LETTER TO THE EDITOR

Massive pyoderma gangrenosum in a 77 year old female with Crohn’s disease responsive to adalimumab

KEYWORDS
Crohn’s disease;
Pyoderma gangrenosum;
Adalimumab;
Biologic;
Inflammatory bowel disease

A 77 year-old woman with a history of breast cancer 10 years ago and refractory fistulizing Crohn’s disease presented with multiple large excavating perineal ulcers extending into the gluteal tissue. The patient failed infliximab and steroids 2 years prior and underwent a proctocolectomy with end-ileostomy for refractory Crohn’s colitis. A biopsy of these recent perineal skin ulcerations revealed acute and chronic inflammation with granulation tissue, but no granulomas. All wound cultures were negative. Surgical incision and drainage and a course of antibiotics were equally unhelpful. The patient was transferred to our service and admitted for severe pain and worsening ulcerated lesions. She had no gastrointestinal complaints other than increased ileostomy output. Her physical exam revealed large multiple purulent based ulcers with irregular shaped raised purplish borders extending into the gluteal tissue diagnosed as pyoderma gangrenosum (PG) (Fig. 1A). Magnetic resonance enterography revealed thickening of the ileostomy wall, with active disease on ileoscopy. There was marked improvement after 2 months of weekly dosed adalimumab (Fig. 1B), and by 1 year of therapy the perineal disease completely healed (Fig. 1C).

PG occurs in 2% of patients with Crohn’s disease most frequently found on the foreleg, but can occur anywhere in the body.1 These lesions begin as erythematous nodules or pustules that develop into irregular shaped sterile ulcers with violaceous edges. Necrosis of the dermis leads to deep purulent ulceration. PG may not parallel active inflammatory bowel disease in approximately 50% of patients.2,3 Initially PG maybe indistinguishable from a pyogenic infection leading to exacerbation and extension of disease.4 The clinician should consider PG when an enlarging ulcerated lesion does not respond to operative therapy and/or antibiotics. Mild cases have been treated with topical, or intraleosonal steroids, whereas more severe cases are best treated with biological agents i.e. anti-TNF antibodies.

Conflict of interest
The authors report no conflicts of interest and have followed the ethical adherence guidelines. All authors have made substantial contributions to the conception and design of the study, drafting of the article, and approval of its final version. This manuscript has not been published and is not available online at www.sciencedirect.com

Figure 1  A.) Irregular shaped excavating perineal ulcers extending into the gluteal tissue. B.) Same lesion 8 weeks after initiation of Adalimumab. C.) Completely healed PG after 1 year of Adalimumab.

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