LEUKOCYTOCLASTIC VASCULITIS

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Leukocytoclastic vasculitis, also called hypersensitivity vasculitis, describes inflammation of small blood vessels. The term leukocytoclastic refers to the debris of neutrophils (immune cells) within the blood vessel walls. The disease can be confined to the skin (cutaneous) or it can affect many different organs of the body such as the kidneys, central nervous system, heart, gastrointestinal tract, and lungs. Systemic involvement is generally associated with a more severe disease course while cutaneous leukocytoclastic vasculitis is usually self-limited and has a better prognosis.

There are multiple causes of leukocytoclastic vasculitis however in nearly half of all cases the etiology is unknown. An allergic reaction to drugs, food, or food additives supports the theory of the immune system playing the dominant role. Infections, inflammatory bowel disease, rheumatoid arthritis, **lupus erythematosus**, Sjögren syndrome, and less often malignancy are some of the various conditions associated with the vasculitis.

In the skin, damaged blood vessels become leaky and small areas of hemorrhage appear as purple-red, raised lesions known as palpable purpura. Multiple discrete or grouped lesions are commonly found on the legs or other dependent areas of the body. These lesions are usually asymptomatic but can be itchy or painful. Large, painful, ulcerated blisters are indicative of more severe vessel inflammation. Lesions are present for 1 to 4 weeks on average before healing (often with some residual scarring). Signs of systemic involvement include fever, muscle aches, joint pain, blood in the urine or stool, abdominal pain, vomiting, cough, numbness, and weakness.

A physician can usually make the diagnosis based on the characteristic clinical presentation. A punch biopsy from one of the lesions can confirm the diagnosis. Additional tests are necessary to rule out associated systemic diseases. Tests to consider include a complete blood count, urinalysis, serum chemistry panel, rheumatoid factor, hepatitis panel, HIV serology, antinuclear antibodies, and chest radiograph.

Treatment for leukocytoclastic vasculitis varies depending on the patient's history. Cases may be acute or chronic. Acute cases involve a single occurrence of skin lesions that diminish after the offending agent such as infection, drug, or food is removed. In recurrent cases, the treatment is more complex. In these patients an underlying systemic disease must be identified and treated. **Systemic corticosteroids** and immunosuppressive agents may be necessary when internal organs are involved or severe ulcerating skin lesions are present. Some studies show evidence that medications such as **colchicine** and **dapsone** may be helpful in chronic cases.

This information has been provided to you compliments of the American Osteopathic College of Dermatology and your physician.