Patients with pyoderma gangrenosum (PG) with moderate to severe disease or mild PG that has failed topical preparation and who are being treated with topical treatments as adjunct to systemic therapy guided by physician judgement. And in whom the following have been trialled:

- Prednisolone with cyclosporin added at 2/3 weeks if required. Followed by,
- Additional 2nd or 3rd line treatments if:
  - at six weeks after initiation of cyclosporin there is no improvement, or,
  - if there is evidence of deterioration at any stage.

See explanations for common treatment options

The ulcer has failed to stabilise or has progressed despite a trial of prednisolone, cyclosporin and one second line agent (see above) for six to eight weeks[1] **OR** If there has been rapid development of several large ulcers such that pain control cannot be achieved and amputation is considered

Immunoglobulin
Administer adjunctive immunoglobulins as per the National Blood Authority (NBA) criteria*

After failure of immunoglobulins as per the NBA criteria

Infliximab^
Infliximab influsion of 5 mg/kg at 0,2 and 6 weeks

Eight week assessment shows stabilisation or improvement

No

Yes

Continue infliximab every 8 weeks. Once healed cease infliximab.

Six month assessment Shows evidence of 50% or more improvement

No → **Refractory disease**
Individual treatment approach

Yes

Yes

Trial a 3 month drug holiday

Deterioration?

Yes

No

Observation/Individual treatment approach

NOTES

**** For patients with inflammatory bowel disease clinicians may consider infliximab prior to immunoglobulins***

^There should be no coadministration of IVIG and infliximab.

[1] Treatments should be tailored to individual circumstances taking into consideration contraindications to agents such as cyclosporin. Contraindications to cyclosporin include existing renal impairment which prohibits the use of cyclosporin; the development of renal impairment soon after starting cyclosporin, and in spite of appropriate dosage reduction; the development of severe hirsutism in women in spite of appropriate dosage reduction; recent history of malignancy.

Systemic therapy includes:
1. systemic corticosteroids 0.5-1.5 mg/kg/d up to a max of 60 mg daily*
2. IV methylprednisolone 1 gm daily for 1-5 days *

1st line steroid sparing agent
3. cyclosporin 5 mg/kg/daily reducing to maintenance of 2.5-3mg per day*

2nd line steroid sparing agent that can be used in conjunction with CS
4. mycophenolate mofetil 2 gms daily^
5. azathioprine 0.5-2.5 mg/day (dependent on TPMT levels)^
6. methotrexate 15 mg orally, weekly or the equivalent dose subcutaneously or IMy^
7. Dapsone 150 mg daily (option to use as monotherapy)^
8. minocycline 100-200 mg daily (only if all other treatments are contraindicated or failed)

*assessment at 6 weeks, ^assessment at 8 weeks