Efficacy of Rituximab for Refractory Pyoderma Gangrenosum-Like Ulcers in Granulomatosis With Polyangiitis Associated to Antiphospholipid Antibodies

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ABSTRACT
Pyoderma gangrenosum (PG) is a neutrophilic dermatosis that most often presents with painful ulcerations of violaceous borders in lower limbs and/or trunk. PG treatment varies according to the severity of the lesion and may either respond to local therapies or require immunosuppressive agents. In this article, we present the case of an antiphospholipid antibody-positive 59-year-old female patient diagnosed with granulomatosis with polyangiitis who developed severe PG-like skin involvement that was responsive to rituximab therapy.

Keywords: Antiphospholipid antibodies, granulomatosis with polyangiitis, pyoderma gangrenosum, rituximab.

Systemic autoimmune diseases are characterized by a wide variety of clinical manifestations, including cutaneous lesions. Pyoderma gangrenosum (PG) and pyoderma-like lesions can be associated with different rheumatic conditions, such as granulomatosis with polyangiitis (GPA).1

Management of this pathology is based on local wound care, avoidance of trauma, and in some occasions, systemic therapy with systemic corticosteroids and cyclosporine being the mainstays of treatment. In recalcitrant PG, biologic medications, such as tumor necrosis factor-alpha (TNF-α) inhibitors, could be necessary. Actually, infliximab (IFX) is the only biologic that has shown efficacy in classic PG in a randomized, double-blind, controlled trial (level 1 evidence).2

Rituximab (RTX) was approved for use in GPA by the Food and Drug Administration in April 2011. The use of RTX for cutaneous and subcutaneous GPA lesions has previously been reported in some case series and case reports.3

In this article, we present the case of an antiphospholipid antibody (aPL)-positive female patient diagnosed with GPA who developed severe PG-like skin involvement that was responsive to RTX therapy.

CASE REPORT

In 2003, a 59-year-old female patient was referred to the Rheumatology Division after developing symmetric polyarthritis of small and
large joints and a solitary pulmonary nodule. She
denied Raynaud’s phenomenon, xerophthalmia, xerostomia and alopecia. Her obstetric history
included a spontaneous abortion in the first trimester of pregnancy. A written informed
consent was obtained from a relative of the patient.

Upon examination, she was afebrile and her
blood pressure was normal. Joint examination
revealed 12 tender joints and 13 swollen
joints, involving wrists, metacarpophalangeal,
proximal interphalangeal, knees and ankle
joints. Pulmonary, cardiovascular, abdominal,
dermatological and neurological examinations
were not remarkable.

The histologic findings from lung biopsy were
compatible with rheumatoid nodule without
vasculitis. Complete blood count; levels of serum
electrolytes, glucose, bilirubin, and protein;
and liver- and renal-function tests were normal
except for an erythrocyte sedimentation rate of
82 mm/hour (Westergren method). Rheumatoid
factor (latex), Rosse Ragan, antinuclear antibody
human epithelial type 2, anti-double stranded
deoxyribonucleic acid, anti-Ro/SSA and anti-La/SSB were negative. Serum complement
levels were normal. Determination of anti-cyclic
citrullinated peptide (anti-CCP) antibodies was
not available in our institution at that time. With a
presumptive diagnosis of seronegative rheumatoid
arthritis, hydroxychloroquine 400 mg/day and
prednisone 10 mg/day were started. Due to
pulmonary involvement, methotrexate (MTX) was
not contemplated.

Two months later, the patient developed
digital ischemic lesions in her hands with
necrosis in the first phalange of her third
left finger that led to autoamputation. Lupus anticoagulant (LAC) was positive and
anticardiolipin antibodies (ACAs) IgG 20 UGPL/
mL and IgM 25 UMPL/mL (low title) were also
positive. Anticoagulation with acenocoumarol
was started. An angiography of upper limbs was
not contemplated.

In the following three years, she progressively
developed distal sensory-motor polyneuropathy,
left ptosis associated with third cranial nerve palsy,
sinusitis, bloody rhinorrhea, and livedo reticularis
in lower limbs with petechiae progressing to small
necrotic ulcerations. Leflunomide was added to
previous treatment.

New laboratory tests showed positive anti-
neutrophil cytoplasmic antibody (c-ANCA): 1/80,
anti-proteinase 3 antibodies (anti-PR3) 46.5 U/
mL (positive ≥3.5 U/mL) and negative anti-CCP
antibodies.

Based on the 1990 American College of
Rheumatology criteria (nasal and pulmonary
compromise, besides c-ANCA and anti-PR3 +)
a diagnosis of GPA was established. Treatment
with intravenous methylprednisolone (1 g/day
for three days) was initiated, followed by oral
prednisone in tapering doses and monthly
intravenous cyclophosphamide 1 g/m² for 12
consecutive months.

In May 2007, the patient developed painful
ulcers in her right leg with the subsequent formation
of a large necrotic eschar. An escharotomy was
performed and its anamomopathological findings
showed thrombosis and leukocytoclastic vasculitis
(Figure 1).

Between June and July 2007, anticoagulation
was stopped due to lower gastrointestinal bleeding
(angiography not performed) and pulmonary
hemorrhage; intravenous gammaglobulin (IVIG)
was administered.

Cyclophosphamide was restarted for a six-
month period, with prednisone in tapering
doses. Since there was no renal involvement and
due to the severity of the arthritis, leflunomide
20 mg/day, and MTX 15 mg/week were added.
Anticoagulation with acenocoumarol was also
restarted.

Figure 1. Light microscopic examination of ulcer showing thrombosis (circle and arrow) and leukocytoclastic vasculitis (H-E ×200).
In February 2009, due to extended skin lesions and necrosis, and considering two possible pathogenic mechanisms; vasculitis and thrombosis secondary to a right-sided retro-orbital pseudotumor developed. In order to cover both clinical manifestations, another infusion of RTX was administered with neurological and cutaneous improvement.

The patient continued maintenance treatment with azathioprine (AZA) 200 mg/day, prednisone 7.5 mg/day, and infusions of RTX every six months with successful response until September 2013, when she became lost to follow-up.

In December 2014, after discontinuing all types of treatment, she came to the office presenting with severe renal failure. Soon after, the patient died due to complications associated with this condition.

**DISCUSSION**

Granulomatosis with polyangiitis is a rare systemic disease characterized by vasculitis and necrotizing granulomatous inflammation that usually affects the respiratory tract, kidneys and eyes. Less frequently, articular and cutaneous involvement is seen.1

Initially, our patient suffered polyarthritis indistinguishable from rheumatoid arthritis. However, during the course of her illness, she developed other clinical features (involvement of the respiratory tract and nervous system) that, along with positive serology tests for ANCA and anti-PR3, helped to diagnose GPA.

The prevalence of aPL has been reported in 17% of patients with systemic vasculitis.5 Recently, LAC presence was associated with a higher vasculitis damage index in patients with ANCA-associated vasculitis.6

Granulomatosis with polyangiitis in particular, has an increased risk of thromboembolism, particularly during periods of activity.7 The presence of vasculitis and thrombosis in the ulcerations allowed us to arrive at a diagnosis of vasculitis and probable antiphospholipid syndrome (APS) despite the not repeated LAC or ACA tests. Indefinite anticoagulation was

![Figure 2. Pyoderma-like ulcers prior to initiation of (a), during (b) and after treatment with rituximab (c).](image)
indicated by the hematology section, due to the increased risk of thrombosis.

Skin involvement is seen in almost half of the patients with GPA and this may be the presenting complaint in 10-25% of cases. The most common cutaneous manifestations are petechiae-purpura, ulcerations, papules, nodules, digital necrosis, and splinter hemorrhages.

Pyoderma gangrenosum is a neutrophilic dermatosis that most often presents with painful ulcerations of violaceous borders in lower limbs and/or trunk. In half of the cases, there is an underlying condition. Pyoderma-like lesions occur in up to 27% of patients with GPA.

On the other hand, livedo reticularis is the most common dermatologic manifestation of APS. Our patient presented with livedo reticularis that progressed to necrotic ulcers.

The pathophysiology of PG remains poorly understood, though it is now believed to involve loss of innate immune regulation and altered neutrophil chemotaxis. Emerging evidence of the clinical efficacy of TNF-α inhibitor therapy for the treatment of PG strongly suggests a key role for this cytokine in the disease.

Pyoderma gangrenosum treatment varies depending on the severity of the lesion and may either respond to local therapies or require immunosuppressive agents such as corticosteroids, MTX, AZA or mycophenolate mofetil. Gammaglobulin and cyclophosphamide are also prescribed for refractory cases, while biologic drugs such as IFX or RTX would be another option in these patients.

On the other hand, RTX has demonstrated efficacy in cutaneous ulcers secondary to APS that were resistant to anticoagulation. Our patient received corticosteroids, cyclophosphamide, MTX, AZA, leflunomide and IVIG to treat the different manifestations of the disease. However, her cutaneous lesions only responded to RTX therapy. Other authors have reported similar findings with RTX in patients with PG or PG-like lesions who had responded unsuccessfully to corticosteroids and immunosuppressive agents (Table 1).

In conclusion, this case shows that accurate diagnosis sometimes remains difficult, particularly in the presence of overlapping autoimmune diseases. This is when histopathological

| Table 1. RTX efficacy in PG-like ulcers associated to granulomatosis with polyangiitis |
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| **Age/sex** | **Clinical findings of GPA** | **Location of ulcers** | **Positive laboratory findings** | **Therapy** |
| Kindle S and Fanciullo | 52/F | Rhinitis, sinusitis, epistaxis, pulmonary nodules. | Legs | ANCA, PR3 | CS, RTX |
| Murthy RK et al. | 50/M | Pulmonary cavities | Legs, arms, scalp, penis, back. | ANCA, PR3, ESR, CRP, hematuria | CS, RTX |
| Sen M et al. | 29/F | Rhinorrea, epistaxis, perforation of the nasal septum, pulmonary cavities. | Legs | ANCA, PR3 | CS, MTX, CYC, MM, RTX |
| Tashtoush B et al. | 52/M | Compromise of upper respiratory tract and nervous system. | Legs | ANCA, PR3, hematuria, RF, ESR, anemia | CS, CYC, AZA, IFX, RTX |
| Our patient | 59/F | Compromise of upper respiratory tract and nervous system. | Legs | ANCA, PR3 | CS, CYC, MTX, LEF IVIG, RTX |

GPA: Granulomatosis with polyangiitis; ANCA: Anti-neutrophil cytoplasmic antibodies; PR3: Proteinase 3; CS: Corticosteroids; RTX: Rituximab; ESR: Erythrocyte sedimentation rate; CRP: C-reactive protein; MTX: Methotrexate; CYC: Cyclophosphamide; MM: Mycophenolate mofetil; RF: Rheumatoid factor; AZA: Azathioprine; IFX: Infliximab; LEF: Leflunomide; IVIG: Intravenous immunoglobulin.
procedures become relevant. Additionally, this case report highlights the potential efficacy of RTX in patients with severe skin lesions due to ANCA-associated vasculitis unresponsive to conventional immunosuppressive therapy.

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