Abstract: Background: Extra intestinal manifestations of inflammatory bowel disease are prevalent in ulcerative colitis. The most common manifestations involve the musculoskeletal and dermatologic systems. Other manifestations involve the hepatobiliary system as well as the ocular, renal, and pulmonary systems. A multidisciplinary team approach is often needed for effective management, and emergency situations require prompt evaluation.

Case Report: This is a case report of a young male age of 30 years, presented with bleeding per rectum for three months. He passed loose stools mixed with blood and mucus. He had loss of weight and appetite for two weeks. He had pain in the lower abdomen which is dull ache in nature, not radiating, relieved by medications. His blood investigations were normal except ESR which was grossly elevated. During admission he developed skin lesion over left leg which was diagnosed as pyoderma gangrenosum. Colonoscopy showed Severe inflammatory bowel disease with Multiple pseudo-polyps present in upper rectum. Upper GI endoscopy was normal study up to D2. He underwent lap assisted total colectomy with end ileostomy. In third postoperative day his ESR values became normal. His skin lesions were healed by sixth postoperative day and discharged. Histopathology showed features of ulcerative colitis with pseudo polyp formation.

Conclusion: Surgical removal of affected colon in ulcerative colitis is an effective management for extra intestinal manifestations which showed rapid recovery following surgery.

Keywords: Extra intestinal manifestations, inflammatory bowel disease, pyoderma gangrenosum

Introduction: Extra intestinal manifestations of inflammatory bowel disease are prevalent in ulcerative colitis. The most common manifestations involve the musculoskeletal and dermatologic systems. Other manifestations involve the hepatobiliary system as well as the ocular, renal, and pulmonary systems. A multidisciplinary team approach is often needed for effective management, and emergency situations require prompt evaluation.
Operative Findings:
Entire colon involved with ulceration and multiple pseudo polyps No peritoneal or pelvic deposits, No ascites.
Operative procedure:
Sigmoid colon mobilized with harmonic scalpel.Sigmoid arteries clipped and divided.Descending colon mobilized upto splenic flexure.Left colic artery clipped and divided.Splenic flexure mobilized by dividing the Spleno-colic ligament.Gastro colic omentum divided an dtransverse colon mobilized.Hepatic flexure mobilized by dividing the Nephro co lic ligament.Right colic,middle colic doubly ligated & divided. ureter was identified at each level and protected. Terminal ileum was divided about 10 cm proximal to ileo-cecal valve.specimen retrieved thorough a 5cm incision in the Right iliac fossa.Brooke end ileostomy done in RIF. Postoperative period In third postoperative day his ESR values became normal. His skin lesions were healed by sixth postoperative day.

Discussion
Pyoderma Gangrenosum begins with a pustule or erythematous papule nodule that quickly breaks down to form an ulcer with violaceous undermined borders. Covered with pus necrotic debris, ulcers contain fistulous tracts that open into characteristic crater-like holes that leave a typical pattern of cribiform scarring when healed. These ulcers be solitary or multiple, unilateral or bilateral, and can range in size from several centimeters to an entire limb. Although the legs are most commonly affected, Pyoderma Gangrenosum ulcers can appear on any part of the body, most notably the abdominal wall adjacent to a postsurgical stoma. Pyoderma Gangrenosum has been reported in 1–10% of UC patients and 0.5–20% of CD patients. In a Turkish study, Pyoderma Gangrenosum was observed in 6 of 234 UC patients and 2 of 118 CD patients. There was no significant difference between genders, which supports previous reports. There have been conflicting data regarding the distribution of Pyoderma Gangrenosum among CD and UC, the Turkish study showed no statistically significant difference between the 2 groups. In the Turkish study, 6 of 8 patients with Pyoderma Gangrenosum had active intestinal disease. Therapy can be concentrated on underlying intestinal disease in these cases, although high-dose steroids usually need to be part of the regimen. Localized disease can be treated with an intra lesional corticosteroid injection. Other immunosuppressive agents such as cyclophosphamide and azathioprine have been used alone or in conjunction with steroids for treatment. Cyclosporine has been used effectively at low doses in patients resistant to steroid therapy. Patients will often show a rapid response, with crusting of lesions in less than 24 hours. Infliximab use in these patients is currently under investigation. In our case Pyoderma Gangrenosum disappeared in early post operative period completely.

Conclusion
Extra intestinal manifestations are very common in both UC and CD patients. Most Extra intestinal manifestations are parallel disease activity and will respond to treatment of underlying bowel disease;surgical excision of diseased colon is feasible and effective management for them. However, some diseases, such as PSC, warrant lifelong monitoring of extraintestinal systems.

References: