Pyoderma Gangrenosum in Ulcerative Colitis

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ABSTRACT

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Pyoderma gangrenosum (PG) is an uncommon ulcerative cutaneous condition. Approximately 50% of the patients have an associated systemic disease like inflammatory bowel disease, monoclonal gammopathy, myeloproliferative disorders, malignancies, HIV, sarcoidosis and Takayasu's arteritis. In adults the lesions are commonly seen on the lower extremities whereas in children, lesions are also seen on the head, face, buttocks, perianal and genital areas

The clinical presentation is described.

Keywords: Bleeding P R, Pyoderma Gangrenosum, Ulcerative colitis.

*See End Note for complete author details

A 42 yr old female presented to Emergency department with bleeding per rectum. On examination patient had bilateral leg ulcers and oral ulcers. Evaluation showed anaemia, leukocytosis and raised erythrocyte sedimentation rate. Sigmoidoscopy showed erythematous friable mucosa with superficial ulceration. Biopsy showed cryptitis and crypt abscesses which was suggestive of Ulcerative colitis. Skin biopsy from the margin of leg ulcer showed mixed cellular inflammation with neutrophil predominance, suggestive of pyodermagangrenosum. She was rescusitated and started on Mesalamine and systemic steroids.

Pyodermagangrenosum (PG), an uncommon ulcerative cutaneous condition was first described by Brunsting, Goeckerman and O'Leary in 1930. Lesions may be solitary or multiple and usually start as painful nodules or pustules which ulcerate to form a progressively enlarging ulcer with tender, raised, undermined, sometimes bluish edge. There are four described clinical variants of PG as follows: ulcerative, pustular, bullous, and vegetative. Each variant has distinctive clinical and histopathological features characteristic rates of progression, different disease associations, and often responses to different types of treatment. Approximately 50% of the patients have an associated systemic disease like inflammatory bowel disease, monoclonal gammopathy, myeloproliferative disorders, malignancies, HIV, sarcoidosis and Takayasu's arteritis. In adults the lesions are commonly seen on the lower extremities whereas in children, lesions are also seen on the head, face, buttocks, perianal and genital areas. The pathogenesis of PG is poorly understood, although neutrophil dysfunction (defects in chemotaxis or hyperreactivity) has been suggested.

PG is a diagnosis of exclusion and histology is not diagnostic. Massive neutrophilic infiltration in the absence of vasculitis and granuloma formation is considered as suggestive of PG.

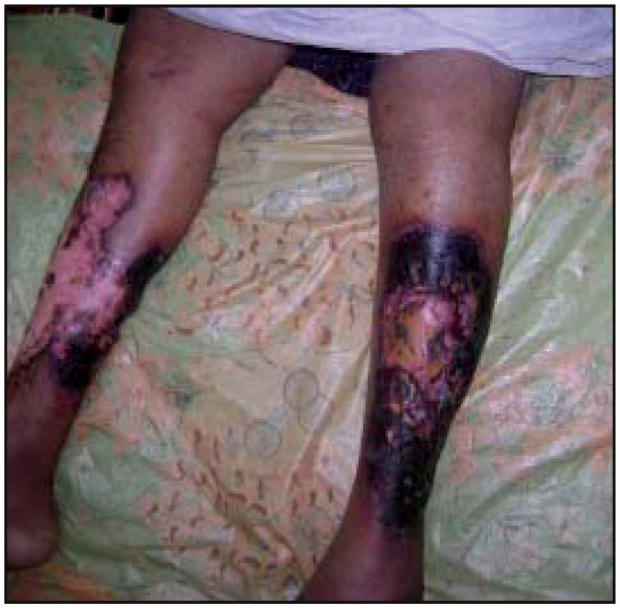

Figure 1. **Pyodermagangrenosum**

The treatment of the underlying disease may aid in healing the ulcer. Local therapy is an important adjunct to systemic therapy and may provide relief from symptoms. Systemic corticosteroids are considered as the drug of choice and are particularly effective in

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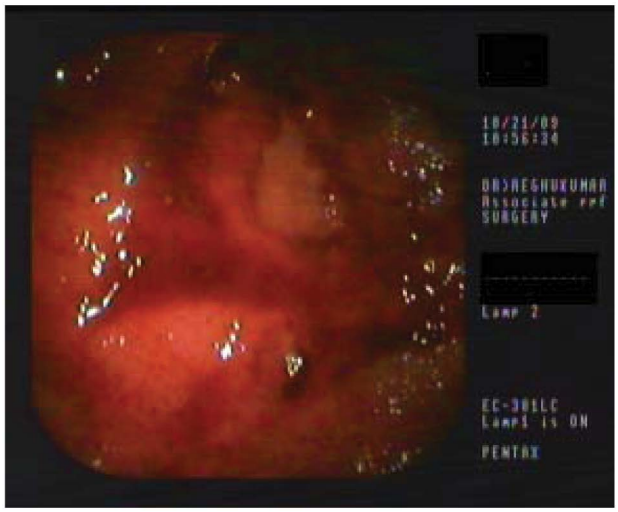

Figure 2. **Sigmoidoscopy showing erythematous mucosa and superficial ulcers**

treating the acute, rapidly progressive form of this disease. Other drugs of value include Sulfasalazine, sulfapyridine, Dapsone and Minocycline. Immunosuppressive agents like azathioprine and mercaptopurine have been used as an adjunctive or alternative therapy to systemic corticosteroids with varying success. Recently, infliximab has shown promising results in the treatment of PG

The diagnosis of PG is often challenging because there is no defining diagnostic clinical, laboratory, or histopathological feature. A high index of suspicion is, therefore, essential to diagnose PG clinically.

END NOTE

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