LETTER TO THE EDITOR

Successful treatment of refractory pyoderma gangrenosum with ustekinumab only after excision of renal cell carcinoma

Dear Editors,

Pyoderma gangrenosum is a rarely diagnosed neutrophilic disease, which is clinically characterised by very painful ulcers with violaceous, undermined borders (1–3). Even if aetiology and pathogenesis are still not completely understood an association with other systemic diseases, especially inflammatory bowel diseases, was frequently reported. Currently, other relevant comorbidities, such as rheumatic arthritis, renal dysfunctions, endocrinological and haematological diseases or neoplasms, have been described (3–5).

We report a 71-year old patient first presented to our outpatient clinic 4 years ago with pyoderma gangrenosum on his shoulder. The patient suffered from chronic venous insufficiency, diabetes and arterial hypertension. We started a systemic glucocorticoid therapy in which the patient demonstrated a quick and good response. The wound healed within 2 months. After 7 months, the same patient developed new pyoderma gangrenosum on both groins after catheterisation. We restarted the systemic glucocorticoid therapy which had to be combined with cyclosporine A because of the prolonged course over more than 3 months. Both wounds healed completely. Again 3 months later, he developed a new pyoderma gangrenosum pectoral on the left hip and left shoulder, so that we restarted a systemic therapy with glucocorticoids and cyclosporine A. Due to the continuing size progress, we decided to switch to ustekinumab therapy but the patient did not show response to therapy and developed new lesions under his breast and clavicle (Figure 1). Because of the untypical clinical course, we decided to reexamine the patient. He underwent an abdominal and thoracic CT scans, which showed a renal carcinoma on the left kidney. The systemic treatments were stopped and a radical nephrectomy was performed. After the post-surgical recovery, the patient presented himself still suffering from the very painful lesions of pyoderma gangrenosum. Therefore, we restarted the systemic therapy with ustekinumab. This time the patient showed a prompt response a few days after the first application. Due to the meanwhile large and deep ulcerations, it took up to 3 months for complete healing (Figure 2).

Up to now, there is no standardised treatment algorithm for patients with pyoderma gangrenosum. Mostly systemic glucocorticoids are described as the standard treatment (6,7). Other therapeutic options are cyclosporine A or biologics such as TNF-α inhibitors or interleukin (IL)-1 antagonist (7,8). Recently, a new therapeutic option with ustekinumab has been introduced. Up to date, there are several case reports on the successful treatment of pyoderma gangrenosum patients with ustekinumab (9,10). Ustekinumab is an IL-12/23 inhibitor, which has been licensed for the treatment of severe plaque psoriasis and psoriatic arthritis. Ustekinumab binds to the common p40 subunit shared by IL-12 and IL-23. High levels of IL-23 have been found in pyoderma gangrenosum, like in other diseases associated with it, e.g. Crohn’s disease (9).

Ioana Cosgarea, Zdenka Lovric, Andreas Körber & Joachim Dissemond, MD

Department of Dermatology, Venerology and Allergology
University of Essen
Essen, Germany
E-mail: joachim.dissemond@uk-essen.de

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