Answers to Dermato-venereological Quiz on pages 147-148

1. Clinical differential diagnoses include bullous leucocytoclastic vasculitis, infections (gonococcaemia, meningococcaemia, and haemorrhagic herpes zoster), vascular occlusion (purpura fulminans and septic emboli), bullous insect bite reaction, bullous pemphigoid and bullous erythema multiforme.
2. Histopathological examination of the skin biopsy showed a subepidermal bulla with superficial and mid perivascular mixed inflammatory infiltrate including neutrophils and apparent nuclear dusts. There was also fibrinoid necrosis of vessel walls and extravasated red cells. Immunofluorescence study (IF) showed vascular stain of C3 (focal trace) and fibrin (3+).
3. The diagnosis is bullous leucocytoclastic vasculitis, possibly precipitated by sepsis. Leucocytoclastic vasculitis is the most common type of small vessel vasculitis. It can be idiopathic or secondary to infections, drugs, connective tissue diseases or malignancies (especially haematological). It can have extracutaneous involvement, affecting the musculoskeletal, renal, pulmonary, gastrointestinal, and neurological systems. It is always crucial to look for underlying causes and systemic involvement for all patients diagnosed with leucocytoclastic vasculitis.
4. The treatment is supportive when symptoms are mild, and in the absence of cutaneous tissue loss (skin necrosis, ulcers, blisters) or systemic involvement. This includes rest, leg elevation, use of pressure stockings, H1 antihistamines and NSAIDs. In view of the extensive disease, we started our patient on dapsone and a tapering course of prednisolone (starting from 0.5 mg/kg). The lesions resolved completely. Other systemic treatments for severe leucocytoclastic vasculitis include colchicine, hydroxychloroquine, immunosuppressants (methotrexate, azathioprine, ciclosporin, MMF and cyclophosphamide).