Cutaneous vasculitis for A+E

Dr Judith Ellison

1.What is vasculitis?

Cutaneous vasculitis refers to inflammation of the blood vessels of the skin. It can affect any size of vessel and includes a variety of clinical presentations. It has many causes.

The commonest presentation to A+E is that of palpable (or sometimes barely palpable) purpura, petechiae and echymoses (bleeding into the skin) which often presents on the lower limbs but can spread to buttocks and forearms. Areas can become necrotic (blister and ulcerate). This is usually because of a small vessel vasculitis (leucocytoclastic vasculitis). Henoch-Sconlein purpura is a common example of this type of vasculitis. Patients may have non-specific constitutional symptoms like fever, arthralgia but symptoms such as abdominal pain or neurological symptoms suggest extracutaneous involvement. Nodules and a livedoid rash may suggest a vasculitis affecting larger vessels eg polyarteritis nodosa.

2. How is it diagnosed?

Vasculitis is usually a clinical diagnosis on the basis of its clinical appearance. In cases of diagnostic uncertainty a skin biopsy may be helpful.

3. What causes it?

50% of cases of vasculitis are idiopathic.

However there are many common and some potentially serious causes that need to be considered:

Infection: Bacterial, viral. Particularly ask about sore throats (streptococcal throat is a common cause). Hepatitis B and C.

Drug causes: Multiple. Ask about drugs recently started (often antibiotics, NSAIDS, diuretics but MANY drug culprits) and check in BNF as to the risk of vasculitis-stopping will usually improve the rash.

Malignancy: ask about red flag symptoms

Autoimmune disorders: SLE, rheumatoid arthritis, polyarteritis nodosa.

4. So what tests do I need to do?

Divided into **A)**:looking for causes of vasculitis and then **B)**: checking that there is no evidence of other organ systems involvement.

A)Looking for the cause:

FBC, ESR, U+E, LFT.

ANA, ENA,C3 C4 –looking for lupus/ autoimmune disorders

ASOT (antistreptococcal antibodies) and **throat swab**- have they got a streptococcal throat infection?

Hep B and C serology

ANCA

CXR

Also ideally: **Cryoglobulins**- (need to be sent straight to lab) and **protein electrophoresis**

B)The **most important tests** are **blood pressure**, **serum creatinine** and a **URINE DIPSTICK** looking for **protein** and **microsopic haematuria**. The most common morbidity in these patients is renal-often glomerulonephritis and **can lead to renal failure**. If there is any microscopic haematuria we would consider urgent referral to the renal team to discuss a renal biopsy – although we often monitor for a few days/weeks to see if it is persistent.

5. How do we treat it?

Generally supportive treatment, simple analgesia, dressings if necrosis occurs, look for the cause as above and stop any responsible medication, consider compression.

Traditionally oral prednisolone has been used for more severe blistering cutaneous vasculitis.

6. Will it get better?

The majority of cases of acute cutaneous vasculitis improve/resolve over weeks. Occasionally we see chronic idiopathic cutaneous vasculitis and use drugs like dapsone for these patients.

If the vasculitis turns out to be systemic and affect the kidneys, gut, brain , lungs etc. it can be life threatening.

There are many rare types of vasculitis which are beyond the scope of this summary including forms of large vessel vasulitis (polyarteritis nodosa, temporal arteritis, Churg Strauss, Takayasu's disease.) These have specific features and signs.

7. Do they need follow up?

In cases of apparently simple cutaneous vasculitis with no evidence of systemic involvement at presentation we would still recommend close follow up from the renal perspective of at least 6 months (GP can intermittently monitor urine dipstick, bp and creatinine) as late cases of renal involvement are well reported.