SESSION 3
EXTRAINTESTINAL MANIFESTATIONS IN IBD: DERMATOLOGICAL

Management of Pyoderma Gangrenosum

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Inflammatory bowel disease (IBD) is the most common systemic disease associated with pyoderma gangrenosum (PG). Typically, PG is more common in long-standing IBD with colonic disease; women than men; Crohn's disease than ulcerative colitis; and in association with other extraintestinal manifestations, such as uveitis, arthritis, and spondylitis. Many variants of PG can be seen in IBD, including classic ulcerative, pustular, peristomal, postsurgical, mucosal, and extracutaneous. PG, a clinical diagnosis with histopathologic support, remains a diagnosis of exclusion. A biopsy for culture and histopathology is commonly taken to exclude other diseases.

The objective of treatment is suppression of all neutrophilic disease activity. Topical therapies include potent topical corticosteroids, calcineurin inhibitors, dapsone, and sodium cromoglycate. Adjunctive intralesional corticosteroids delivered into the active edge of lesions can limit spread. Systemic therapy usually includes prednisone 1 mg/kg/day; cyclosporine (2–5 mg/kg/day), mycophenolate mofetil, and intravenous immunoglobulin have the most evidence as steroid-sparing agents. Tumour necrosis factor-α inhibition can be helpful in 70 to 90% of patients with PG. Newer agents, including interleukin (IL)-1 and IL-12/23 inhibitors, have limited data to support their use. Drugs that inhibit neutrophil chemotaxis have been used with some success. Important components of overall management of PG are wound care with compression, minimization of secondary bacterial infection, and pain control.

References

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