Introduction

Bullous pemphigoid (BP) constitutes the most common autoimmune subepidermal blistering dermatosis. It is associated with tissue-bound and circulating autoantibodies directed against BP antigen 180 (BP180, BPAG2 or type XVII collagen) and BP antigen 230 (BP230 or BPAG1e – epithelial isoform). The latter are components of junctional adhesion complexes called hemidesmosomes that promote dermal–epidermal cohesion. BP typically develops in patients older than 70 years.[1,2] The mean age of patients at diagnosis in Europe is around 80 years. The severity of itch and cutaneous lesions significantly disturbs the quality of life in affected patients. The disease carries considerable morbidity and a two- to threefold higher mortality compared with the age- and sex-adjusted general population.[3–5]

Its annual incidence has been estimated to range from 6 to 43 new cases per million population per year. Advanced age, concomitant neurologic diseases, poor general condition, and long-term use of high-dose corticosteroids (CS), among others, portend a poor prognosis.[6,7]

The consensus for the management of BP has been updated because of new clinical information, and changes in evidence on existing therapeutic interventions and in outcomes. Specifically, in the past two decades, the incidence of BP seems to have significantly grown, which might be related to raised awareness of atypical non-bullous forms, an increased frequency of dementia and debilitating neurological disorders, which are significantly associated with BP, and finally to an increasing use of drugs potentially triggering BP. In particular, gliptins and immune checkpoint inhibitors have been recognized to increase the risk of and cause BP, respectively, highlighting the importance of a systematic evaluation of drug triggers in the development of BP, and needing to address the question of the usefulness of stopping these drugs. Furthermore, results obtained from either new open or randomized controlled trials (RCTs), assessing immunomodulatory drugs and biologics, as well as novel diagnostic tools, are available. Finally, quality of life as patient-reported outcome and importance of shared-decision making for treatment planning constitute important elements to systematically consider whenever possible.

This consensus further takes into consideration that healthcare settings and modalities are different among European countries, in particular, hospitalization rules, home care availability and the possibility of financial reimbursement for different treatments. The aim of this revised consensus is to make recommendations for the most common situations and is not intended to exhaustively cover specific disease variants of BP, including childhood pemphigoid.[1,2,8] The consensus is also not intended to specifically address and review the predictable and potential side-effects of the proposed drugs. Differences between the recommendations in the present consensus statement of European experts and other national guidelines reflect incomplete knowledge on the matter of optimal treatment modalities in BP due to the paucity of RCTs in this area. The latter may lead to divergent expert opinion on a number of open questions, which ongoing and future studies need to clarify.

Methodology for updating the guidelines

To facilitate this process, a writing group, i.e. LB, NVB, CF and PJ appointed by the EADV Task force *Autoimmune blistering diseases*, revised the first version of the guidelines published in 2015 by reviewing all new relevant knowledge on clinical practice, and evidence about benefits of novel diagnostic and therapeutic interventions and outcomes.

The following syntax was used for specific recommendations based on the following levels of evidence:

- Strong recommendations from large randomized prospective multicentre studies (level of evidence 1): '***is recommended***';
- Recommendations from small randomized or non-randomized prospective multicentre or large retrospective multicentre studies: '***may be recommended***';
- Recommendation pending from case series, or small retrospective single-centre studies: '***may be considered***';
- We have also used: '***may be considered***' when a consensus could not be reached among experts; and
- Negative recommendation: '***is not recommended***'

Thereafter, members of the EADV Task force *Autoimmune blistering diseases* (notation group) were invited to assign scores (ranging from 0 to 5 according to the increasing degree of consensus) to each of the recommendation's statements using the syntax shown above. This process identified the statements of major agreement or disagreement.

Indicated major statements were then voted upon, and the degree of consensus was indicated for all statements. Based on the marks of the notation group, the writing group then prepared a second, third and a fourth version of the guidelines, until each of the statements was given a mark >4 by the voting group. The manuscript was then reviewed by different European patient organizations.

Initial evaluation of bullous pemphigoid

The initial clinical examination should search out features consistent with a BP diagnosis and evaluate the patient's general condition and potential comorbidities (Table 1).

Major objectives

- To confirm the diagnosis of BP;
- To assess clinical condition and comorbidities, including cognitive status, search for risk factors, including neurological diseases and potential drug triggers (4.88 ± 0.33);