



ORIGINAL RESEARCH PAPER

General Medicine

CASE REPORT ON HENOCH-SCHÖNLEIN PURPURA

KEY WORDS: Henoch-Schönlein Purpura, Vasculitis, Palpable purpura,

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ABSTRACT

Henoch-Schönlein purpura (HSP) is a small-vessel vasculitis mainly affecting children but also occurring in adults, characterized by palpable purpura, joint pain, abdominal symptoms, and occasionally renal involvement. We present a case of a 21-year-old male who presented with abdominal pain, joint pain, and fever along with palpable purpuric rash over the lower limbs. Laboratory investigations revealed neutrophilic leukocytosis, elevated inflammatory markers, and mild proteinuria. Imaging showed abdominal lymphadenopathy and enteritis, while skin biopsy confirmed neutrophilic leukocytoclastic vasculitis. Treatment with prednisolone led to symptomatic improvement. This case highlights the clinical features, diagnostic findings, management, required follow-up of Henoch-Schönlein purpura (HSP) in adults.

INTRODUCTION

IgA vasculitis (Henoch-Schönlein) is a small-vessel vasculitis characterized by palpable purpura (most commonly distributed over the buttocks and lower extremities), arthralgias, gastrointestinal signs and symptoms, and glomerulonephritis. It is usually seen in children ages 4-7 years; however, the disease may also be seen in infants and adults. The male-to-female ratio is 1.5:1[1]. The presumptive pathogenic mechanism for IgA (Henoch-Schönlein) vasculitis is immune-complex deposition. A number of inciting antigens have been suggested including upper respiratory tract infections, various drugs, foods, insect bites, and immunizations.[1] IgA is the antibody class most often seen in the immune complexes and has been demonstrated in the renal biopsies of these patients.[1] Diagnosis is primarily clinical, supported by laboratory tests and sometimes a skin biopsy (confirming leukocytoclastic vasculitis with IgA and C3 deposition by IFA) or kidney biopsy (for diagnosis and to determine prognosis). Mild cases of HSP are self-limiting, resolving spontaneously within a few weeks without severe complications requiring symptomatic treatment, though some patients may experience significant renal impairment requiring long-term follow-up. The global incidence rate of HSP is estimated to be about 10-20 cases per 100,000 children per year. Data for India might be scarce, but regional studies and hospital-based reports suggest that the incidence aligns with global trends. For instance, a study conducted at a tertiary care center in South India reported an incidence of around 13 cases per 100,000 children annually[2].

Case Study

A 21 yr old male, came with complaints of abdominal pain, joint pain with fever since 14 days. Abdominal pain was associated with nausea and vomiting. Patient also experienced red colored rash over bilateral legs and thigh, appear 10 days back, sudden in onset, associated with burning sensation.

On Examination

Patient was conscious and oriented and well oriented and cooperative. Patient was vitally stable on presentation. Per abdomen patient had tenderness over umbilical region without any guarding rigidity, without any palpable mass and bowel sounds were present. He had palpable purpuric papules and plaques over bilateral lower limb with local burning sensation.

Investigations

Test	Result	Normal ranges
Hemoglobin	12.4	13-18 gm/dl
Total white cells	19.55	4-11/UL
Platelets	296	150-450/UL
Erythrocyte Sedimentation Rate	65	0-14 mm at 1 hr
C- Reactive protein	54	0-5 mg/L
Serum Creatinine	0.47	0.5-1.5 mg/dl
Bilirubin Total	0.5	0.2-1.3 mg/dl
24 hr. Urinary Protein	315 (microalbuminurea)	mg/24hrs
IgA Total	226	70-400 mg/dl
Anti-Nuclear Antibody	Negative	

On investigation we got Neutrophilic Leucocytosis 19.55 (83.4% neutrophils) with raised markers of inflammation (ESR And CRP, mentioned in investigation chart). Platelet level, Serum Creatinine, Serum Urea, Liver Function Test, Coagulation Panel, Urine Routine, Rheumatoid factor were found out be normal. HIV, Hepatitis serology, Blood Culture were found out to be negative. 24 hr Urinary Protein was found out to be 315 mg/24hrs (micro-albuminuria). Serum IgA level and ANA by IFA normal.

Ultrasonography Abdomen and pelvis without any significant findings. Computed Tomography suggestive of non-necrotic abdominal lymphadenopathy and thickening of duodenal and distal ileal loops suggestive of enteritis.



Pic:- Showing pruritic rash over the lower limbs (palpable in nature).

Patient's skin biopsy from the margin of pruritic lesion showing dense perivascular neutrophilic infiltrate around small capillaries with leucocytoclasia at Dermis-Epidermis level with Mild fibrinoid necrosis and extravasation of RBCs. Suggesting small vessel neutrophilic leucocytoclastic vasculitis.

CONCLUSION

In adults, symptoms primarily affect the skin (palpable purpura) and joints (polyarthralgia), with gastrointestinal issues (colicky pain, nausea, vomiting, diarrhea and constipation rarely bowel intussusception). Renal disease may be more severe in adults and progresses slowly to end stage renal disease(1-5%), requiring close monitoring. Myocardial involvement is rare in children but possible in adults[1].

Laboratory tests often show mild leukocytosis, normal platelet count, occasional eosinophilia, normal serum complement, and elevated IgA in about half of the patients. The prognosis for IgA vasculitis (Henoch-Schönlein) is excellent, with rare mortality. Most recover fully, often without therapy. Prednisone (1 mg/kg per day) can reduce edema, arthralgias, and abdominal discomfort but is ineffective for skin or renal disease and does not shorten disease duration or reduce recurrence risk. Combining glucocorticoids with another immunosuppressive agent may help in rapidly progressive glomerulonephritis. Recurrences occur in 10-40% of patients.

In this case, we started patient on prednisolone (weight based) for 2 weeks followed by gradual tapering of dose. Patient discharged with symptomatic improvement and advised follow up to monitor protein-urea and any renal disease progression.

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