# 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.

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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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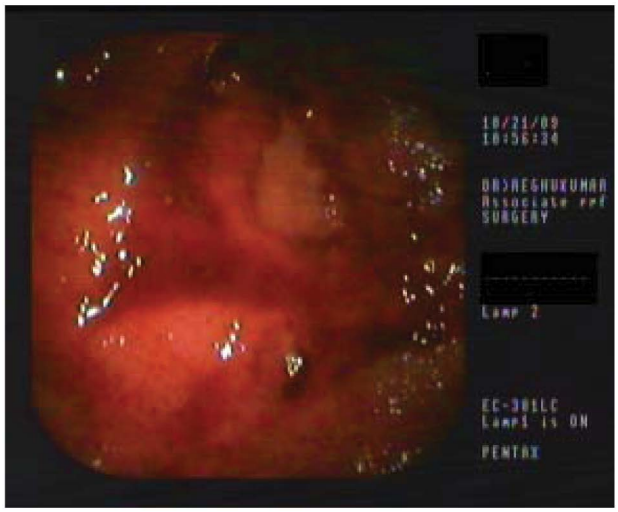


Figure 2. **Sigmoidoscopy showing erythematous mucosa and superficial ulcers**

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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**Conflict of Interest:** None declared

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# Sandwich sign in mesenteric lymphoma


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Sir,

Mesenteric lymphomas are asymptomatic in the early stage and present late in the course of disease. They have typical imaging findings among which 'sandwich sign' is the most specific.

A 31-year-old female presented with self detected upper abdominal lump of one week duration. There was no associated pain, bowel symptoms, fever, weight loss or night sweats. Clinical examination revealed a firm irregular mobile 10 × 8 cm intra abdominal mass in epigastrium and umbilical region. Laboratory parameters were within normal limits. CT scan of abdomen showed multiple large rounded and ovoid, homogenous soft tissue density mass lesions involving the small bowel mesentery measuring up to 5 cm in size, some of which were confluent, with no evidence of calcification or central necrosis. The lesions were encasing the mesenteric vessels without significant luminal narrowing (sandwich sign). Para aortic, inter aortico caval and para caval lymphnodes were enlarged [Figure 1]. Mesenteric lymph node biopsy was suggestive of follicular lymphoma [Figure 2].

Mesenteric lymphadenopathy can result from lymphoma,


**Figure 1:** Sandwich sign

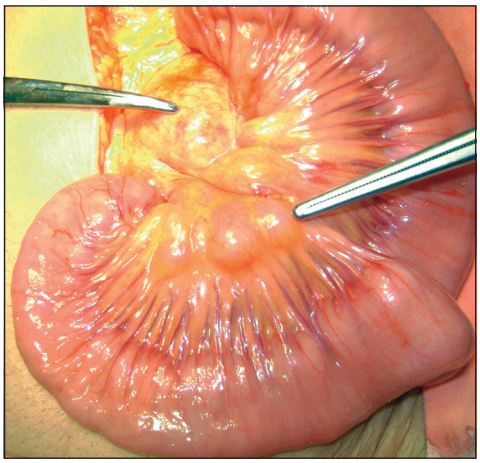

**Figure 2:** Intraoperative image- Enlarged mesenteric nodes

sarcoma, acquired immunodeficiency syndrome (AIDS), tuberculosis, Whipple's disease and post transplant lymphoproliferative disorder (PTLD), of which non Hodgkin's lymphoma is the most common cause.[1] Mesenteric lymphomas grow to a large size and cause bulky adenopathy encasing mesenteric vessels without producing clinical symptoms. On CT or ultrasound imaging, the confluent mesenteric nodes resemble two halves of a sandwich and the tubular mesenteric vessels and perivascular fat resemble the sandwich filling.[1,2] This sign is also seen in PTLD, which should be considered in patients who have undergone transplantation. PTLD is characterized by gastrointestinal involvement and the absence of superficial nodal disease. Other causes of mesenteric adenopathy have typical clinical symptoms and do not produce the large bulky adenopathy that results in the sandwich sign.[1,3] Mesenteric lymphomas can also show retroperitoneal adenopathy and increased attenuation of the mesentery (misty mesentery).[1,2]

In our case, the absence of symptoms, imaging findings of mesenteric soft-tissue nodules producing sandwich sign and retroperitoneal lymph nodes made lymphoma the most likely diagnosis. The sandwich sign is specific for mesenteric lymphoma (typically non-Hodgkin's) unless the patient has had a transplant.

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