Dear Sir,

Crohn’s disease (CD) is an inflammatory disease of the digestive tract, which could affect any part of the gastrointestinal tract from mouth to anus, causing a wide variety of symptoms. It is often associated with extra-intestinal manifestations, complications, and other autoimmune disorders. Although dermatofibromas (DF) are benign dermal nodules mostly affecting the extremities, shoulders, and buttocks of young adults it has not been reported among the skin manifestations of CD. Reported herein is the first case of a newly diagnosed CD with dermatofibroma.

A 19-year-old female had been in good health until 15 days before hospital admission when she complained of fatigue, abdominal pain, and rectal bleeding of bright red blood. Physical examination revealed pallor, tachycardia and hypotension (blood pressure 90/45 mmHg), and mild abdominal tenderness. Her laboratory analyses were within normal ranges except for: hemoglobin, 8.9 g/dl (14–18); hematocrit, 26.2% (40–55); erythrocyte sedimentation rate, 41 mm/h (0–15); high sensitivity C-reactive protein (Hs-CRP), 7.6 mg/l (0–0.74). Stool culture and Clostridium difficile cytotoxin assay were negative. Colonoscopy (performed with Olympus CF-1T20L) revealed highly inflamed mucosa with aphthous lesions, deep indurative ulcerations and pseudopolyps involving the 40 cm from the anal verge. Approximately 60 cm from the anal verge, villous projections were seen, obscuring the lumen of the colon. The mucosa between 40 and 60 cm appeared normal. Histologic studies from rectal biopsies revealed chronic active colitis. During examinations, the patient developed hyperemic and erup- tive skin lesions on right lumbar region (Fig. 1a) and on her thigh. Biopsy from these lesions revealed a moderately cellular fibrous tumor located in the dermis, consistent with dermatofibroma (Fig. 1b). With these findings sulphasalazine and prednisolone therapy was initiated. The patient responded favorably to combination therapy, her skin lesions were also regressed after treatment.

CD and ulcerative colitis, the 2 main subtypes of inflammatory bowel disease (IBD), are autoimmune disorders of unknown etiology that are characterized by ulcerative lesions of the bowel. Multiple other organ systems can be affected, including the skin, bones and joints, eyes, hepatobiliary system, lungs, and kidneys. Collectively, these are called extra-intestinal manifestations of IBD, and they can occur prior to, in conjunction with, or subsequent to active bowel disease. The overall prevalence of any extra-intestinal manifestation in IBD patients ranges from 21% to 40%. In most large studies of IBD, the prevalence of extra-intestinal manifestations is higher in CD compared with ulcerative colitis. Cutaneous manifestations of inflammatory bowel disease are quite common, with various studies suggesting skin involvement in 9–40% in patients with CD and 9–19% of patients with UC.1–3 Pyoderma gangrenosum, erythema nodosum, aphthous stomatitis, vesiculopustular eruptions, necrotizing vasculitis and cutaneous polyarteritis are well known extra-intestinal skin manifestations of CD. Miscellaneous dermatologic manifestations, namely epidermolysis bullosa acquisita, vitiligo, psoriasis, secondary amyloidosis, bowel associated and dermatosis–arthritis syndrome were also reported in literature associated with IBD.3,4 Dermato- fibromas (DF) are benign dermal nodules mostly affecting the extremities, shoulders, and buttocks of young adults. The histogenesis remains unclear, with the two major hypotheses being a post-inflammatory fibrosing process and a benign tumor. The arguments raised in support of the first hypothesis include the presence of inflammatory cells, development of fibrosis in older lesions of DF, and the possible association of DF with trauma.5 Although our patient had a negative history for trauma but an ongoing inflammatory process we strongly believe a possible association between these two entities.

In conclusion based on the similar immunopathogenetic mechanisms it is reasonable to suggest that dermatologic manifestation of our patient could well have been attribut- able to the altered immune states which have also been implicated in the pathogenesis of CD. We also highlight the necessity of further studies which could contribute to the understanding of the pathogenesis of these two diseases, which is as yet unknown.

References


Figure 1 (a) Clinical photograph of red papules with rim of hyperpigmentation on right lumbar region. (b) Moderately cellular fibrous tumor located in the dermis, separated by a narrow clear zone from the hyperplasic epidermis. (H&E, ×200).

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