbes H, Mathur R, van Staa T, et al. Data resource profile: Clinical Practice Research Datalink (CPRD). International Journal of Epidemiology. 2015;44(3):827-36.
2. Persson MS, Harman KE, Vinogradova Y, Langan SM, Hippisley-Cox J, Thomas KS, et al. Validation study of Bullous Pemphigoid and Pemphigus Vulgaris recording in routinely collected electronic primary healthcare records in England. BMJ open. 2020;10(7):e035934.
3. Persson M, Harman K, Vinogradova Y, Langan S, Hippisley Cox J, Thomas K, et al. Incidence, Prevalence and Mortality of Bullous Pemphigoid in England 1998–2017: a population based cohort study. British Journal of Dermatology 2020.

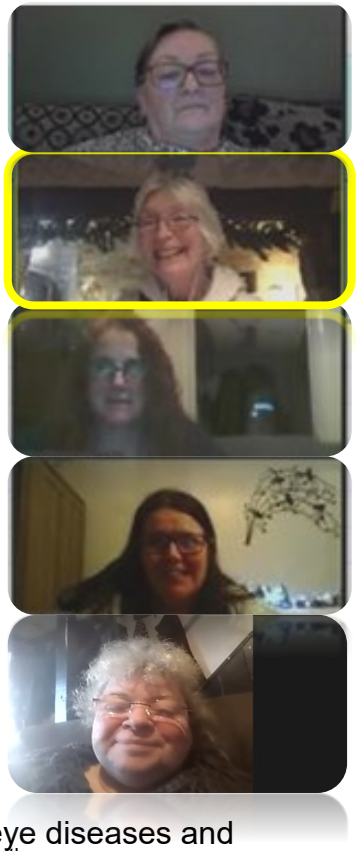
It's a Zoomie world!

Since the Zoom subscription covered by the grant provided by the National lottery Community Fund, we have been able to have regular weekly meetings for any PEM Friend to call in and chat.

These have developed into an opportunity to invite speakers on relevant topics to join us.

We have also been able to participate in various webinars and conferences arranged by other organisations such as the International Pemphigus and Pemphigoid Foundation, Global Skin and Findacure. The IPPF Annual conference was particularly interesting and allowed us to find out much more, as well as potentially get more involved in research and the development of new treatments into autoimmune bullous diseases.

PEM friends Ingrid, Jag and Isobel were involved at the start of the year in a very important UK study into the prevalence and impact of Bullous Pemphigoid. There were several routes for the roll out of the study results, but at the very start, Monica Persson from the Centre of Evidence Based Dermatology talked to us about the findings on a special Zoom call. Videos and podcasts followed.



In the Autumn, we had a Q&A session with Professor Jane Setterfield, particularly focussed on Covid-19 and our diseases

And in November 2020, Professor John Dart came and told us about his research work related to OMMP. The work and the talk were also done in collaboration with Si Rauz at Birmingham Eye Hospital. As a result of the session, we were invited to attend the Birmingham PINGU meeting (the local Uveitis Group) who were discussing autoimmune eye diseases and vaccines/Covid-19. On 28th January 2021, we were able to have a session with Dr Roddy McMillan from the Eastman Dental Clinic on the subject of oral pain management. A very appropriate discussion topic.

"Grant applications"

We have been very fortunate to be awarded our first grant by the National Lottery Community Fund for Covid-19, in order to reach more patients with Pemphigus or Pemphigoid and offer more support during these difficult times.

We have a small group working on our campaign to improve our existing support and to make more people aware of our work.

Emboldened by our success at winning some funding to boost our meagre resources, we applied for a GlobalSkin grant, which will allow us to enhance our awareness campaigns to very relevant groups, particularly using the UK study into Bullous Pemphigoid.

We would welcome anyone who is able to help in planning and implementing the projects.

HM Government

In partnership with

THE NATIONAL LOTTERY COMMUNITY FUND

GLOBALSKIN.ORG

International Alliance of Dermatology Patient Organizations

Patient stories

One journey to a diagnosis of Mucous Membrane Pemphigoid by Marie Sheppard

In August 2018 I noticed that I had bleeding gums and wondered if I was turning into a vampire as I would clean my teeth and on looking in the mirror see blood running from between my two upper front teeth. I had a horrid feeling that I would be out and about and frighten small children if I smiled at them! I had recently started using some nice soft toothbrushes and also bought some for my sister. I wondered if they could be the cause as I mentioned this to my twin sister and she said 'that's funny as this has happened to me', so we both put this bleeding down to the new toothbrushes! As my dentist and hygienist say I have good oral hygiene I didn't think I could be getting gum disease but resolved to spend extra time on cleaning and flossing during my imminent holiday to Italy. This made no difference and I felt a little bothered about why I was having these problems, which by then were the bleeding and rough feeling gums especially at the rear of my lower teeth. It felt stingy between my upper two front teeth and my palate felt stingy and burny.

October - Initial NHS dentist consultation. My dentist was puzzled with my bleeding gums and said she couldn't understand it for someone with good oral hygiene. The hygienist, however, had a theory. She thought the roughness of my gums and bleeding could be caused by an allergy to SLS in toothpaste and advised I use one without this ingredient. So began some months of carefully scrutinising the labels of toothpastes.... and a bathroom cupboard overburdened with many tubes. I spent quite a lot of that time wondering what I could do to soothe my sore gums. I developed an area below my lower central teeth that was incredibly sore – far worse than it looked. I also couldn't eat any citrus or sharp foods or alcohol. I went to the chemist's fairly often to buy and try yet another toothpaste and started to accumulate a big range of traditional pastes and health store pastes. In the end I almost had to stop brushing at all and was using coconut oil in the hope that would be soothing. I did a fair amount of grumbling too.

In November, we were invited to stay with a friend in Devon for the weekend. My mouth felt very sore on driving down and as soon as we arrived in Barnstaple I said I must go to a chemists and buy something for the soreness. I came out with a bag of unguents for sore and ulcerated gums. Wow! Did one of them sting! It was an ointment to seal mouth ulcers and did it make me jump! The next day it felt even worse and I emailed my dentist some photos as I was then concerned that I must have a gum infection. I happened to ask if antibiotics (which I hate taking) might work and was told to go ahead and take them, and indeed I had a slight improvement. I saw my dentist again on return home and she was very puzzled and said she couldn't understand it and would refer me to a Maxillo Facial Specialist. I met with a friend and was telling her about this and she said she had just been diagnosed with oral Lichen Planus and immediately been referred to hospital in case it was anything more serious. She had then been prescribed a steroid spray Beclomethasone in inhaler form as used by people with asthma. This had helped and she had been able to stop using it after two weeks. I had been told that the wait for appointment would be short but heard nothing. After about a month the dentist phoned and said that unfortunately they would have to do another referral. They had referred to a consultant in Sussex (where my dentist is and where I live) but as my GP service is in Surrey they had to re refer to Surrey.....so the wait restarted.

My research and a trip to the Periodontist. I read a lot of medical papers as in addition to wanting a diagnosis I was curious, probably because of my nursing experience. Eventually I decided that the most likely diagnosis according to my symptoms and peeling gums was erosive Lichen Planus. I decided to seek the advice of a private periodontist. He didn't pull any punches and said I had 'desquamative gingivitis' which is a symptom not a diagnosis. He also said I had 'incompetent lips' and that this probably meant my mouth was open at night and dried the gums out so this was why I had the soreness at the front of my mouth. He said to come back In January for a review. I then went to the chemist to look for products for dry mouth. I found a spray but it didn't help. I did more 'googling' and found a Mouth Ulcers website in the UK which sold dry mouth lozenges that can remain in the mouth all night – Xylimelt, and also very gentle toothpaste called Squiggle: SLS free and available with or without fluoride. They also sold the very soft Curaprox toothbrushes which I have found very helpful. Spent about £500 at the Periodontist's but still with no diagnosis.

My dentist had said that the Sussex specialist was very good, I decided to try and get a private appointment. This was totally messed up by the private hospital and I couldn't get an appointment with him so asked if they could recommend anyone else. I saw a dermatologist which was most unsatisfactory as she said that she couldn't take a biopsy as dermatologists couldn't take oral biopsies. That was £200 wasted. My husband has asthma so I had access to a supply of Beclomethasone steroid inhaler . I tried this and it really helped, so I went to my GP and asked if she could prescribe it. She refused to prescribe it without a diagnosis having been made. I carried on using it anyway as it was helping. Fortunately my husband is a bit of a stock piler so we had plenty for both of us.

March - I was finally seen at the Maxillo Facial clinic in Surrey. I was assessed by a very pleasant junior dentist/

doctor. She called the Consultant in and he took one look and said I think it is more likely to be Mucous Membrane Pemphigoid than Lichen Planus. He seemed happy with me using the steroid inhaler and recommended that I continue to do so whilst waiting for a biopsy. I asked him if a diagnosis of Mucous Membrane Pemphigoid was 'better' than one of Lichen Planus. He shrugged and said 'the treatment is the same' and that was that! I then obtained my own supply of steroid inhaler from the GP!

Biopsy - I had written to ask if the steroid treatment should be stopped prior to the biopsy as I was concerned that it might mask any disease. I had a letter back saying 'no' it was fine to continue the treatment. My heart sank when I saw who was to perform the biopsy as I had found this dentist to not be very empathetic when I had had a difficult extraction some years previously. She asked if I had stopped the steroids prior to the biopsy and I explained why I hadn't. She wasn't impressed! She decided to take the biopsy from the incredibly sore area below my central lower teeth. Of course it didn't hurt at the time, but I heard her say to the dental nurse 'oh dear I have put it in the wrong specimen pot' 'we will have to do another'. She then chose to take the second from the area above the two central upper teeth. I left with a rather muttered 'thank you'. The lower biopsy site took a month to heal and was very painful. There is still a grey area on the gum that looks like an ulcer but is the healed wound site. I hadn't expected it to be so painful and again was quite grumpy as eating was even more difficult. I stopped the steroid spray as I didn't want the steroids to inhibit healing. The upper biopsied area healed very quickly and painlessly. I read a bit more about biopsies and found that the biopsies should not be taken from affected areas as the disease shows up in other areas of the gums too, so I felt quite upset about that, as I think I had had needless pain and not even an apology for putting the tissue in the wrong specimen pot!

Diagnosis At the follow up appointment I was told I had MMP and that I would be referred to Guy's Hospital for management oversight but continue to attend the Surrey hospital for yearly review. I said that I had a burning mouth as well and so the consultant suspected that I had non visible thrush and prescribed an anti fungal rinse. I don't think I had thrush as the burning mouth comes and goes but is not really a problem. Beclomethasone spray contains alcohol and there is no spray without this. It stings if the gums are sore so I asked the Consultant to prescribe some Clobetasol ointment so that I could target very sore areas and he agreed. In their wisdom the GPs decided to prescribe Clobetasol cream so there was another delay while that was sorted out – especially as the Receptionist told me that people 'normally want to put it all over their bodies'....Perhaps they have a lot of pemphigoid patients!

Referral to Guy's – another problematic referral I didn't hear from Guy's within the time frame that I expected so I contacted them and found out that they had never received my referral. They said that they only received electronic referrals and if a letter had been sent they would just return it!!! I found this unbelievable. I contacted the referring hospital and found that they had indeed sent a letter but they also said that it had not been returned. I talked them through how to make the referral and off it went again. Around this time I started reading up on MMP and found that it was a very variable disease but one in which eye involvement could occur and become very serious. I wrote to my consultant and he agreed to refer me for an ophthalmology appointment. I see that BAD recommends this.

July – Ophthalmology appointment and Dr Setterfield A grumpy ophthalmologist makes it clear I am wasting her time but at least tells me my eyes seem to be clear so that is good news. Unfortunately I am not well on my Guy's appointment day as I have a burgeoning migraine. My husband accompanied me and I was grateful for that. It was a very hot day. Dr Setterfield had a good look and carried out the disease scoring system. She said I had mild disease and was interested to see the photos that I had from pre steroid treatment times. She didn't change my treatment but took some blood and said to come back in 6 months time.

Adaptation - I think I found the PEM Friends group during this time as I can see that I have posted a few times about trying alternative treatments such as turmeric when I thought I had Lichen Planus. I found it very interesting and supportive to read about people's experiences and discussions about consultants and hospitals that can help, as well as new developments and research. I am aware that in comparison to many people I have mild disease and was diagnosed comparatively quickly although I don't think I would have been if I hadn't persisted and maybe had some medical knowledge. **An object of interest -** I have found that at other medical appointments doctors look rather interested when I say I have MMP! Rather than a routine A.N.Other they sit up a bit more and a light goes on in their eyes....

Unfortunately since my dad died in early 2018, I have had a nearly full Bingo card of referrals and diagnoses : chronic migraine, strange recurrent lump in the palm, pins and needles in the thigh, vulval symptoms (not thought to be MMP but possibly Lichen Sclerosis, which my twin has) and a persistent hoarse voice (not MMP). I do wonder if this has all happened as a consequence of both age and stress after years of caring for my dad.

The chronic migraine is the worst of the problems and I have recently started a monoclonal antibody treatment called Ajovy a CGRP inhibitor. If I hadn't been desperate with the migraine I would have not started this as it is a very new injectable drug and the long term side effects including on the mucosa are unknown. It is meant to be available now on the NHS but because of Covid it isn't so that is another huge drain on my resources.

The good outcome

I can now manage the oral MMP very well as follows:

- By maintaining very good oral hygiene – regular 3 monthly appointments at the hygienist really help though because of Covid they aren't available to me as they were before.
- Using 3 betamethasone steroid tablets dissolved in water as a mouth rinse after cleaning my teeth at night
- Clobetasol ointment to excessively sore spots.
- Using Squiggle toothpaste, a Curaprox toothbrush in the morning and an extra sensitive brush on my Oral B electric toothbrush at night along with interdental brushes and floss.
- Xylimelt lozenges if my mouth is dry at night.
- Keeping up to date with PEMfriends and all the comments and research.
- I can eat and drink most things but find that citrus and alcohol still sting and I rarely have these. I am also concerned about how the disease might progress and how to get relevant appointments with Opthalmology and ENT to monitor potential sites.

Another Journey by Helen Robinson

I started my PF in February 2017, with something resembling a heat rash under my breasts and stomach, then a rash on my back/shoulder and a very itchy scalp. My doctor was brilliant and kept trying creams and shampoos. I then started with blisters and he put me on steroids and said I needed to see a dermatologist. He was great and after a while increased my steroids and said I needed a biopsy. This told me I had PF and he increased my steroids up to 60mg the blisters had spread a lot. I had approximately 3 months of bad blisters and then it calmed down and by the end of September it was completely gone and I was off steroids completely.

I reacted badly to coming off the steroids, I now realise it was too quick, all of me really ached and it affected my mobility badly. Mentally I couldn't cope at all and I had to leave my preschool work at Christmas. December 23rd the blisters appeared on the top of my feet and I thought oh I will go to the dermatologist after Christmas! My second attack of PF attacked my body so fast and this time I was covered, I had a new dermatologist and she put me on Azathioprine as well as 60mg steroids and after 3 months it stopped spreading and started to calm down. It's now 2 and a half years later, I always have PF on my face, scalp and neck and small bits of me flare up from time to time. I take 200g of Azathioprine daily and can control my own steroids up to 10mg. If I go below 5mg it starts to flare up.

How did I feel before the zoom meetings? I follow the group which I find interesting and helpful. I also have an email friend with PV who this group introduced to me 2 years ago and we message each other every week. He is my Pem rock. I'd already had time to get used to not going to work, so nothing different there. My children are all grown up and live away so I am used to not seeing them, but I did find it very hard not to see them at all. We did do a couple of day trips, 275 and 380 miles round trip for the day was a long day, but worth it. Our son came home for the first lockdown and lived in the caravan for 2 weeks then moved back in and worked from home. My husband's school had the virus first, shut down and were very understanding because of me and he went back in September. So, of course it's been tricky but I consider myself lucky and hopefully life will return to normal one day.

Positive impact of Covid-19

Due to Covid-19, our PEM Friends group leader Isobel set up weekly zoom meetings. It's been great for me to see and meet the people whom I share information and my feelings with in the group. It's good to be able to all talk together with friends. It makes living with PF easier to cope with when you don't feel so isolated. The Facebook group is great but I really look forward to the zoom meetings.

My Bullous Pemphigoid Diary by Maeve Miller

It all began in January 2015 with a very itchy rash all over my body. Unfortunately this corresponded with my G P becoming ill and retiring. Her patients were moved to the other GPs in the practice. My allocated one had gone on leave, so I was left with useless locum doctors. The first one said I had been bitten by bed bugs (couldn't understand why they were not biting my Husband) I also had a blister on my navel which she claimed was an infection from dirt. I now know that it was probably a Pemphigoid blister. I went home in tears not sure what to do. I couldn't stop the itchy rash and the blister burst.

Spots began to blister, back to another locum he didn't have a clue. Same with another locum.

- 26 June 2016 - A GP thought it was Pemphigoid or Pemphigus but said I should see my own G P.
- 3 July - eventually my GP who had seen 1 case before thought Pemphigoid and said I needed a biopsy to confirm.

Off I go to Bristol Royal Infirmary Dermatology (as hubby had not yet retired, transport was 11 miles on the bus). Dermatologist said for a biopsy the blisters must be intact but mine had burst. 'Come back when you have one'. A few times thought this possible but it was difficult getting dressed and not bursting them.

- Eventually 27 August with 2 small blisters on left breast (think wearing a bra stopped them bursting) met Dr Wiodek, go, into operation room in Dermatology. Anaesthetic injections into left breast and 2 small blisters removed.
- Given Doxycycline and Dermovate.
- Histology confirmed Bullous Pemphigoid. I then had monthly appointments.
- 18 December started Azathioprine this made me vomit and have nausea.
- 11 January 2016 started Nicotinamide which didn't help.
- 20 February given Prednisone and stopped 10 March - huge side effects and did not stop blisters forming, high blood pressure, blood shot eyes, nose bleeds, hives, itchy skin, disturbed sleep, aching arms and legs.

It took various antihistamines to relieve Urticaria. I Have tried Protopic and Betnovate cream but prefer Dermovate for blisters. In August was given Tacrotimus to apply to thinner on skin chest and face.

- 2 May started Dapsone this made my feet swell and couldn't get shoes on.

Also gaining weight not good at Slimming World. When I stopped it,weight went back to normal.

- 29 September tried Prednisone again but stopped it 7 October - 8lbs heavier.
- 11 December tried Azathioprine again same problem as before.
- 12 December phone call from Dr de Berker telling me to stop taking it immediately because of abnormal blood count.
- 13 December run to nurse for blood test after blood running down my leg.
- 29 December 2016 started Mycophenolate but as this takes 5/6 months to take effect blisters getting larger
- February 2017 left leg turned red and swollen I was sent from G P to Dermatology and admitted with Cellulitis. Given drugs intravenously, as they don't have a ward of their own and hospital filling up my bed was transferred to the ladies gym for the first night. 2 weeks later discharged to my G P nurses to continue aspirating the blisters.

Blisters have now settled down taking Mycophenolate and Doxycycline. I also take 2 Penicillin daily. My Dermatologist is worried Cellulitis will return. Now only occasional tiny blisters which Dermovate helps. Nothing like the plum size of before.

A small anecdote By Ingrid Thompson

Those of you who know me may know I have a thing about watches and cats of course, so cat watches are perfect. Since my illness I have not been able to wear a watch. Look at this hideous thing which my steroid-induced mania made me order. I thought it was fantastic and jumped at the chance to buy it. The day I can wear it will be another step on the road to recovery but, a reminder of some of the effects of steroids no one mentions!!

RESEARCH INTO OCULAR MUCOUS MEMBRANE PEMPHIGOID

By John KG Dart MA DM FRCOphth
Hon. Consultant ophthalmologist
Hon. Professor, University College London

The MMP research is going ahead. We have recently published two important papers on the diagnosis of ocular MMP in Ophthalmology which is the clinical ophthalmology journal with the highest international impact (the one with the greatest reach amongst ophthalmologists). These have resulted in the acceptance, by the European Academy of Dermatology and Venerology (EADV) MMP Guideline Committee, that ocular monosite MMP can be diagnosed without the need for either a positive biopsy or positive autoantibodies (from a blood test). The EADV Guideline is to be published this year, having been in development since March 2018. The EADV is the major organisation for European Dermatologists but also has a worldwide membership. Our first study has shown that patients with ocular monosite MMP and negative Direct Immunofluorescence (DIF) on biopsies have disease indistinguishable from that in DIF positive biopsy patients ; in patients with a negative biopsy the diagnosis of ocular MMP can be made by following a protocol for excluding the other conjunctival scarring disorders. The publication (referenced below) received an Editorial stating that at last we had evidence to refute the “eminence based” Consensus (published in 2002) that a positive biopsy test is necessary for diagnosis. The latter Consensus has been damaging for many patients with predominantly ocular disease by denying them the diagnosis of MMP and the immunosuppressive treatment that is needed, to prevent progression, by 80% of patients with ocular MMP. Subsequently we explored the possibility that a panel of auto-antibody tests (blood tests) might help to confirm an immunological diagnosis in this patient group with a negative biopsy on DIF but meeting these new criteria for ocular MMP; this study showed that the currently available tests are unhelpful for diagnosis in ocular MMP. These publications came from the 112 patient cross-sectional study that so many PEM Friends contributed to.

- Ong HS, Setterfield JF, Minassian DC, Dart JK. Mucous Membrane Pemphigoid with Ocular Involvement: The Clinical Phenotype and Its Relationship to Direct Immunofluorescence Findings. Ophthalmology. 2018;125 (4):496-504. doi: 10.1016/ j.ophtha.2017.10.004. Epub 2017 Dec 6.
- Dart J, Setterfield J, Groves R, Mee J, Diercks G, Pas H, Minassian D. Autoantibody detection for Diagnosis in Direct Immunofluorescence Negative Mucous Membrane Pemphigoid: ocular and other sites compared. Ophthalmology (published online first 31 Jul 2020)

Another publication out this year (see below) was carried out on 55 patients, who attended twice on Saturdays, allowing us to develop a validated tool (reproducible both for one observer and between observers) for measuring inflammation, scarring and morbidity (the resulting damage) resulting from all causes of cicatrising (scarring) conjunctivitis including MMP. This is called the Cicatrising Conjunctivitis Assessment Tool. The Tool is on 2 sides of A4 and its parts can be used independently - for example most patients will have the inflammation assessment every visit (it takes a minute or two to do) and the full assessment once a year. It will be used with the custom-made fornix depth measurer (FDM) to measure scarring. The latter has been validated in separate studies and we have normative age-related values for both Caucasians and South Asians so that it is possible, in these ethnic groups, to establish whether or not a measurement might indicate scarring in early disease. In established disease this tool allows us to measure progression, as we have shown in an earlier study.

- Ong HS, Minassian D, Rauz S, Mehta JS and Dart JK, (2019). Validation of a clinical assessment tool for cicatrising conjunctivitis? The Ocular Surface 2020;18(1):121-9.

Continued.. RESEARCH INTO OCULAR MUCOUS MEMBRANE PEMPHIGOID

I have 2 PhD students. One is at UCL Royal Free working on the mechanism of scarring resulting from the ALDH/Retinoic acid pathways that we have shown is central to the conjunctival scarring process in MMP. The other is a UCL student, but also now an ophthalmology consultant in Singapore, who is finishing off his PhD on gene expression as a biomarker for inflammation and scarring activity in the conjunctiva and a study on the ocular microbiome which may relate to the disease - this is a hot area at present and this will be the first study on the microbiome in MMP. The samples are being analysed now.

The development of disulfiram as a topical (eye drop or ointment) anti-scarring therapy is still going ahead. The publication on the Assessment Tool is necessary for the Grant that we will submit to the MRC DPFS scheme in a month. Saeeha (Si) Rauz, Reader at Birmingham University, has taken over as lead PI on this and now has the patent from UCL to allow them to push this forward. I am a co-investigator on this with David Abraham (also from UCL) and Professors Ijeoma Uchegbu and Andreas Schatzlein from the UCL School of Pharmacy. The latter have a formulation of disulfiram which is patentable and soluble. Si works with Prof Nick Barnes, a pharmacology expert and Graham Wallace, an immunologist. Graham and Si have shown that ALDH levels are elevated in conjunctival washings from MMP patients vs Controls which gives us a biological readout. These Grants are difficult to get but we are hopeful. If we are successful, we will be able to go through the necessary formulation and toxicity studies followed by human Phase I and human Phase II studies which will give us efficacy data in patients. We anticipate the eye drop being used once a day in the long term for the control of scarring in MMP. It is also anti-inflammatory and we will also evaluate this using our new Assessment Tool. The Grant will be for 5 years - if we get it this and the drug is successful, we will then involve a commercial pharmaceutical company in the final stage of development which will require a Phase III randomised controlled trial.

What can we tell you about PEM? (From a non-expert perspective)

Pemphigus and Pemphigoid (as well as some related diseases) are groups of auto-immune diseases that affect the skin and/or mucous membranes. They are also grouped under the title auto-immune bullous diseases (AIBD).

Like other auto-immune diseases, they occur when your immune system starts to attack parts of the body that it shouldn't and, in our case, that is your skin. Sometimes the blisters start in your mouth. The anti-bodies which are a consequence of your faulty immune activity attack the glue which holds the layers of your skin (the dermis and epidermis) together and this, in turn, creates blisters. Although quite often, the early stages of Bullous Pemphigoid appear like a rash and do not always erupt into blisters.

Differences in the various blistering diseases are created by the way the immune system attacks the various levels of the dermis and epidermis. No-one knows what causes PEM. We do know that, like many other related diseases, there is a genetic fault at the start, and that usually a trigger such as stress, another illness or a drug used to treat another condition that causes the PEM to erupt. It is possible also, that the fact that the immune system weakens with age, that these diseases tend to appear in later years.

The PEM diseases are generally very rare, although the symptoms can easily be confused with other skin ailments. That causes problems with finding a diagnosis and treatments are usually from the range of borrowed drugs – drugs that have been "repurposed" from other similar inflammatory or auto-immune diseases. Pemphigus and Pemphigoid can be disfiguring but are not infectious and cannot be caught or passed on to anyone else.

A cure for these diseases is unavailable today, but they can be treated successfully, and you can achieve remission from them, with either no ongoing treatment or a very small maintenance dose of the drug that manages your PEM. To have a confirmation of the Pemphigus or Pemphigoid, there are several tests. In Pemphigus, blisters tend to form when the skin is rubbed (Nikolsky sign). An ELISA test is an enzyme linked immunosorbent assay also called that detects and measures antibodies in your blood. It involves taking a blood sample. The most reliable test is an indirect immunofluorescence test which shows if and where the layers of the dermis or epidermis are being targeted. This test involves taking a biopsy from a blister.

Working with other groups

One of the marked changes in 2020 was the extent to which we have engaged with and been helped by other organisations.

Collaboration with other groups supporting people with PEM around the world has been facilitated by the International Pemphigus and Pemphigoid Foundation (IPPF) and in addition, our relationship with our French friends the APPF has grown from strength the strength. We are particularly grateful for their work representing our diseases on the e-PAGS. These are the patient groups who work with the European Reference Networks (ERN's) – groups of medical specialists from across Europe whose aim is to pool knowledge to ensure better access for patients with rare diseases to highly specialised healthcare, improving diagnosis and care in medical domains where expertise is rare. This type of collaboration can maximise the speed and scale of adoption and spread of innovations in medical science and health technologies. We are hopeful that, despite BREXIT, UK participation in these ERN's, particularly the one relevant to us on SKIN and Autoimmune Bullous Disease in particular continues.

The International Alliance of Dermatological Patient Organisations, better known as GlobalSkin (we are a member) has, with the IPPF, provided us with information, advice, links to other groups and access to potential new treatments and trials. Following the IPPF Conference, we have spoken to several BioPharmaceutical Companies who are doing great work on new treatments for Pemphigus and Pemphigoid.

Findacure in the UK has also helped a lot. They run training and information exchange sessions which keep us informed and building (some) expertise in important areas such as social media marketing – important if we are to grow awareness.

Several other organisations, including the Coronavirus Community Support Fund (CCSF) Learning Hub (a result of being provided with the National Lottery Community grant) have also provided us with much needed ideas, information, learning opportunities and an important boost to morale.

And last, but not least, we are very pleased to be allied with the wonderful Penny at the PV Network at last.

Thank you to them all as well as to those not mentioned here!

www.pemfriendsuk.co.uk

You will find a wealth of information as you look around the new PEM Friends website.

PEM Financials

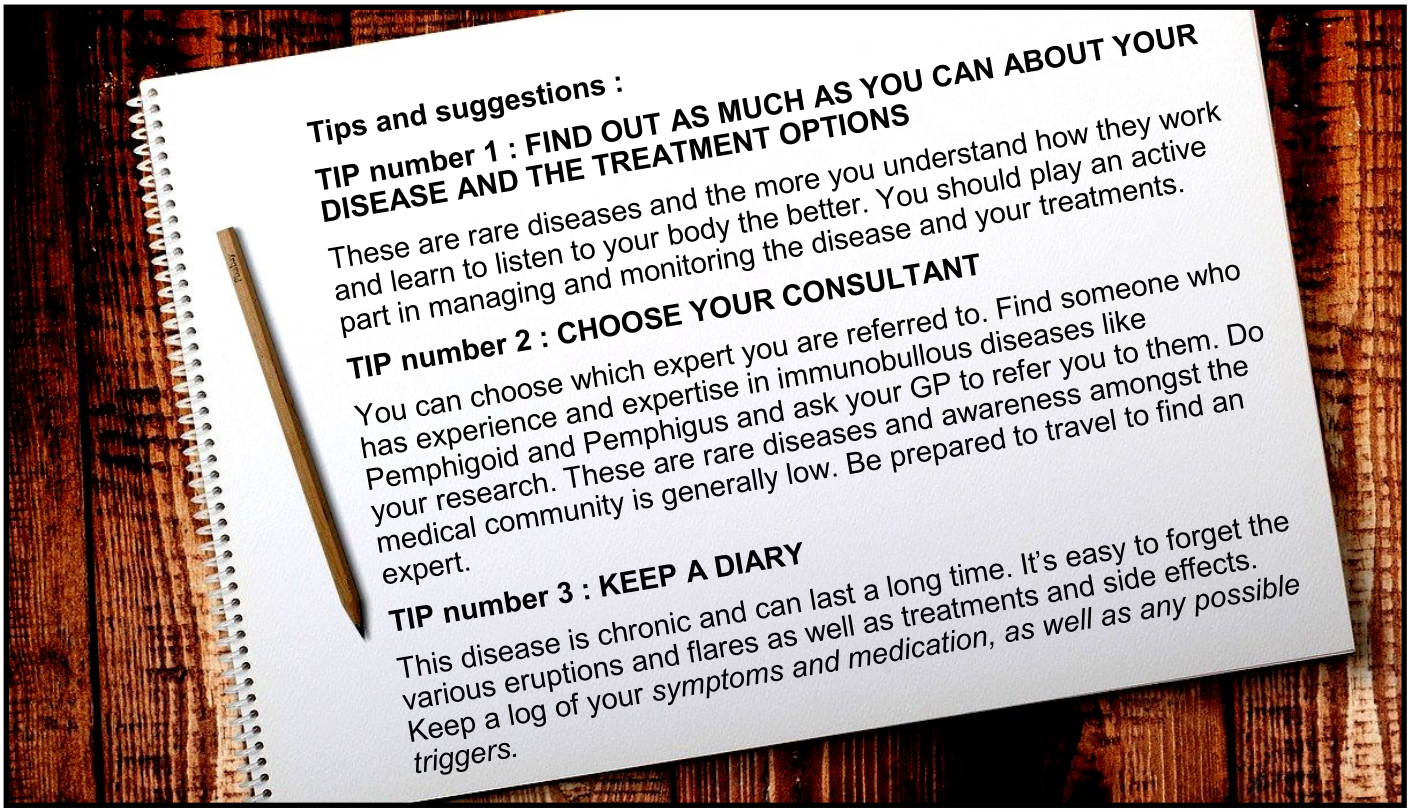
From Kalpesh Patel, our treasurer

Happy New Year!!! I wanted to start off by thanking everyone who has donated throughout the year, your continued support is very much appreciated and vital to our work. Without you, we would be unable to continue in the way we have. If you can spare even a few pounds every so often, it would enable us to offer our support to more people.

In the year 2020, the net funds raised from Donations and Grants was £3125.00. of which £2500 grant from the National Lottery and £625.00 from Friends of PEM Friends! £562.96 was spent on Website improvement, Zoom Subscription and Thank You Vouchers to our invited guests.

Isobel, Caroline, Trina, Sharon and Ingrid are all working very hard to identify effective ways of spending the National Lottery Grant to increase the awareness of PEM Friends , the PEM diseases and support services.

Bank name:	**HSBC**
Account Number:	**51504525**
Sort Code:	**40-08-33**
Account name:	**PEM FRIENDS**



SPECIAL ANNOUNCEMENT

We are delighted to announce our brand new little PEM Friend, Aoife who was born on 10th December 2020. Proud parents Siobhan & James are both besotted with their baby girl and are so thankful to have been so well supported by Prof Nelson-Piercy and Prof Setterfield and a team of midwives.

Siobhan suffers with Pemphigus Vulgaris and its wonderful to share her news. More details coming up in the next edition of PEM Lives…

The Virtual Rare Disease Showcase

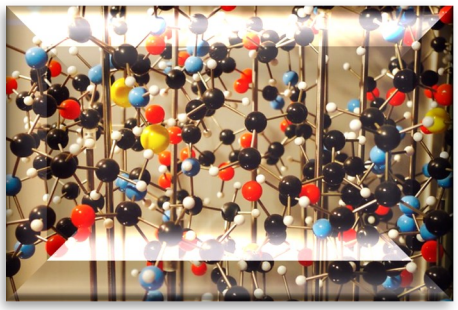
By Julie Martin

Rare disease conferences are one place where patients, doctors, carers, medical students and representatives from the pharmaceutical industry can meet, share knowledge and mingle. 2020 brought a whole different agenda to the conference platform: how to manage a three day event virtually in this new world of Covid-19. Findacure (www.findacure.org.uk) hosted the event in November 2020, and I was the patient representative for PEM Friends. Below are my notes from the three days. Like 'in person' conferences, there were a number of guest speakers within the patient, pharmaceutical and medical community followed by a number of fascinating break-out sessions. There were also opportunities to connect with other conference members and further one-to-one sessions. I found the whole experience both educational and extremely comforting. Those of us with rare diseases certainly are not alone. We have the support of patient-led groups and the vast and ever growing knowledge base of the medical and pharmaceutical industries.

Day 1/November 17:

Covid 19 certainly didn't go unnoticed during this conference. One topic covered was the repurposing of drugs to fight Covid-19, which was able to speed up development from six years to one year. Another common theme throughout the three days was how to engage the rare disease community virtually. The session 'Building Patient Communities' explored ideas on how rare disease groups can improve communication to patients. These included dedicated Covid-19 pages on rare disease websites, hosting webinars with medical specialists and creating newsletters for those individuals who aren't computer comfortable. I had my first introduction to a wonderful organisation called Medics 4 Rare Diseases (www.m4rd.org), and PEM Friends looks forward to linking up with this group in the future. This is a group of medical students and doctors in training who have a particular interest in rare diseases.

Day2/November 18:



The day included an introduction to Genomics and its use to lessen the time patients spend on their diagnostic odyssey to find not only what disease they have, but also the most appropriate form of treatment. It is worth noting that an underlying genetic cause is common with rare diseases. Two other sessions I attended were 'Going Digital: Opportunities to build and engage new communities' which discussed the use of platforms such as Instagram and Twitter to reach out to patients and the medical community and 'Engaging Diverse Communities in Rare Diseases' which was hosted by the Breaking Down Barriers project supporting members of the BAME community.

Day 3/November 19:

The final day was more focused towards the medical and pharmaceutical attendees, but what I took away with me from that day was the importance of patient input with the medical/pharmaceutical industry in drug trials and research. The importance of patient advocacy with drug companies can offer an opportunity for rare disease sufferers to play a part in their patient odyssey.

Hopefully next year we'll be able to attend in person and meet up with members of our rare disease community.

PEM Friends Crossword

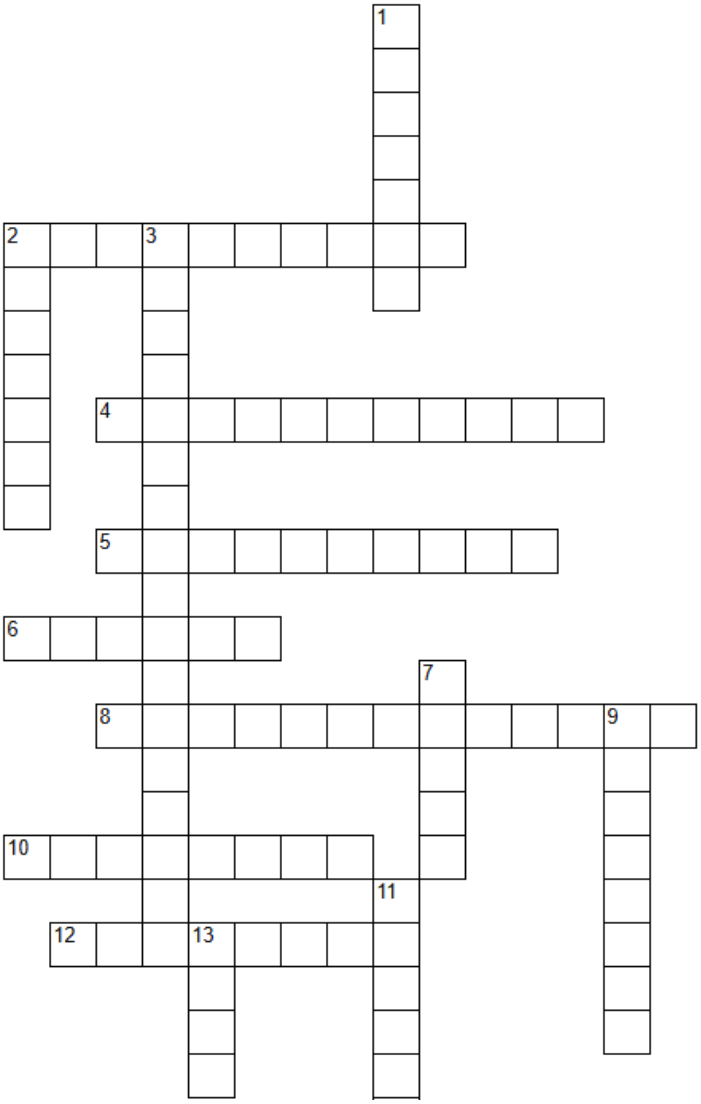
A little bit of fun

Across

2 What are the proteins your immune system makes called?
4 Blisters that pop open can get infected. These drugs help prevent an infection?
5 A disease which causes an individual's immune system to react against his or her own tissue.
6 When your doctor removes a piece of skin and looks at it under a microscope?
8 Someone who looks closely with interest at your skin?
10 An illness which is the result of the body not producing sufficient amounts of certain adrenal hormones?
12 What is an eight-letter word meaning 'a mental condition of fixed opposition to or dislike of some particular thing'?

Down

1 A small pocket of body fluid under a layer of skin?
2 What is a seven-letter word meaning 'loud enough to be heard'?
3 Our medicines are call this type of medicine?
7 This test can show how severe your condition is. It can also help the doctor see whether treatment is working.
9 A drug used to decrease inflammation.
11 Someone who is extremely rare?
13 Intriguing object worth collecting.



Answers revealed in the next issue!

Can you unscramble these words related to us and our everyday lives?

1. **EPIPOIDMGH** _____
2. **MUCSUO** _____
3. **ESGHIPUMP** _____
4. **GOMIARTTDSEOL** _____
5. **TODCOR** _____
6. **UPOSTPR** _____
7. **IERNSFD** _____
8. **OMOZ** _____
9. **ACER** _____
10. **NMEAEBMR** _____

Thought for the day for PEM Friends...

Friendship is good for your health. Believe it or not, people with larger networks of friends actually live longer! Having friends can reduce stress and depression and add immensely to your happiness. Isn't it true that you always feel especially cheerful and at ease when you're with your friends?

Links to other groups:

Rareconnect: https://www.rareconnect.org/en/community/pemphigus-and-pemphigoid

The International Pemphigus and Pemphigoid Foundation: http://www.pemphigus.org

NHS: http://www.nhs.uk

Findacure: https://www.findacure.org.uk

PV Network: http://www.pemphigus.org.uk

GlobalSkin: https://www.globalskin.org

CCSF Learning hub: https://www.tavinstitute.org/projects/coronavirus-c

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