LETTER TO THE EDITOR

Monster parastomal pyoderma gangrenosum effectively treated by topical tacrolimus

Dear Editor,

Here we report the case of a 56-year-old woman affected by ileo-colic Crohn's disease (CD) accompanied by a large parastomal pyoderma gangrenosum as a complication.

Five years before our clinical examination, the patient had undergone ileo-colic resection with lateral ileostomy due to her severe refractory CD with perianal and ano-vaginal fistulas. About 6 months after surgical intervention a large (20 x 10 cm)溃疡性 skin lesion appeared in the parastomal region. Dermatological and histological evaluation led to the diagnosis of parastomal pyoderma gangrenosum.

Once diagnosed, our patient, intolerant to azathioprine (hepatitis), was treated with topical and systemic steroids (methylprednisolone 1 mg/kg/die) with no significant improvement of the cutaneous lesion.

After 3 months, she started therapy with infliximab (5 mg/kg) which was discontinued after the second infusion due to the onset of high fever and diffuse arthralgias. Thus, the anti-TNF alpha drug was definitively suspended without significant beneficial effect.

As a consequence of these multiple unfavourable pharmacological events, the patient refused to undergo therapy with other systemic immunosuppressors/biologics (i.e. adalimumab, cyclosporine, tacrolimus, etc.).

However, she accepted the topical treatment option and underwent a course of therapy with tacrolimus 0.1% (Prosopic®, 2 applications/day). After 4 months, complete healing of the skin lesion could be observed (Fig. 1). At present the patient is in dermatological remission with cyclic application of topical steroids.

At present, it is recommended that steroid-resistant pyoderma gangrenosum complicating CD should be treated in the first instance with anti-TNF alpha agents (grade of evidence B), while systemic cyclosporine, tacrolimus, mycophenolate mofetil and azathioprine represent less effective options. In previous reports (only a few of which regarding patients affected by inflammatory bowel diseases) topical tacrolimus has shown its efficacy in healing therapy-resistant pyoderma gangrenosum, offering an important alternative to those patients who prove unresponsive or intolerant to systemic steroids, immunosuppressors and/or biologics.

In our opinion the present case and the relative impressive images of the lesion before and after treatment confirm these considerations and provide further support for using topical tacrolimus in this condition.

References


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Figure 1  The large parastomal pyoderma gangrenosum before and after treatment with topical tacrolimus. The complete healing of the skin lesion is shown on the right.