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Topic: Inflammatory skin diseases

Cutaneous Crohn's disease without gastrointestinal manifestations: 5-year follow-up.

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Introduction

Crohn's disease is a multisystemic condition dependent on Th1 pathways. Involvement can extend throughout the gastrointestinal tract. It can affect the skin before or after intestinal involvement.

On the skin, one can observe vulvar and perianal erythema and induration, asymmetric vulvar swelling, perianal erosions, lymphedema of the prepuce, lymphedema and induration of the scrotum, inflammation and lymphedema leading to twisting of the penis along its long axis, referred to as a "saxophone penis," perianal tags and indurated plaques, firm erythematous plaques of the mons pubis and labia majora and minora, intraoral ulcer, draining sinuses, and enlargement of the vermilion lip due to granulomatous inflammation.

In both cutaneous and oral lesions of Crohn's disease, small, nodular, non-caseating, epithelioid granulomas with surrounding lymphocytes are found in the superficial and deep dermis, sometimes extending into the subcutaneous fat. There are a few scattered multinucleated Langhans-type giant cells and a sparse perivascular lymphohistiocytic infiltrate; overlying ulceration may be present. Clinically, "knife-like" fissures are characteristic.

Materials and Methods

Case report.

Results

A 28-year-old female patient presented with linear ulcers on facial sections in the axillas, groin, buttocks, inframammary regions, gluteal fold, and labia majora for 3 months (Figure 1). There were plaques with seropurulent discharge on the genitalia. A biopsy was performed that included normal skin and ulcer (Figure 2), which showed an area of ulceration. The adjacent epidermis has a reparative appearance, with irregular acanthosis, moderate spongiosis, and foci of parakeratosis. The superficial and deep dermis exhibits numerous well-formed granulomas, with frequent multinucleated giant cells, associated with mixed inflammatory infiltrate (lymphocytes, plasma cells, neutrophils, and eosinophils), compatible with granulomatous dermatitis (Figure 3), which reinforces the clinical hypothesis of cutaneous Crohn's disease.

Endoscopy, colonoscopy, and fecal calprotectin were performed over 5 years and were normal.

The patient is being treated with infliximab and methotrexate, showing a good response (Figure 4).

Conclusions

Cutaneous manifestations related to systemic diseases are important tools that aid in the early diagnosis of conditions with high morbidity and mortality. Furthermore, the specific recognition of cutaneous diseases in systemic contexts allows for appropriate and early treatment.

