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A Case Study: Henoch-Schonlein Purpura in a Geriatric Patient with Gastrointestinal Involvement

Suberna Basnet, Sanjana, Yalla Sai Vijaya Durga, Allu Tejaswi, Amit Kumar

Department of Pharmacy Practice, Aditya College of Pharmacy, Surampalem, Andhra Pradesh, India

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Abstract

IgA-mediated immune vasculitis known as Henoch-Schonlein purpura affects the small blood vessels in the joints, kidneys, GI tract, skin, and, less frequently, the brain and lungs. The present case report describes a 62-year-old female patient with Henoch-Schonlein purpura (HSP). HSP is a type of vasculitis that affects small vessels and is characterized by purpura, arthritis, abdominal pain, and kidney involvement. In this case, the patient presented with a rash with red lesions on the upper and lower limbs, crusted lesions on both lower limbs, and acute onset abdominal pain with hematochezia. Endoscopy revealed diffuse ulcerations in the stomach, duodenum, and right colon (fig.1). Biopsies revealed a leukocytoclastic vasculitis in the skin (fig2) and gastrointestinal tract. The patient had a history of hypertension and smoking, and laboratory investigations revealed leucocytosis, anaemia, and electrolyte imbalances. The diagnosis of HSP was made based on the clinical presentation, laboratory findings, and biopsy results. The patient was treated with a combination of steroids, antibiotics, and supportive care, which led to significant improvement of symptoms and laboratory findings. Steroid therapy was given according to guidelines for the treatment of HSP, and tapering the steroid therapy helped to improve gastrointestinal symptoms. The case report highlights the importance of careful monitoring and appropriate treatment of HSP in geriatric patients, as well as the potential benefits of immunosuppressant therapy.

Keywords: Henoch-Schonlein, leukocytoclastic vasculitis, gastrointestinal tract, Eosinophilic Colitis, use of steroid like, Dexamethasone.

***Corresponding Author**

Suberna Basnet

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Case Report

A62-year-old female patient came to general medicine department with chief complaints of rash with red lesions on upper and lower limbs since 10 days and crusted lesions on both lower limbs 10 days back (fig3) and abdominal pain since 4 days.

Patient was apparently alright 11 days back. There is history of neck pain for which patient took some medication Following which she developed red maulo-vesicular lesions that gradually crusted ever both lower limbs since last 10 days. Red lesions over both upper limbs since 4 days.Abdominal pain acute onset 4 days duration,colicky in nature a/w Franks blood loss per rectum (haematochezia) .she has a history of hypertension since 3yrs for which she is taking unknown medication. She has history of smoking chutta since childhood 5-6 pack years.

Observation

Under general physical examination, blood pressure was found to be 140/90mmHg, pulse rate 85 beats per minute, respiratory rate 16 per minute and temperature found to be afebrile. On systemic examination cervical lymphadenopathy present, diffuse tenderness in right ileac and hypogastric region, palpable purpura of varying size developed at proximally from both feet to thighs and legs with a burning pain and with On endoscopic examination ileocolonic ulcer was observed and multiple biopsies from ileal and caecal ulcer was

observed (figure 1 and 2) and send for biopsy on which ileal ulcer show feature of leucocytoclastic vasculitis and caecal ulcer show feature of Eosinophilic Colitis was found (fig4). CT of abdomen show THICKENED AND EDEMATOUS CAECUM, IC JUNCTION, ILEAL LOOPS, SLUDGE/MICROLITHS IN GB, MINIMAL ASCITES were observed.

Laboratory test show a Hb level 10.4gm/dl, WBC is 13400cells/cumm (leucocytosis),urine ketone body was positive (++,ketoacidosis),serum sodium 137meq/L, serum potassium 3.0meq/L, serum creatinine 0.8mg/dl, urine analysis :no haematuria and proteinuria, ANA-IFA show weak positive homogenous staining pattern, ASO titre was found negative, stool for occult blood:positive, H.pylori test was negative,by those all test and examination the diagnosis was made as Henoch-schonlein purpura according to the american college of rheumatology and the european league against rheumatism. Then the treatment was started with intravenous dexamethasone injection 1cc, Diprobate plus cream, and monocef injection for infection there observe a significant improvement on the patient.

Treatment provideds

On 89% of adult HSP was self-limiting but the geriatric patient should be treat carefully and special monitoring should be done the patient was admitted on the general medicine ward for the further treatment. Symptomatic treatment was started with IV fluid DNS 100ml/hr, inj. Ceftriaxone 1gm iv BD, azithromycin 500mg OD, inj. **Dexamethasone 1cc iv OD** was started, T. shelcal 500mg OD, Syp .potklor 5ml BD in 1 glass of water, T. tramadol, injpantop 40mg, oint. Diprobate plus E/L, those treatment was given in first 3 days then the antibiotic was change to inj. Metronidazole 100ml and t.cefixime 200mg was given and keep her for observation, patient show a significant improvement of symptom and lab report was get to normal on her 10th day laboratory report.

She was discharge on 11th day of hospitalization with the oral medication tab. Prednisolone 30mg OD for 8 days and tapper down to 10mg and then stop by tapering the steroid therapy help to improve the gastrointestinal symptoms within 5 days compare to the patient treated without steroid. So, steroid is given according to the guidelines of treatment of HSP. Tab. Bilastine 20mg, Tab. Pantop 40mg, Tab. Shelcal 500mg, Tab. Sporolac-ds for 2 days, lotion Diprobate l/a H/S, Bact ointment L/A, and follow up in the OPD after 8 days. She has significant recovery good bowel movement and all CRP, Ketone body get normalized with the normal WBC count on her laboratory finding after 18 days of treatment.

Immunosuppressant therapy or combination with steroid will be recommended when the individual steroid therapy did not relieve from the symptoms however not all the research has proven that immunosuppressant prevent the kidney involvement. On referring to different article it was found that dapsone also helps for the significant improvement of the symptoms of HSP.

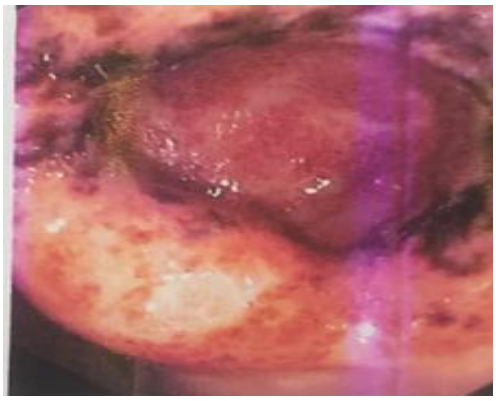

Figure 1.Ileocolonic ulcers r/c vasculitis.

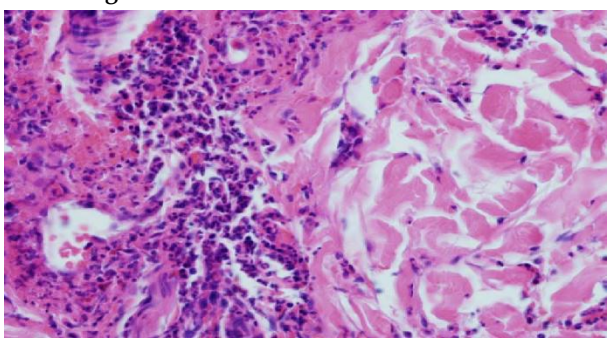

Figure 2. Leukocytoclastic vasculitis pattern in skin biopsy of patient

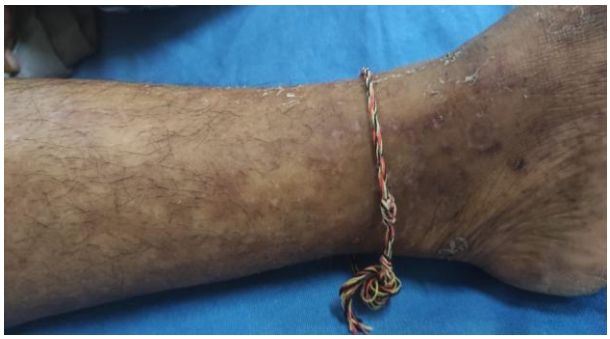

Figure 3.crusted lesions on lower limb which get treated & picture after 15 days of treatment.

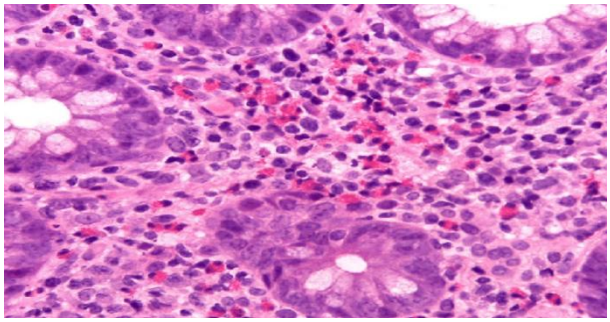

Figure 4.Eosinophilic Colitis.

Discussion

The present case report describes a 62-year-old female patient with Henoch-Schonlein purpura (HSP) who presented with a rash with red lesions on the upper and lower limbs, crusted lesions on both lower limbs, and acute onset abdominal pain with hematochezia. The patient had a history of hypertension and smoking, and laboratory investigations revealed leucocytosis, anemia, and electrolyte imbalances. The diagnosis of HSP was made based on the clinical presentation, laboratory findings, and biopsy results showing leucocytoclastic vasculitis and eosinophilic colitis. The patient was treated with intravenous dexamethasone, antibiotics, and supportive therapy, which resulted in a significant improvement in symptoms and laboratory parameters. HSP is a rare systemic vasculitis that primarily affects children and young adults, with a reported incidence of 10-20 cases per 100,000 children per year. However, the incidence in adults is less well established, with some studies reporting a higher incidence in older individuals, particularly those with comorbidities such as hypertension, diabetes, and chronic kidney disease. The clinical presentation of HSP is characterized by palpable purpura, arthritis, abdominal pain, and renal involvement, and the diagnosis is based on clinical and laboratory criteria. Biopsy is not always necessary but may be helpful in confirming the diagnosis and excluding other causes of vasculitis.

The management of HSP in adults is challenging, particularly in those with comorbidities and severe symptoms. Symptomatic treatment with analgesics, antihistamines, and supportive therapy is usually recommended, along with the management of comorbidities such as hypertension and diabetes. Corticosteroids are often used in severe cases, particularly those with gastrointestinal involvement, and may reduce the risk of renal involvement and the need for dialysis. However, the optimal dose and duration of steroid therapy remain unclear, and long-term use may increase the risk of infection, osteoporosis, and other complications.

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Conflict of Interest

All authors are declared that no Conflict of Interest.

Informed Consent

Inform consent was taken from the patient.

Ethical Statement

Not Applicable

Author Contribution

All authors contributed equally

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Conclusion

Henoch-Schonlein purpura (HSP) is a rare autoimmune disorder that is characterized by purpura, abdominal pain, and joint pain.The patient presented with a rash with red lesions on the upper and lower limbs, crusted lesions on both lower limbs, and acute onset abdominal pain with haematochezia. The diagnosis was made based on the clinical presentation, laboratory findings, and biopsy results showing leucocytoclastic vasculitis and eosinophilic colitis. The patient was treated with a combination of symptomatic treatment, antibiotics, and steroid therapy, which resulted in a significant improvement of symptoms and laboratory findings. The case highlights the importance of careful monitoring and tailored management in geriatric patients with HSP, as they may have a more severe disease course and comorbidities that need to be addressed.However, more research is needed to determine the role of immunosuppressants in the management of HSP. In geriatric patients, special attention should be paid to the potential complications of HSP, and careful monitoring and treatment should be provided to prevent any adverse outcomes. Early recognition and appropriate management of HSP are crucial in improving patient outcomes and preventing long-term complications.

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