MODERN METHODS OF TREATMENT FOR HEMORRHAGIC VASCULITIS

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Abstract

Vasculitis poses a great diagnostic, investigative and therapeutic challenge to the treating physician. The classification of vasculitides itself still eludes universal acceptance. Comprehensive management comprises establishing the diagnosis of true vasculitis after ruling out vasculitis mimics, finding the etiology if feasible, assessing the caliber of the vessels involved, deciphering the pathological process of vessel damage, investigating for the existence and extent of systemic involvement and finally planning the therapy in the background of co-morbidities. Successful management also entails regular monitoring to foresee complications arising from the disease process itself as well as complications of immunosuppressive treatment. Although steroids remain first line drug, biologics are emerging as popular agents in the treatment of immune-mediated vasculitis. Triphasic treatment is the best plan of action comprising induction, maintenance of remission and treatment of relapses.

Keywords: Biomarkers, classification, management, vasculitis.

Vasculitis affects nearly 38-40 persons per million population.[2] Cutaneous vasculitis is predominantly due to infections in 22%, drugs in 20%, connective tissue disorders in 12%, Henoch Schonlein purpura (HSP) in 10% and <5% each due to malignancy, primary systemic vasculitis or systemic inflammatory disease.[3,4] Yet, exact etiology may not be established in spite of exhaustive work up in many case scenarios and idiopathic nature predominates. The mean age of onset is 7 years in children, 47 years in adults, vasuclitis being, commoner in adults than children.[5] Successful management of the patient with vasculitis syndrome depends on good history taking, diligent physical examination and relevant investigations to confirm the diagnosis of vasculitis and assess systemic involvement.[6] The article attempts to cater this need providing a checklist for dermatologists to approach a case of vasculitis and treatment update

Vasculitis is a syndrome with an array of clinical features as localized/systemic symptoms, visceral signs due to stratified dysfunction at specific cellular, tissue or organ involvement, specific and non-specific inflammatory symptoms to be put together for final diagnosis evolving over weeks to months [Figure 1]. In primary vasculitis (inflammation of vessel wall as an initial event in the absence of recognized precipitating disease or associated disease), auto immune mechanism is believed to

play a key role.[7] Both humoral and cell-mediated immunity are implicated. Genetics, environmental factors, immune regulatory mechanisms render the patient susceptible to develop vasculitis.[4,5] Selective involvement of few vessels may be explained by the distribution of the antigen, local immune and inflammatory cascade.

Blood tests. These tests look for signs of inflammation, such as a high level of C-reactive protein. A complete blood cell count can tell whether you have enough red blood cells. Blood tests that look for certain antibodies — such as the anti-neutrophil cytoplasmic antibody (ANCA) test — can help diagnose vasculitis.

Imaging tests. Noninvasive imaging techniques can help determine which blood vessels and organs are affected. They can also help the doctor monitor whether you are responding to treatment. Imaging tests for vasculitis include X-rays, ultrasound, computerized tomography (CT), magnetic resonance imaging (MRI) and positron emission tomography (PET).

X-rays of your blood vessels (angiography). During this procedure, a flexible catheter, resembling a thin straw, is inserted into a large artery or vein. A special dye is then injected into the catheter, and X-rays are taken as the dye fills the artery or vein. The outlines of your blood vessels are visible on the resulting X-rays.

Biopsy. This is a surgical procedure in which your doctor removes a small sample of tissue from the affected area of your body. Your doctor then examines this tissue for signs of vasculitis.

References:

1.Wolfe F, Freundlich B, Straus V (2003) Increase in cardiovascular and cerebrovascular disease prevalence in rheumatoid arthritis. J Rheumatol 30:36–40

2.Douglas KMJ, Pace AV, Treharne GJ, Saratzis A, Nightingale P, Erb N, Bankd MJ, Kitas GD (2005) Excess recurrent cardiac events in rheumatoid arthritis patients with acute coronary syndrome. Ann Rheum Dis 65:348–353.

3.Avina-Zubieta, J. A., Thomas, J., Sadatsafavi, M., Lehman, A. J. & Lacaille, D. Risk of incident cardiovascular events in patients with rheumatoid arthritis: a meta-analysis of observational studies. Ann. Rheum. Dis. 71, 1524–1529 (2012).