



Fig. S1. UC Davis PG algorithm. Once a patient has been diagnosed with PG, a clinical assessment of disease severity is made. As there are currently no validated outcome measures, the algorithm divides PG patients into two categories, severe (multiple ulcers, a large ulcer, or involvement of the face) and mild. Patients with mild disease are initially treated with monotherapy (e.g. topical clobetasol, intralesional kenalog, or 0.5 mg/kg of prednisone) (114). If complete resolution is not achieved the physician can consider the use of a biologic. In contrast, patients with severe PG are started immediately on either prednisone or cyclosporine. The fast onset of prednisone and cyclosporine make them ideal choices for initial therapy (tacrolimus can also be considered), as patients with severe PG have a high tendency to develop additional ulcers. The next step is to consider a biologic agent. Biologics are not used as the initial agent in the algorithm because of the time needed for them to reach their peak effect. Commonly used biologics for mild and severe PG include infliximab and adalimumab. Other less studied biologics like ustekinumab may also be a reasonable alternative especially if anti-TNF agents fail. Three weeks after starting a biologic agent, a slow taper of the initial agent (either prednisone or cyclosporine) should be started. For patients that do not respond completely to biologic therapy, the frequency of the biologic may be increased and/or a compatible agent may be added to the immunosuppressive regimen (e.g. low dose prednisone or methotrexate). If a complete response is still not achieved, re-evaluation of the ulcer is indicated to confirm the presence of an inflammatory border; alternatively another biopsy at the ulcer edge may be obtained. If the inflammation is largely resolved, wound care should be maximized. If significant inflammation persists, then the dose of the non-biologic agent may be increased or the non-biologic can be changed. Alternatively, another biologic can also be considered. For management without using biologics, a second compatible agent may be added. If the patient still fails to respond completely, a third compatible agent can be started. One triple drug regimen that that may be considered for severe PG is prednisone, cyclosporine, and mycophenolate mofetil. If a complete response is not achieved on triple drug therapy for severe PG or dual drug therapy for mild PG, the clinician should reassess the wound and reconsider starting a biologic. If the inflammation appears to be resolved but the wound is not resolving, maximize wound care.