

Fact Sheet

News from the IBD Help Center

SKIN COMPLICATIONS

After arthritis, skin disorders represent the next most common extraintestinal complication (complications that occur outside of the intestine) of inflammatory bowel disease (IBD), affecting up to 20% of people with IBD.

Common Skin Disorders

- **Erythema Nodosum** literally means “red bumps.” These tender red nodules, which usually appear on the shins or ankles and sometimes on the arms, can affect 2-10% of the IBD population. Women are more commonly affected than men. Erythema nodosum generally appears in conjunction with an IBD flare, but also may occur just before a flare. It tends to improve with adequate treatment of the underlying bowel disease.
- **Pyoderma Gangrenosum** is most often found on the shins or ankles but sometimes occurs on the arms. Beginning as small blisters, these lesions eventually join together to form deep chronic ulcers. The disorder is more common among people with ulcerative colitis than those with Crohn’s disease. Pyoderma gangrenosum often follows a similar course to the pattern of the IBD itself, and may heal as the symptoms of IBD are brought under control. Antibiotics, injections of medications into the ulcers, and topical ointments all may be used as treatments.
- **Skin Tags** are fairly common in people with Crohn’s disease. They often develop around the anus. When the swellings go down, the skin around them thickens and forms small flaps. Fecal matter may attach to skin tags, irritating the skin. Practicing good hygiene will help reduce discomfort and calm the irritation. It is helpful to avoid surgical removal of skin tags because there is a possible risk of damaging or scarring the anal sphincter or the anal canal itself. When the tags enlarge and become tender and rubbery, this may be a sign that Crohn’s disease is becoming active.
- **Enterocutaneous Fistulas** is an abnormal channel that forms from the intestine to the skin—often from the rectum to the vagina, bladder, or buttocks. It also may be a complication of surgery. This type of fistula may leak pus or fecal matter. Fistulas are more common in Crohn’s disease than in ulcerative colitis, affecting approximately 30% of people with Crohn’s. Treatment depends on the location and severity of fistulas and may require surgery.
- **Anal Fissures** are small tears in the lining of the anal canal. They may crack and bleed, causing pain and itchiness. Warm baths and topical ointments, such as low dose nitroglycerin, may be helpful.
- **Aphthous Stomatitis** (also known as canker sores) are small mouth ulcers most often found between the gums and lower lip or along the sides or base of the tongue. They are usually seen during severe flare-ups of IBD and generally subside as the bowel disease comes under control. Medicinal mouthwashes may be helpful, along with a balanced diet and a multivitamin/mineral supplement.

Uncommon Skin Disorders

- **Sweets Syndrome** is a rare condition that predominantly affects women. Patients get fever and tender red skin lesions, usually on the upper body. Treatment with steroids or anti-TNF agents has been successful.
- **Acrodermatitis Enteropathica** is a flaky rash that generally appears on the face, hands, feet, and perineum. It is often caused by a zinc deficiency, resulting from chronic diarrhea. Various vitamin deficiencies may produce skin manifestations, such as bleeding, swollen gums and/or a flaky rash. These problems are less common today because of the increased attention to the importance of good nutrition in chronic illnesses such as IBD.
- **Pyoderma Vegetans** can affect people with ulcerative colitis, and is believed to be due to abnormal immune system activity. The condition appears as blisters, plaques, or patches around the groin and under the arms that darken as they heal. Treatment of this disorder often involves treating the IBD itself.
- **Vasculitis**, which means “inflammation of the blood vessels,” is marked by raised reddened areas that can sometimes be ulcerous. It is believed to be due to abnormal immune system activity. Treatment of this disorder often involves treating the IBD itself.
- **Epidermolysis Bullosa Acquista** may develop in people who have had Crohn’s disease for many years. It is a blistering condition that appears on the knees, elbows, hands, and feet.
- **Vitiligo** (marked by areas of decreased pigmentation) and **Psoriasis** (a scaly, itchy disease) are occasionally linked with IBD, as is **Clubbing** (in which the skin beneath the nails becomes thickened). The first two may respond to ultraviolet light therapy and oral medications. There is no treatment for clubbing.
- **Skin Cancer** (non-melanoma and melanoma) rates are higher for IBD patients taking immunosuppressive medications (ex. azathioprine, 6-mercaptopurine, methotrexate, and anti-TNF agents) compared to the general population. It is helpful for patients on these medications to use sun block regularly and have annual skin checks by their primary doctor or dermatologist.

Drug Reactions

In some cases, a skin disorder is not caused by IBD, but rather the medications used to treat it. For example:

- Sulfasalazine, may produce an allergy-type skin rash in some people. The reaction is attributed to the sulfa component of this agent.
- Steroids may cause skin problems when used on a long-term basis. These include stria or stretch marks, thinning of the skin, aggravation of acne, facial puffiness, ankle swelling, and slow wound healing.
- Anti-TNF agents (such as infliximab, adalimumab, certolizumab pegol, and golimumab) may cause a psoriasis-like rash (psoriasiform), which usually occurs on the palms, feet, scalp, and behind the ear. It can occur in up to 18% of patients taking these medications and may not improve if the anti-TNF agent is changed. In over 70% of cases, dermatologic treatment of the rash allows the patient to continue the anti-TNF agent.

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