

the complications of this debilitating condition. After all, it is far easier to prevent a complication than it is to treat one and regain a patient's health.

### Promoting engagement

A pressure ulcer often results in patient pain and suffering, poor patient outcomes, decreased quality of life, and increased costs for both patients and their providers. The integration of pressure ulcer prevention into required patient education using the teach-back method empowers and engages patients, fostering their active participation in their own health promotion. Healthcare providers and patients can work together as a team to prevent the many costs of pressure ulcers. ■

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### Online Resources

A. <http://www.teachbacktraining.org/>

B. <http://www.nchealthliteracy.org/toolkit/tool5.pdf>

C. [https://www.youtube.com/watch?v=cGtTZ\\_vxjyA](https://www.youtube.com/watch?v=cGtTZ_vxjyA)

## CASE STUDY: Peristomal pyoderma gangrenosum

By Susan Lee, BSN, RN, WCC

As a wound care specialist, you have learned about many skin conditions, some so unusual and rare that you probably thought you would never observe them. I've been a nurse for 38 years, with the last 10 years in wound care, and that's certainly what I thought. But I was wrong. Let me tell you about my challenging patient with an unusual skin condition.

### A perplexing patient

Mrs. Thompson\*, a 77-year-old resident in a long-term care facility where I work, had diabetes, peripheral vascular disease, and a history of a cerebrovascular accident in 1993, which left her with left-sided paralysis.

In February 2010, Mrs. Thompson underwent a colostomy in her left lower abdominal quadrant as a result of a large sigmoid colon volvulus. She was doing well until November 2011, when peristomal skin breakdown began, presumably caused by leakage. Over the course of the next 18 months, her skin breakdown would often improve without any change in treatment, which made subsequent exacerbations frustrating.

Here are the appliance-related adaptations my colleagues and I tried with Mrs. Thompson:

- stoma powders and paste
- wafer adaptations
- plain and medical-grade honey hydrocolloid applied directly to peristomal lesions.

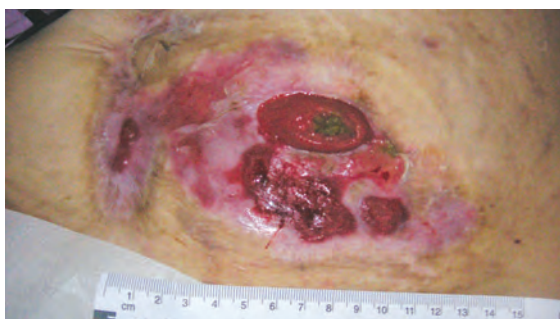
Unfortunately, none of these efforts solved the problem. A March 2013 dermatology consult resulted in no definitive diagnosis or alternative treatment options.

My “Aha” moment came when a computer search for causes of peristomal breakdown revealed illustrations of various conditions. One image, labeled pyoderma gangrenosum (PG), resembled what was occurring with Mrs. Thompson.

### About pyoderma gangrenosum

PG, a skin ulceration, was first described in 1930 by Brunsting and colleagues. It's associated with Crohn's or inflammatory bowel disease, cancer, blood dyscrasias, diabetes, and hepatitis.

PG has been described in several forms, but ulceration usually occurs on the abdomen, perineum, and lower extremities. The lesions begin as discrete pustules that erupt and coalesce into a classic painful ulcer with a violaceous border and undermined edge. Multiple lesions are common.



*Mrs. Thompson's wound at the time of diagnosis*

### Diagnosis

The diagnosis of peristomal PG is based on the patient's history and characteristics of skin breakdown because biopsies and cultures can't confirm the diagnosis. The lesions are typically very painful, but Mrs. Thompson didn't experience pain because of the left-sided sensory deficits caused by

her stroke. In one study, the time to onset of peristomal PG after creation of a stoma ranged from 2 months to 25 years; in Mrs. Thompson's case, onset was 20 months. The erratic progression of this rare disease is considered a hallmark of the disorder.

Even though diagnosis of skin conditions can be difficult, it's important not to give up.

My colleagues and I validated the diagnosis of peristomal PG by characteristics of the lesions and exclusion of other skin conditions.

### Management

The unknown etiology of the peristomal lesions makes treatment decisions challenging. Because the condition is rare, recent evidence-based practice data are limited, with most reported as part of research trials. When lesions are mild and there is absence of systemic disease, it may be possible to control the condition with topical corticosteroids and dressings.

Based on what we could find in the literature and discussion with the geriatric nurse practitioner and Mrs. Thompson's primary care physician, we decided to start her on high-dose steroid cream.

### Positive results

On April 4, 2013, Mrs. Thompson began receiving daily clobetasol propionate

0.05%, a high-dose steroid cream applied to the peristomal area. We gently rubbed in the cream completely, followed by an aerosol skin barrier and a one-piece appliance. The treatment was re-evaluated every 14 days, as recommended by the manufacturer, because of the risk for hyperglycemia, which did not occur.

By June 13, 2013, 72 days later, the lesions had healed and we resumed bi-weekly appliance changes.



*Lesions healed after 72 days of clobetasol propionate 0.05%.*

This healing time of about 2.4 months was much faster than what we found in the literature: One study reported an average healing time for peristomal PG of 11.4 months (median, 7.5 months; range 1-41 months).

After the initial PG exacerbation was healed, Mrs. Thompson occasionally experienced minor exacerbations, but not to the extent it was when first diagnosed and treated with clobetasol.

One 60-g tube of clobetasol propionate 0.05% (cost of \$328) was required to successfully treat the breakdown.



*Complete wound healing at 120 days*

## Committed to healing

Comorbid conditions play an important role in effectively diagnosing and treating skin breakdown. In Mrs. Thompson's case, sensory deficits from a stroke sustained almost 20 years earlier diminished her ability to feel pain at the stoma site, which is the signature diagnostic characteristic of PG.

I learned that even though diagnosis of skin conditions can be difficult, it's important not to give up. My commitment, along with the commitment of my colleagues, resulted in our ability to find a solution for Mrs. Thompson's condition. ■

\*Name is fictitious.

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