Editorial

Cutaneous vasculitis

Vasculitis is a group of disorders characterized by inflammation of blood vessels involving arteries, veins, and capillaries of any size, leading to structural damage to vessel walls and perivascular tissues.1 Vasculitis targets the skin and nearly all internal organs, including the nervous system, lungs, kidneys, heart, and gastrointestinal tract. Cutaneous vasculitis includes a spectrum of disease states, ranging from cutaneous manifestations of systemic vasculitis to skin-limited variants of systemic vasculitis to various types of single-organ vasculitis.2 Regarding severity, cutaneous vasculitis can also range from benign, self-limited, short-course to life-threatening conditions with multiple-organ failure.3 It may be caused by an unknown etiology or secondary to underlying diseases like connective tissue diseases, infections, cancer, vaccination, and drugs.4 Vasculitis can be classified as small, medium, and large vasculitis depending on size of the affected vessels.

Cutaneous Small-Vessel Vasculitis (CSVV), also known as Leukocytoclastic Vasculitis, is the most frequently encountered type of vasculitis to dermatologists in clinical practice.5 Adults are more prone to develop cutaneous vasculitis compared with children. In children, IgA vasculitis is common, and diseases are mostly due to underlying infections, and they are commonly self-limiting.4 In adults, cutaneous vasculitis is mostly due to unknown causes or is associated with background systemic vasculitis, connective tissue disease, or cancer.5 The most frequent cutaneous presentation of vasculitis is palpable purpura, followed by other nonspecific lesions including plaques, nodules, urticaria, ulcers, livedo reticularis, livedo racemosa, hemorrhagic vesicles, pustules, targetoid lesions, pitted scars, and white atrophy1. Biopsy of skin lesions and histopathology is the gold standard for the diagnosis of cutaneous vasculitis. In medium vessel vasculitis e.g., Polyarteritis Nodosa, biopsies must be deep enough to sample medium vessels in the subcutis. Histological confirmation should be followed by DIF and indirect IF serological assessment to detect specific immunoglobulins and/or ANCA for the diagnosis of specific types of vasculitis.6 Cutaneous vasculitis is mostly a self-limited, single-episode phenomenon where general measures play important roles in relieving pain and discomfort. Measures such as resting the affected part, elevating the legs, and avoiding triggers, including prolonged standing, cold exposure, and tight-fitting clothing are helpful. If systemic involvement can be excluded, the treatment of skin limited vasculitis should be symptomatic e.g., analgesics (NSAIDs) and antihistamines7. For treatment of chronic, recurrent, severe (ulcerative or painful) vasculitis or coexistence of systemic diseases, corticosteroids and other immunomodulators (azathioprine, dapsone, colchicine, cyclophosphamide, methotrexate, mycophenolate mofetil), biological agents (infliximab and rituximab), and IVIg might be needed.8 A systematic clinical and diagnostic approach to vasculitis leads to successful diagnosis and management. As vasculitis has a higher rate of skin involvement, dermatologists can take the opportunity to play an important role in early detection and initiation of treatment.

Funding:

None

Conflict of interest:

None

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