Extensive postoperative pyoderma gangrenosum

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DESCRIPTION

A lady in her 60s re-presented to hospital 2 weeks after a laparoscopic abdominal-approach perineal hernia repair. She complained of severe abdominal pain and oozing from a wound site. On examination she was noted to have serosanguinous discharge from the abdominal port site with surrounding erythema.

A working diagnosis of abdominal wall cellulitis was made. Blood cultures and wound site swabs were taken and the patient was admitted for intravenous antibiotic therapy and analgesia. Haematological and biochemical investigations revealed raised C reactive protein, a neutrophilia and lymphocytosis.

Neither blood nor port site cultures showed significant bacterial growth. Over the following days the erythema failed to resolve, rapidly extending into an ulcerating, macerated, hyperalgesic lesion involving the entire anterior abdominal wall (figure 1).

Following dermatology review, a clinical diagnosis of pyoderma gangrenosum was made. Biopsy of the lesion was advised in order to exclude other differential diagnoses, but was rendered impossible by the severity of the patient's pain. Treatment with high-dose oral prednisolone, topical steroids and

regular dressing changes was started. Her pain was managed with a complex regime of multiple analgesics, with regular input from the acute pain team.

The patient required a lengthy total of 10 weeks' in-patient management before her wound was of manageable size and her pain adequately controlled for her care to be continued in the community setting.

This case revises the important presentation of pyoderma gangrenosum in the postoperative patient, and serves as a reminder to consider it in one's differential diagnoses.

Learning points

- ▶ Pyoderma gangrenosum is a rare, non-infectious, inflammatory skin condition of unknown aetiology.¹
- ▶ Diagnosis is clinical, although biopsy can be considered in order to excluded other diagnoses.²
- ▶ It should be considered as a differential in any non-healing wound or ulcer, as misdiagnosis, which is common, leads to delay in appropriate treatment. Treatment is with immunosuppression, corticosteroids being first line.²

Competing interests None.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCES

- 1 Pauser S, Goerge T, Eickelmann M, et al. Pyoderma Gangrenosum After Cesarean Delivery. *Clinical Medicine Insights: Dermatology* 2009;2:23–6.
- 2 Brooklyn T, Dunnill G, Probert C. Diagnosis and treatment of pyoderma gangrenosum. *BMJ* 2006;333:181–4.

Figure 1 Extensive pyoderma gangrenosum originating from abdominal port site, left, spanning the entire abdominal wall.

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