Research Paper Medical Science

Bullous Pyoderma Gangrenosum In Association With Ulcerative Colitis

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ABSTRACT

Pyoderma gangrenosum is rare inflammatory disease of unknown etiology characterized by neutrophilic infiltration of dermis and destruction of tissues. Bullous PG is commonly associated with myeloproiferative disorders and rarely associated with inflammatory bowl disease. I report a case of this rare association of bullous pyoderma gangrenosum with ulcerative colitis.

KEYWORDS bullous pyoderma gangrenosum, ulcerative colitis.

INTRODUCTION:

Pyoderma Gangrenosum is a rare, non-infectious, neutrophilic dermatosis characterized by recurrent ulceration and usually associated with underlying systemic diseases. Brocq first described pyoderma gangrenosum (PG) in 1916, later described in 1930 by Brunsting et al.[1]

CASE REPORT:

A 58 yr male presented with fluid filled lesions and ulcers over right cheek, right elbow, left wrist, left shoulder, both legs and left gluteal region for two months duration , associated with excruciating pain. There was history of recurrent episodes of loose stools mixed with blood and mucus off and on. H/O loss of weight for three years. No history of joint pain and lymphadenopathy was present. Examination revealed multiple, vesicles and bullae and tender ulcers of size varying between 5x3 to 10x 8 cms with undermined violaceous borders,[2] with necrotic slough at floor, distributed over face, shoulder, forearm, buttock, wrist, elbow and bilateral lower limbs. Hair and nail were normal. Digital rectal examination showed ulcers. On colonoscopy and sigmoidoscopy there was continuous involvement of mucosa showing red colonic mucosa with multiple superficial ulcers and loss of normal vascular pattern and multiple pseudopolyps distributed throughout colon and reported as pancollitis Systemic examination showed no abnormality.

Peripheral blood smear showed microcytic hypochromic anemia with neutrophilia and few metamylocytes. Hb was 8.3gm%, There was leukocytosis, liver function test and renal function test revealed no abnormality. Sputum for AFB was negative and was sterile for bacterial and fungal growth.CXR showed old healed calcified tubercular lesions.USG abdomen was normal. On bone marrow aspiration no abnormality was found .Immune status was non-reactive. Per rectal examination showed ulcers. On colonoscopy and sigmoidoscopy there was continuous involvement of mucosa with multiple superficial ulcers and loss of normal vascular pattern and few pseudopolyps distributed throughout colon and reported as pancollitis. Histopathological examination of tissue taken from border of lesion which was suggestive of pyoderma gangrenosum. so patient managed as case of bullous variant of Pyoderma Gangrenosum in association with ulcerative colitis. General measures like bed rest, correction of anaemia and local wound care were done. Specific treatment in the form of dexamethasone cyclophosphamide pulse with oral steroids and mesalamine 2.4gm once a day was given. The patient showed improvement in ulcers and decreased frequency of loose stools.

DISCUSSION:

Pyoderma Gangrenosum is rare. non infectious neutrophilic dermatosis. It is diagnosis of exclusion and commonly associated with systemic disease.[2] Both humeral and cell mediated abnormalities have been associated with Pyoderma Gangrenosum.3 History of pathergy is seen in 25% cases.3 Main clinical variants are ulcerative, pustular, bullous and vegetative. Approximately 50 to 70 % of patients will have an underlying disease. With an associative disease 15 to 20% of patients are associative with inflammatory bowl disease; conversely 2% of patients with IBD develop PG.[4] Bullous PG presents as rapidly arising, superficial, hemorrhagic bull which ultimately ulcerates to heal to with cribriform scarring.[5] Bullous PG is especially associated with myeloproliferative disorders and if it occurs with IBD it is usually in patients with a significant disease flare.

Whats rare- Further association with ulcerative colitis besides the rarity of the disease

I confirm adherence to the guidelines of Helsinki as well as the hospitals ethics committee approval.

images

Fig. Initial haemorrgic bulla progressinfg to ulcer

Fig.2 Well defined ulcer on Rt leg

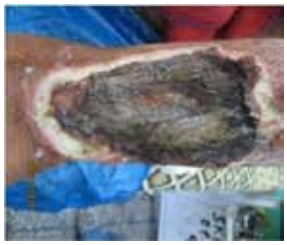

Fig.3 Well defined ulcer on Lt leg

Fig 4 showing ulcer after one wk of treatment

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