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PYODERMA GANGRENOSUM MASQUERADING AS TB CUTIS

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An 8-year-old boy presented with multiple recurrent painful ulcers mainly over legs for the last 2 years. A diagnosis of TB cutis was made and he was put on anti tubercular therapy for last 1 year without any signs of improvement. This lead us to suspect the diagnosis of pyoderma gangrenosum.

Introduction

Pyoderma gangrenosum (PG) is a destructive, necrotizing, non infective ulceration of the skin which presents as a furuncle like nodule, pustule or haemorrhagic bulla.[1] Half the cases of PG are associated with ulcerative colitis.[2] Rheumatoid arthritis and its variants, Crohn's disease,[3] Behcet's syndrome, Wegener's granulomatosis or Chronic active hepatitis may be at times associated with PG. Most interesting and important associations are with reticuloendothelial disorders like congenital and acquired hypo-gammaglobulinemia, frank myeloma, or non-Hodgkin's lymphoma.[4] Bullous haemorrhagic form may be associated with leukemia, polycythemia rubra vera or myelofibrosis.

Case Report

An 8-year-old boy presented with multiple painful ulcers over trunk and limbs for last 2 years. Initially, vesicular lesions developed over thighs which ruptured to leave painful ulcers that increased in size and spread to new areas. the patient was diagnosed as a case of TB cutis and was treated with Anti-Kochs' therapy (INH and rifampicin) for 1 year without any clinical improvement. The patient gave history of weight loss and intermittent high grade fever.

Family history of similar ulcerative lesions in sister, who was also given anti tubercular treatment irregular treatment for 1 year. Father gives history of taking anti tubercular for 1 year for suspected pulmonary TB. He also had multiple painful ulcers over trunk and limbs.

During hospitalisation, the patient developed similar vesicopustular eruption resulting into ulcers at the site of Mantoux testing and venepuncture site (pathergy). On examination, vital signs were normal, there were multiple discrete, nontender, bilateral inguinal lymphnodes. Multiple tender ulcers of varying size with well-defined margins, erythematous necrotic base and a zone of erythema surrounding the ulcer were present over the right forearm, left cubital fossa, posterolatelral aspect of right thigh and over both legs. Multiple atrophic scars of old lesions were present over trunk, back and limbs.

Investigations showed Hb-10.5 gm %, total WBC count - 7600 cells/cu mm, differential WBC count - P_{51},L_{44},E_5,ESR 60 mm/1 hr, Urine-WNL, X-ray chest P/A view NAD, Serum R.A. factor, Blood for VDRL reaction and serum ELISA for HIV infection were negative. Stool for

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occult blood/ova/cyst - NAD, Barium enema studies - NAD.

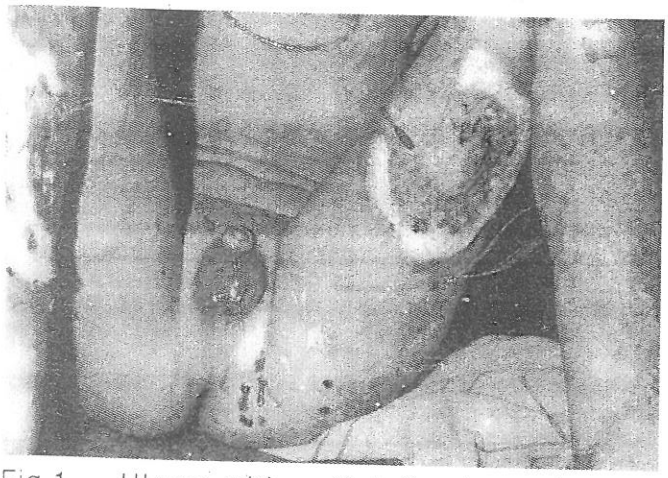

Fig.1. Ulcers with well-defined margins and erythematous necrotic base over thighs, legs and groin

Skin biopsy from the edge of the ulcer showed marked dermal infiltration with neutrophils leading to necrosis, features suggestive of PG. Autituberculous drugs were stopped and the patient was put on systemic steroids - the pain in the ulcers subsided and the lesions showed signs of healing. After 15 days, patient developed pyogenic meningitis and he succumbed to the illness.

Discussion

Amoebiasis cutis, cryptococcosis, blastomycosis, TB cutis are important differential diagnosis PG in the tropics. Other disorders to be excluded are Sweet's neutrophillic dermatoses, purpura fulminans and burrowing ulcer of Meleny.

Skin TB is an important differential diagnosis of PG in our country. This case is being presented because the patient was initially considered to have TB cutis. Most of the cases of PG occur in adults[5] although here we have a case history of an 8-year-old boy. No familial clustering of cases of PG has been reported in the literature, here we had similar lesions seen in patient's sister and his father. Moreover, there was no evidence of associated ulcerative colits or other hematological disorder. The patient prematurely succumbed to pyogenic meningitis - this may indicate some overt immunological dysfunction which could not be detected with the diagnostic facilities available in our hospital set up.

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