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**PICTURES IN DIGESTIVE PATHOLOGY**

# Pyoderma gangrenosum with extensive perianal involvement

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## CASE REPORT

71-year-old male with no personal events of interest was admitted to the emergency department due to a large perianal ulcer with gluteus extension of 1 month of evolution and multiple inguinoscrotal ulcers of later onset (Fig. 1). The patient denies sexual intercourse the previous months and had not consulted earlier because of shame, but due to progression of ulcers and increasing pain he went to the emergency department. On digital rectal examination anal, sphincter maintained good tone and feces without pathological products were palpated in rectal ampulla.

In the emergency department, we made sampling for culture and biopsy of ulcers and wound cleansing. The serological tests for HIV, HBV, HCV, syphilis and VZV were negative. Histopathological study showed areas of ulceration in the epidermis and inflammatory infiltrate in dermis.

Colonoscopy and pelvic MRI showed no relevant findings. He was valued by dermatology department and a exclusion iagnosis of ulcerated pyoderma gangrenosum without associated systemic disease was established. Topical treatment with 2% cromoglycate and 0.1% protopic ointment (tacrolimus) and oral prednisone was indicated. He was discharged at 2 months after admission with partial reepithelization of the lesions. At one year follow-up, the patient showed almost complete reepithelization of the lesions (Fig. 2).

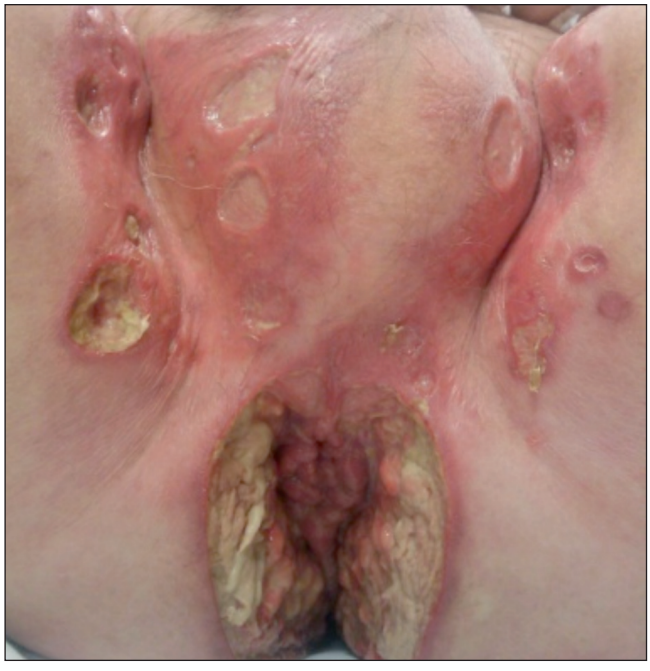

Fig. 1. Large perianal ulcer with gluteus extension and multiple inguinoscrotal ulcers.

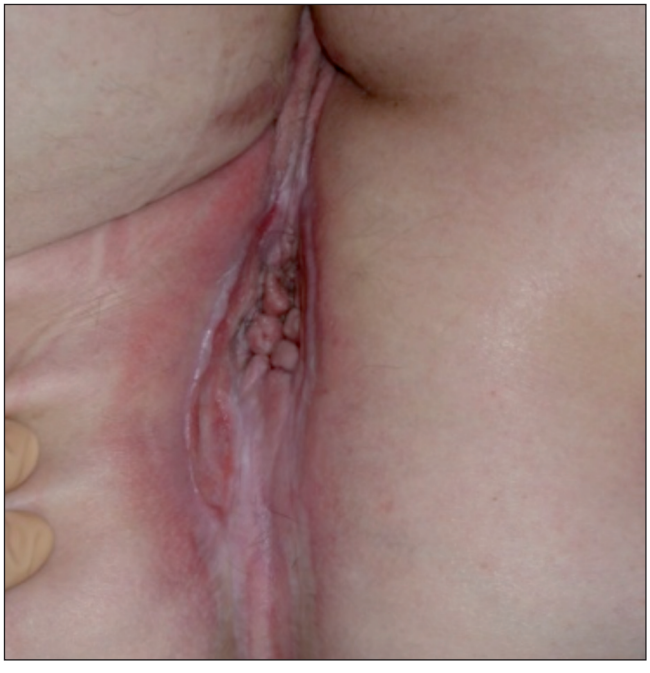

Fig. 2. Almost complete reepithelization of the perianal ulcer at one year of follow-up.

## DISCUSSION

Pyoderma gangrenosum (PG) is an inflammatory dermatosis of unknown origin, characterized by necrotizing ulcers rapidly evolving destructive, which usually affect the legs, thighs and arms, being rare the perianal affectation (1,2).

Its diagnosis is by exclusion. Fifty per cent of patients with PG have associated systemic disease, most commonly inflammatory bowel disease (33%) and rheumatoid arthritis (3).

The treatment is complex and consists of cleaning the ulcers without debridement, in order not to favor the pathergy phenomenon. Topical or systemic drugs can be prescribed, such as corticosteroids and immunosuppressants. Response is variable and relapses are frequent (2,3).

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