"What is going on with my skin?"

J. K. Pawlak, MD, MSc, PhD; T. J.Kroczak, BSc

An 83-year-old male with a long history of hypertension and prostatic hypertrophy developed malaise, myalgia and joint pain following by non-itchy erythematous spots on his upper and lower extremities, abdomen and chest. A few days before the rash appeared, he started a herbal medication for his problems with prostate.

Figure 1. Non-itchy erythematous spots.

Figure 2. Non-itchy erythematous spots.

Medical history

His medical history includes that he has been hypertensive for the last 12 years and is well controlled with perindopril one tablet daily. He has a problem with benign prostatic hypertrophy (BPH) and is taking tamsulosin hydrochloride CR 0.4 mg q.d. Also, he

- is not smoker,
- does not have any allergies and
- has an unremarkable family history.

Physical examination

- Weight: 210 lbs
- Height: six feet
- BP: systolic 138 mmHg, diastolic 83 mmHg
- Heart rate: 82 bpm, mild systolic murmur best heard at the apex
- Lungs: prolonged expiration
- No ankle edema

Clinical investigations

- Chest x-ray normal
- Left ventricular hypertrophy on ECG
- Complete blood count (CBC) normal, no thrombocytopenia
- Liver function test normal
- Kidney function test normal

What's your diagnosis?

a. Erythema nodosum
b. Ecchymoses
c. Vasculitis
d. Meningococcal septicaemia

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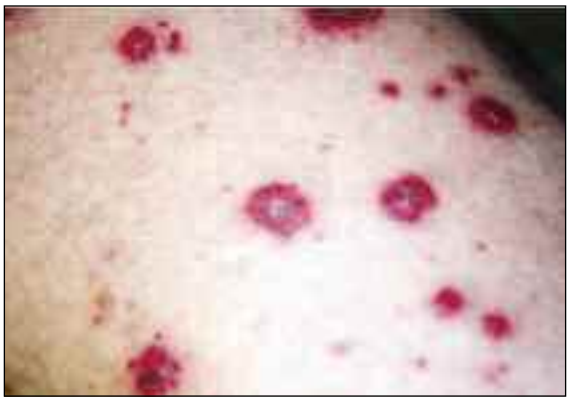

Figure 3. Close-up of erythematous spots.

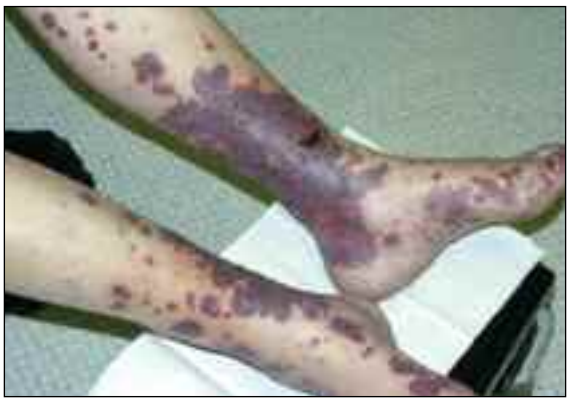

Figure 4. Follow-up rash.

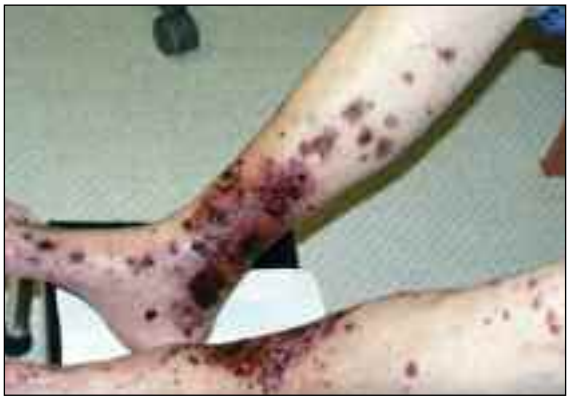

Figure 5. Follow-up rash.

Dr. Pawlak is a General Practitioner, Winnipeg, Manitoba.

Mr. Kroczak is a Medical Student, University of Manitoba, Winnipeg, Manitoba.

Answer: Vasculitis

Leukocytoclastic vasculitis (LCV) is a histopathologic term commonly used to denote a small-vessel vasculitis. Many possible causes exist for this condition, but a cause is not found in as many as 50% of patients. Systemic vasculitis is a heterogeneous group of disease characterized by inflammation and necrosis of the blood vessel walls. Depending on the size of the involved vessels (small-, medium- or large-vessel vasculitis) different systems can be affected; therefore, patients might present with a wide variety of clinical signs and symptoms.

The disorder may be localized to the skin, or it may manifest in other organs. The internal organs most commonly affected are the GI tract and the kidneys. Joints are also commonly affected. The prognosis is good when no internal involvement is present. The disorder may be acute or chronic.

Systemic vasculitis is a heterogeneous group of disease characterized by by inflammation and necrosis of the blood vessel walls.

Between one-third and one-half of cutaneous vasculitis cases are idiopathic; the remainder have a variety of causes. Antibiotics are the most common drugs that can cause cutaneous vasculitis, particularly ß-lactams. NSAIDs and

diuretics also frequently cause vasculitis. However, almost all drugs are potential causes. Various infections may be associated with vasculitis. Upper respiratory tract infections (particularly ß-hemolytic streptococcal infection) and viral hepatitis, particularly Hepatitis C, are most often implicated. HIV infection may also be associated with some cases of cutaneous vasculitis. Ascertaining whether a drug (*e.g.*, antibiotic) or an infection (*e.g.*, upper respiratory infection) is responsible for the disease is impossible because the occurrence of vasculitis postdates infection and the drug used to treat the infection. Foods or food additives may cause vasculitis. Hepatitis C is a regularly recognized cause of vasculitis, probably through the presence of cryoglobulins. Collagen vascular diseases account for 10% to 15% of cases of vasculitis.

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Treatment

Identify and remove the offending antigen (herbal medicine in our case). Short courses of prednisone (40 mg to 60 mg q.d.) may be useful for patients with severe symptoms. Indomethacin (25 mg to 50 mg q.i.d.) resulted in complete clearing of lesions in urticarial vasculitis and may be effective in classic leukocytoclasic vasculitis. Dx

References:
1. Callen, Jeffery P: Hypersensitivity Vasculitis (Leucocytoclastic Vasculitis). eMedicine. www.emedicine.com.
2. Lawee, D: Atypical Clinical Course of Henoch-Schonlein Purpurea. Can Fam Physician 2008; 54(8):1117-20.