Case report

Metastasis of ulcerative colitis in peristomal skin - an extremely rare case

I. Ahmed, T. Wardle, I. Javed

SUMMARY

Extra-intestinal complications affect 20-30% of patients with Ulcerative Colitis and contribute significantly to morbidity and mortality. While some disorders parallel the activity of the colitis, other abnormalities run a clinical course independent of the bowel disease. Cutaneous manifestations are well-recognized complications, the incidence of which varies widely but, at the time of diagnosis, the mean incidence is around 10%.1-2 We present a very unusual case in which the skin around Ileostomy stoma showed features of active ulcerative colitis many years after having proctocolectomy.

Key-words: Cutaneus manifestations, Ulcerative Colitis, Inflammatory bowel disease, Proctocolectomy

CASE REPORT

A 75 years old Caucasian man with a longstanding history of UC presented with a few months' history of skin symptoms around the stoma. He had a panproctocolectomy and ileostomy performed in 1968. His symptoms were described as recurrent itchy eryhematous blisters, which were quite painful at times, weeping skin and occasionally ulceration. He was initially treated with topical therapy in the form of Betnovate and Orobase etc by the GP and stoma nurse for a few months but of no avail.

He was later referred to our clinic for further management. Initial Examination of skin (fig.1) around the stoma showed scaly, erythematous rashes with excessive granulation tissue and some ulceration.

As he did not respond to routine therapy, a skin biopsy was performed. This ruled out common skin disorders in patients with inflammatory bowel disease including pyoderma gangrenosum but showed (Fig. 2 & 3) features of large bowel mucosa with ulcerated colonic glands, depletion of mucin, extensive paneth cell metaplasia and presence of crypt abscesses with surrounding moderate acute on chronic inflammatory cell infiltrate. This feature favoured the presence of active ulcerative colitis. As it is extremely unusual to have this kind of inflammatory reaction for years following a panproctocolectomy, an ileoscopy was performed. This showed normal appearance of the mucosa but peristomally the mucosa was erythematous with multiple polypoid lesions. The biopsy from internal ileal mucosa was unremarkable but the external stoma mucosal biopsy showed features of both small and large bowel mucosa without any evidence of neoplasia. Fungal infection was also ruled out by taking scrappings of involved skin, therefore the working diagnosis was that of metastatic ulcerative colitis.

The patient was initially treated with topical steroid in the form of Haelen Tap and a topical form of 5- ASA drug and later he had treatment with liquid nitrogen but his problems continued despite various treatments. The option of refashioning of the stoma was considered at some point but disregarded considering the healthy condition of the stoma itself.

After involvement of a dermatologist, he has been treated with topical sucralfat powder and has shown much improvement in his symptoms.[8]

From the Department of Gastroenterology, Countess of Chester Hospital NHS Foundation Trust, Chester, United Kingdom

Author for correspondence:

Dr. Iftikhar Ahmed, Department of Gastroenterology, North Cheshire Hospitals NHS Trust, UK, e-mail; ansari35@yahoo.com, Phone: 00 44 7725868862

Abbreviations:

5- Amino salicylic Acid (5-ASA), Ulcerative Colitis (UC)

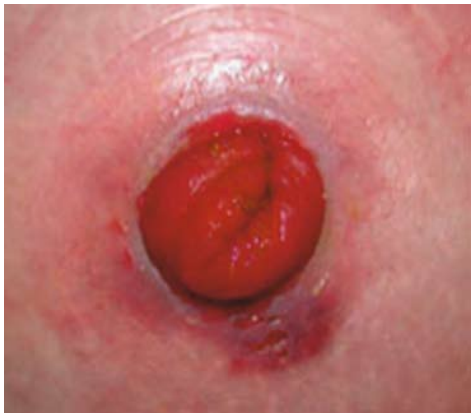

Fig. 1. Macroscopic appearance

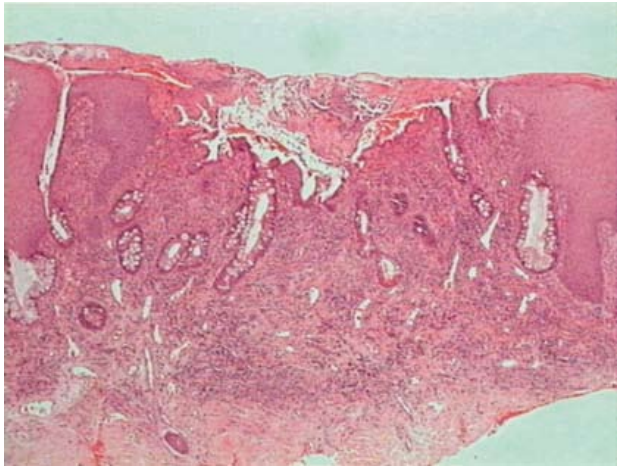

Fig. 2. Skin Biopsy

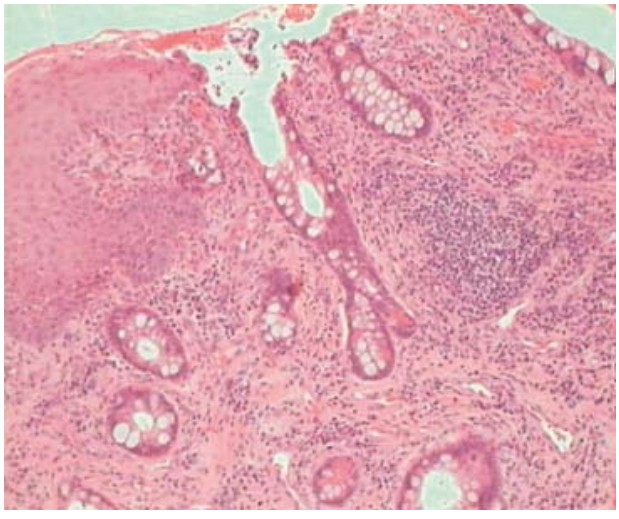

Fig. 3. Skin Biopsy

DISCUSSION

IBD (5) is a systemic disease, since its clinical manifestations can affect not only the bowel but also practically any other organ i.e., eyes, liver, osteoarticular system, kidneys, and skin etc. During the course of disease a great variety of skin lesions may develop, the incidence of these is estimated to be 15-20% in case of Crohn's disease and 10% in case of ulcerative colitis.[1,2,3] Many of these conditions are secondary to granulomatous cutaneous disease, reactive skin eruptions, nutritional deficiency and other associated conditions. The so called specific lesions which are part of the skin symptoms associated with IBD, show intimate connections with the bowel disease itself, as they histologically show granulomatous inflammation with epitheloid cells, similar to the ones seen in the intestines. The reactive lesion (erythema nodosum, pyoderma gangraenosum), that form the second main group of skin changes, can also be found is other systemic diseases, but they are more frequently associated with IBD than the average. Cutaneous manifestations may occur due to malabsorption or drug therapy. Finally, there are dermatoses (epidermolysis bullosa acquisitia, acne fulminans) which still have a questionable connection with IBD.[3,4,5]

Metastatic Ulcerative Colitis is a rare complication defined as the occurrence of specific cutaneous lesions remote from the intestinal disease. It manifests as subcutaneous nodules or ulcers mainly at the lower extremities or even involves peristomal skin in patients treated with some form of surgery with stoma formation. It seems unrelated to the bowel activity. It is extremely rare and reports of such conditions are nearly non-existent in the literature.

Other common conditions which could affect the skin around the stoma are irritant reactions, particularly from leakage of urine or faeces (42%); pre-existing skin diseases, principally psoriasis, seborrhoeic dermatitis and eczema (20%); infections (6%); allergic contact dermatitis (0·7%) and pyoderma gangrenosum (0·6% annual incidence).

The differential diagnosis between these skin manifestations may be very difficult as signs and symptoms are similar in most condition and skin biopsy remain the only reliable way of diagnosis.[4] In our case, presentation was similar to the common skin manifestation but it remains unclear why the disease was active in the skin when no activity was demonstrated in the bowel.

Although the skin condition often responds to treatment of the bowel, it may require additional therapy. Corticosteroids, antibiotics, azathioprine, methotrexate, and more

recently infliximab and Tacrolimus have been used successfully in steroid resistant cases. Relocation of stoma is reserved for persistent ulceration failing other therapy.[6-7]

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