Dermatology Digest

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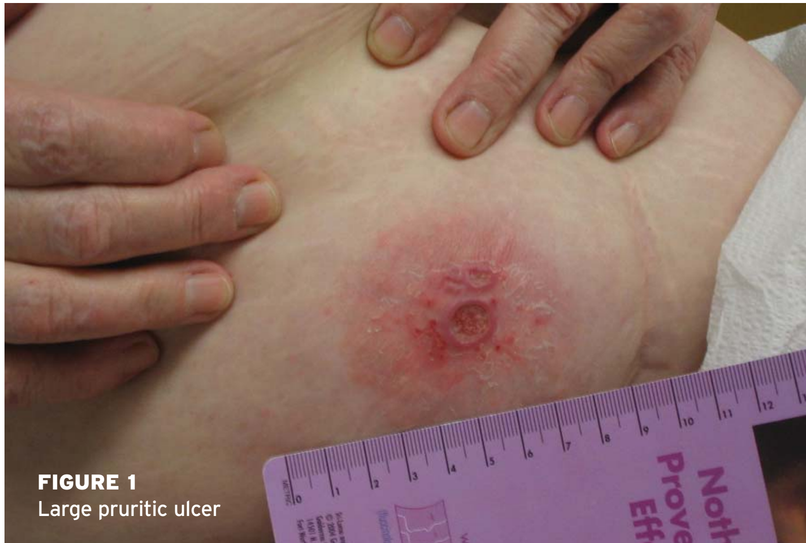

FIGURE 1
Large pruritic ulcer

A rare ulcer with a common cause

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›CASE

A 65-year-old woman presented to our primary care clinic with a lesion on her right superior abdomen. The patient reported that she first noticed the lesion approximately 2 months before this visit. The lesion began as a small red bump and progressed into a large, painful, pruritic ulcer (see Figure 1). She denied any trauma, spider bites, or diabetes. The patient's history was significant for hypertension, hyperlipidemia, ulcerative colitis, and generalized anxiety disorder.

Physical examination revealed a 1.5-cm, well-demarcated ulcer undermined with a reddish-purple border and a purulent base. A 5-cm halo of erythema surrounded the lesion. Two 5-mm violaceous satellite ulcers were found above the primary lesion.

A 4-mm punch biopsy of the inflamed area surrounding the ulcer demonstrated polymorphic nuclear cells. A second 4-mm punch biopsy of the edge of the primary ulcer showed the area to be consistent with ulcer formation. The results of blood cultures were negative. A CBC and basic metabolic panel showed no abnormalities.

›THIS LESION IS MOST LIKELY

- *A venous ulcer*
- *Cutaneous tuberculosis*
- *Pyoderma gangrenosum*
- *Sweet's syndrome*

›DISCUSSION

The lesion was pyoderma gangrenosum, a rare, noninfectious neutrophilic ulcerating skin disease. Pyoderma gangrenosum often occurs in patients who have a chronic underlying inflammatory or malignant disease, such as ulcerative colitis, rheumatoid arthritis, or a hematologic malignancy.[1] A diagnosis of pyoderma gangrenosum is based on clinical and pathologic findings and is formulated after excluding other causes of ulceration.

Most venous ulcers are located over the medial malleolus and are often associated with diabetes.[1] Our patient had no history of diabetes, and the results of her basic metabolic panel were within normal limits. No acid-fast bacilli were produced by bacterial cultures, which ruled out cutaneous tuberculosis.[2]

Sweet's syndrome, also a neutrophilic dermatosis, differs from pyoderma gangrenosum in that Sweet's syndrome often manifests with fever and leukocytosis. Our patient did not present with fever, and her CBC was normal. Additionally, ulcerations in Sweet's syndrome are most frequently located on the dorsum of the hands and fingers.

TREATMENT The patient was given prednisone, 60 mg tapered over 10 days. She responded remarkably well to the treatment, and within 2 weeks the lesions had healed with minimal scarring.

As with many dermatologic problems, properly treating the underlying condition may be the most beneficial course of action in preventing recurrence. Our patient's lesions were caused by ulcerative colitis, an inflammatory bowel disorder, which was treated with sulfasalazine, 0.5 mg twice a day. The dosage was increased as tolerated to 1 g three times a day. The patient also was advised to follow a low-roughage diet. To date, she has not had a recurrence of the pyoderma gangrenosum. JAAPA

Joe R. Monroe, PA-C, MPAS, department editor

REFERENCES

1. Habif TP. *Clinical Dermatology: A Color Guide to Diagnosis and Therapy.* 4th ed. Philadelphia, Pa: Mosby; 2004.
2. James WD, Berger TG, Elston DM. *Andrew's Diseases of the Skin: Clinical Dermatology.* 10th ed. Philadelphia, Pa: Saunders; 2006.