CLINICAL PRACTICE
Clinical Images

IgA Vasculitis

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A 37-year-old male presented with 2 weeks of abdominal pain, petechiae, palpable purpura, and arthralgias (Figs. 1 and 2). Past medical history was significant for hypertension, GERD, and family history of IBD. Initial rash began on the thighs and spread diffusely with significant burden on the nose, hands, and feet. Initial labs were notable for normal platelets, hematuria, and normal creatinine. An initial skin biopsy revealed leukocytoclastic vasculitis, and a secondary skin biopsy with immunofluorescence sent to Johns Hopkins revealed IgA immunoglobulins and C3 deposition in blood vessel walls, resulting in the definitive diagnosis of IgA vasculitis. Although IgA vasculitis notoriously affects the kidney blood vessel walls, a 24-h urine protein revealed minimal proteinuria. Treatment with prednisone improved symptom burden and led to full recovery.

IgA vasculitis, previously known as Henoch-Schonlein purpura, classically presents with the tetrad of arthralgias, abdominal pain, kidney disease, and palpable purpura without thrombocytopenia. Diagnosis of IgA vasculitis is typically made clinically but can be confirmed via skin biopsy showing IgA deposition in blood vessels. While commonly seen in the pediatric population, it is important to consider the diagnosis of IgA vasculitis in adults, as adults experience greater risk of recurrence, kidney damage, and disease relapse.[1–3]

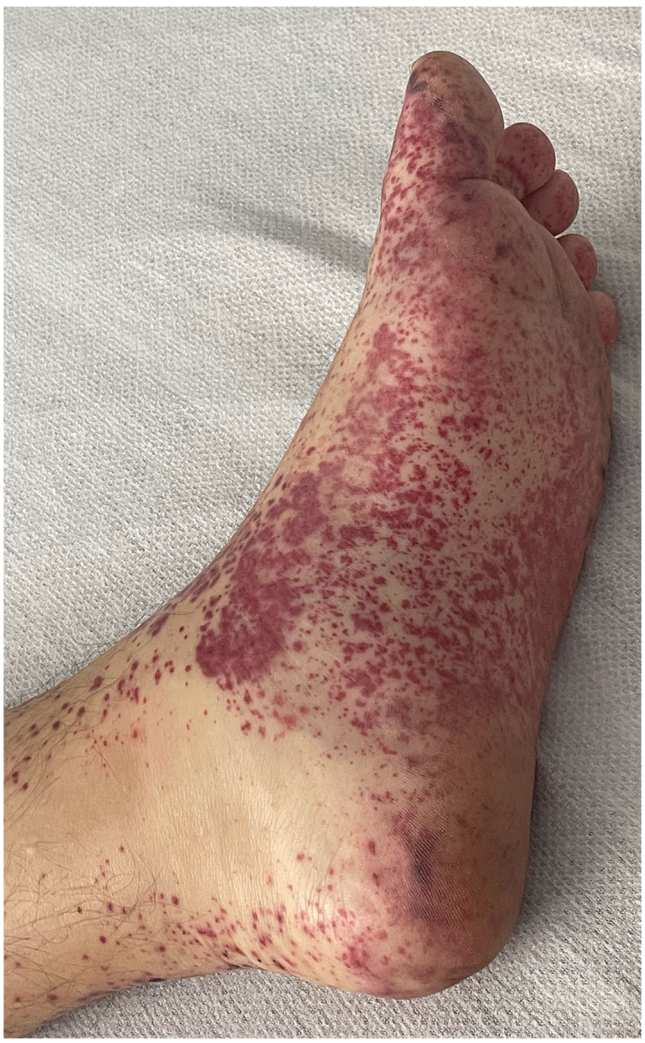

Figure 1 Palpable purpura and petechiae of the foot

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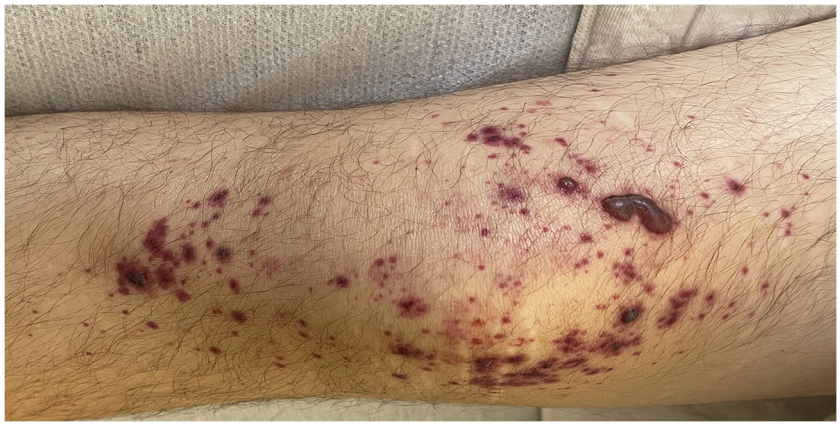

Figure 2 Palpable purpura and petechiae of the knee

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Declarations:

Conflict of Interest: *The authors declare that they do not have a conflict of interest.*

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