

Cutaneous Leukocytoclastic Vasculitis in a Case of Ankylosing Spondylitis

Sir,

Small vessel necrotizing vasculitis is a syndrome with many etiologies, but the underlying cause is detected in only half of the patients (1). Diseases associated with immune complexes (e.g. lupus erythematosus, dermatomyositis, rheumatoid arthritis) are possible causes (1). We report a case of cutaneous leukocytoclastic vasculitis in a patient with ankylosing spondylitis.

CASE REPORT

A 31-year-old man was referred for a diffuse papulopustular and purpuric eruption with a follicular distribution. Cutaneous biopsy showed neutrophilic infiltration of blood vessel walls with marked leukocytoclasia and fibrinoid necrosis of dermal blood vessels with extravasated erythrocytes. Clinical examination revealed tetrapyramidal syndrome, low back pain, rigid spine and talalgia. Radiography showed bilateral sacroileitis, calcaneum spines and diffuse syndesmophytes in the dorsolumbar spine. Myelography showed cervical medullar compression. Blood cell count, creatinemia and liver function were normal. There was no proteinuria. Antinuclear antibodies, antineutrophil cytoplasmic antibodies and rheumatoid factor were negative. Serum complement was normal. The HLA-B27 antigen was present.

The purpuric rash disappeared in one month without specific treatment. The patient was then treated with indometacin and salazopyrine. There was no recurrence of vasculitis during a 4-year follow-up.

COMMENTS

Some patients suffering from ankylosing spondylitis have developed cutaneous leukocytoclastic vasculitis with renal involvement. In some cases, cutaneous vasculitis was indistinguishable from Schönlein Henoch purpura (2). IgA glomerulonephritis has been described alone (3), or associated with cutaneous vasculitis in ankylosing spondylitis (4).

In the case reported, the patient had severe ankylosing spondylitis, until then untreated, and he developed marked small-vessel necrotizing vasculitis without systemic involvement. This association may be coincidental. Nevertheless there is some evidence for a link between the two conditions. A retrospective study demonstrated a higher frequency of recurrent hematuria in ankylosing spondylitis patients (16.9%)

as compared with rheumatoid arthritis patients (1.9%) (5). Of the 28 ankylosing spondylitis patients, 2 had renal biopsies. One case was consistent with IgA nephropathy. In another prospective study, IgA serum levels were higher in active phases of ankylosing spondylitis (6). Moreover, systematic cutaneous immunofluorescence studies have shown increased IgA deposits in ankylosing patients compared with those in healthy controls (7).

In this case, we cannot prove the direct role of ankylosing spondylitis, but immune dysregulation in ankylosing spondylitis may play a role in the occurrence of leukocytoclastic vasculitis.

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