Supplementary Online Content


**eTable 1.** New Cases of Necrotizing Neutrophilic Dermatosis Misdiagnosed As Necrotizing Fasciitis in San Francisco, CA; Portland, OR; Minneapolis, MN

**eFigure 1.** Necrotizing Sweet Syndrome Morphology Mimicking PG

**eFigure 2.** Necrotizing Sweet Syndrome Histopathology

**eFigure 3.** Necrotizing Sweet Syndrome Histopathology

**eReferences**

This supplementary material has been provided by the authors to give readers additional information about their work.
eTable 1. New Cases of Necrotizing Neutrophilic Dermatosis Misdiagnosed As Necrotizing Fasciitis in San Francisco, CA; Portland, OR; Minneapolis, MN

<table>
<thead>
<tr>
<th>Case, Year</th>
<th>Age, Gender</th>
<th>Initial insult</th>
<th>Comorbidities</th>
<th>Site</th>
<th>Class</th>
<th>Clinical features</th>
<th>Histology</th>
<th>Imaging</th>
<th>Key Lab Findings</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case 1, 2017</td>
<td>43, M</td>
<td>None</td>
<td>Drug abuse (methamphetamines)</td>
<td>Leg</td>
<td>PG</td>
<td>- Ulcerated, purpuric skin plaques - Violaceous, undermined borders - Satellite lesions: flank, back</td>
<td>Ulcerative, dense neutrophilic dermatitis</td>
<td>None</td>
<td>- Culture: negative - WBC: 42,000/µL - CRP: 250mg/L - fever, shock</td>
<td>Antibiotics Debridements Amputation Systemic corticosteroids</td>
</tr>
<tr>
<td>Case 2, 2017</td>
<td>69, M</td>
<td>None</td>
<td>MDS</td>
<td>Leg</td>
<td>NS S</td>
<td>- Erythematous, tender plaque - Nodular violaceous center - Surrounding pitting edema - Post-debridement: ulcer with violaceous border and bleeding base extending to muscle</td>
<td>Subcutaneous necrosis - Inflamed and necrotic skeletal muscle - Muscle fascicles with multinucleated myocytes, neutrophils - Fascia with fibrin deposition and extravasated erythrocytes with widening fibrous septa</td>
<td>U/S: - soft tissue swelling - without abscess or fluid collection</td>
<td>- Culture: negative - WBC: 5,900/µL - Temperature: 39°C - tachycardia, shock</td>
<td>Antibiotics Debridement Systemic corticosteroids IVIG</td>
</tr>
<tr>
<td>Case 3, 2017</td>
<td>69, M</td>
<td>None</td>
<td>MDS</td>
<td>Face</td>
<td>NS S</td>
<td>- Erythematous, violaceous, edematous plaque - Admixed areas of necrosis and eschar formation - Overlying yellow-brown thick crust</td>
<td>Dense, neutrophilic dermal infiltrate - Marked papillary dermal edema - Slight overlying dermal vesiculation</td>
<td>CT: - soft tissue swelling - extension into soft tissue &amp; scalp - adenopathy</td>
<td>- Culture: S. hominis, coagulase negative Staphylococcus, Candida albicans - WBC: 35,000/µL - Temperature: 40°C - fever, tachycardia, shock</td>
<td>Antibiotics Debridement Systemic corticosteroids</td>
</tr>
<tr>
<td>Case 4, 2016</td>
<td>65, F</td>
<td>None</td>
<td>Essential thrombocytosis, hypothyroidism, CKD</td>
<td>Breast</td>
<td>PG</td>
<td>- Non-pustular, non-tender nodule - Satellite lesions: elbow, buttocks</td>
<td>Dense infiltration of polymorphonuclear neutrophils involving the dermis, subcutaneous fatty tissue and skeletal muscle</td>
<td>None</td>
<td>- Culture: negative - WBC: 49,000/µL - CRP: 14mg/L - Temperature: 38°C</td>
<td>Antibiotics Debridements Topical steroids Systemic corticosteroids Mycophenolic acid</td>
</tr>
<tr>
<td>Case 5, 2016</td>
<td>32, M</td>
<td>None</td>
<td>History of DVT</td>
<td>Butt ocks</td>
<td>PG</td>
<td>- Pustule - Painful, erythematous nodule</td>
<td>Ulcerative, dense neutrophilic dermatitis</td>
<td>CT: normal</td>
<td>- Culture: negative - WBC: 37,000/µL - Temperature: 40°C - shock</td>
<td>Antibiotics Debridements</td>
</tr>
<tr>
<td>Case 6, 2015</td>
<td>67, M</td>
<td>Abrasions/s/p MVA</td>
<td>Clotting disorder, DM2, kidney</td>
<td>Foot</td>
<td>PG</td>
<td>- Ulcer w violaceous border - Bullae with sloughing</td>
<td>Ulcerative, dense inflammation of the skin and subcutaneous tissue</td>
<td>None</td>
<td>- Culture: negative - WBC: 33,000/µL - Temperature: 39°C</td>
<td>Antibiotics Debridements Amputation</td>
</tr>
<tr>
<td>Failure, HTN</td>
<td>Satellite lesions: leg (purple discoloration 2 weeks after insult)</td>
<td>Subcutaneous abscess formation and fat necrosis - Margins viable though mildly inflamed</td>
<td>Systemic corticosteroids MMF Steroid injection Topical gentamicin</td>
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</table>

CKD, chronic kidney disease; CRP, c-reactive protein; CT, computerized tomography; DM2, DVT, deep vein thrombosis; DM2, diabetes mellitus type 2; ESR, erythrocyte sedimentation rate; F, female; HTN, hypertension; IVIG, intravenous immunoglobulin; M, male; MDS, myelodysplastic syndrome; MMF, mycophenolate mofetil; MVA, motor vehicle accident; NF, necrotizing fasciitis; NSS, necrotizing Sweet syndrome; PG, pyoderma gangrenosum; S., Staphylococcus; s/p, status post; U/S, ultrasound; WBC, white blood cell count
eFigure 1. Necrotizing Sweet Syndrome Morphology Mimicking PG

Violaceous margins, surrounding warmth, and necrotic skin and/or tissue in NSS typically follow pathergic insults, such as debidement.
**eFigure 2.** Necrotizing Sweet Syndrome Histopathology

A diffuse infiltrate of neutrophils and karyorrhectic debris arrayed throughout the papillary and superficial reticular dermis. (Hematoxylin and eosin (H&E) stain, original magnification x 400).
eFigure 3. Necrotizing Sweet Syndrome Histopathology
Surgical debridement of the leg tissue demonstrated an acute inflammatory infiltrate in the muscle and subcutaneous fat involving the fibrous septa and lipocyte lobules without involving the dermis or epidermis, diagnosed as septal and lobular panniculitis. (H&E stain, original magnification x 250).
**References**


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