Case reports : CELLOSORB® and URGOTUL® in the treatment of pyoderma gangraenosum and chronic venous ulcers

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MEDICAL HISTORY

PATIENT 1

Female, age 53, reporting about weight loss (20 kg in the last 2 years) and relapsing painful, erythematous maculopapules on the lower limb. Some skin lesions were enlarged and ulcerated, others remain painful with dark coloured macules. There, she presented two, highly secreting ulcers with inflammatory, violaceous and undermined borders, sized 10.9 x 9.8 cm and 4.5 x 4.3 cm. In both ulcers highly secreting pus and wound exsudate was observed. Wound surrounding showed medium maceration. A minor trauma was not recalled. Her past medical history was unremarkable, gastro-intestinal complaints were answered negative.

PATIENT 2

Female, age 79, history of four deep venous thromboses in the past, followed by venous insufficiency on both legs, which was treated with sclerotherapy. Relapsing ulcerations were reported in the past and multiple Type-IV-sensibilizations against amerchol L 101, lanolin alcohol, chlorhexidindigluconat, phenoxyethanol, fusidine acid, bufexamac, propylenglykol, hydrocortison-17-butyrat and budesonid were verified by epicutaneous testing to type IV allergens. Now she presented a new painful, fibrinous and deep ulceration on the outer ankle of her left leg, a beginning lipodermatosclerosis and an inflammatory surrounding. The local therapy consisted of various wound dressing such as **Mepithel®, Tielle®, Trionic®, Allevyn®** and **Cutinova foam®**. However the ulceration was still in progress.

MEDICAL COURSE

PATIENT 1

Laboratory : ESR 101/133 mm, WBC of 14.400, neutrophiles 10.980, anaemia. A histological examination verified a neutro-philic dermatosis according to a pyoderma gangraenosum, chest x-ray and ultrasound of the abdomen were unremarkable.
A systemic therapy was started using **Lamprene®** (100 mg/3x day) and **Ibuprofen®**. The local therapy consisted of **Elidel Crème®** (for the ulcer borders) and an alginate with **Lavasept Gel®** in the ulcer ground. However, the ulcers and skin lesions still improved slowly. Still macerations on the borders were observed. Subsequently, the local therapy was changed to **Cellosorb®**. After improvement **Urgotul®** was applied on the wound, weeks later the ulcer was healed.
Only slight itching lesions could be observed, which were sufficiently treated with **Optiderm®**/ Polidocanol Crème topically. In the follow no relapse of ulceration appeared.

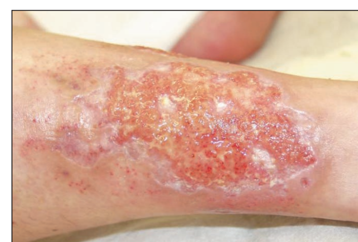
PATIENT 2

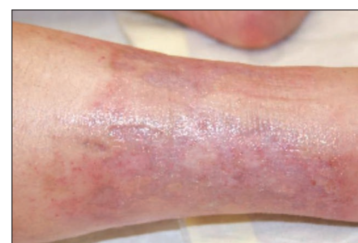
At the beginning, the patient was treated with **Nu-Gel®** and **Cellosorb®**, wound dressings were removed every 2 days. In the follow-up, no sensitization to contact allergens were observed. After 7 weeks, the ulcer was healed. In the follow-up no new ulceration occurred.

CONCLUSIONS

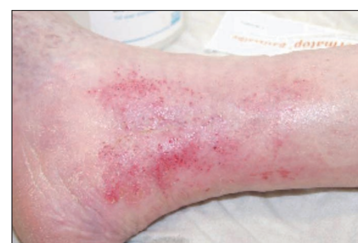
A variety of etiologies are responsible for chronic ulceration. The systemic therapy has to be adapted to the cause of the ulceration. However, optimized regimen of local treatment to improve wound healing have to be considered.
In our study, Patient N°1 tolerated the immunosuppressive medication for the treatment of pyoderma gangraenosum. After a while, wound dressings with exsudate management were necessary to absorb the still highly secreting ulcera and to improve wound healing. In summary, **Cellosorb®** is suitable for wounds with high exsudation and does not traumatize sensitive wounds during the dressing changes. This is an important aspect with regard to the pathergy-phenomenon of pyoderma gangraenosum.
In Patient N°2, an epicutaneous testing to type IV with various wound dressings revealed positive reactions against **Allevyn®** and **Cutinova®** foam after 96 h. In conclusion, **Cellosorb®** and **Urgotul®** are helpful and well tolerated wound dressings for the treatment of pyoderma gangraenosum and chronic venous ulcerations.

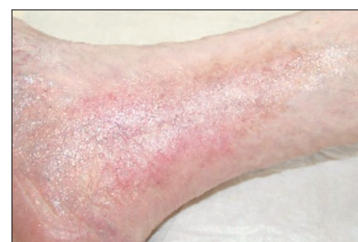
PATIENT 1


Patient 1, at the beginning of therapy


Patient 1, ulcer healed

PATIENT 2


Patient 2, with inflammatory surrounding at the beginning of therapy


Patient 2, no sensitization, ulcer healed

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