Cutaneous vasculitis: Report of 117 cases

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Introduction. Cutaneous vasculitis (CV) is defined broadly as inflammation of the blood vessels of the dermis. We retrospectively analyzed a cohort of 117 patients with biopsy-proven CV.

Patients. We performed a single-centre retrospective review of 117 patients who met the histologic criteria for cutaneous vasculitis between 2003 and 2012.

Results. The mean age was 55.34 years (15–95) and 65 (55.6%) were females. The most frequent clinical lesion followed by plaques (17.09%), papules (13.3%), and urticarial (10.25%), lymphocytic vasculitis (65.81%) followed by urticarial (10.25%), lymphohistiocytic (7.6%), neutrophilic (4.2%), nodular (2.5%), granulomatous necrotizing and other type of CV (3.4%). Palpable purpura (65.81%) was the most frequent clinical lesion followed by plaques (17.09%), papules (5.9%) and others (11.1%). Systemic symptoms were observed in 47 cases (41.02%) when 70 cases (59.08%) did not have any symptom. The most common systemic symptom was fever (30.43%) followed by arthrosis (18.84%), oral or genital ulcers and uveitis (10.14%), renal disease (8.60%), respiratory symptoms (5.7%) and others (26.08%). Only eight patients showed positive ANCA antibodies, being five MPO positive and three PR-3 positive. Forty-nine cases (41.8%) had idiopathic cutaneous vasculitis being the leukocytoclastic type the most frequent. Sixty-eight patients (58.1%) had an aetiological condition. Thirty-four patients (29%) had a systemic autoimmune disease, systemic vasculitis was the most common disease (18), 16 (13.6%) were caused by drug reaction and 16 (13.6%) were due to infections. Only two cases had a malignancy cause.

Discussion. In 58.11% of cases, CV occurred either as part of a primary systemic vasculitis or as secondary vasculitis related to an underlying disease, such as an autoimmune disease, drugs, infections or malignancy. In the remaining 41.8% of cases, CV occurred idiopathically. Leukocytoclastic vasculitis was the most frequent histological pattern observed.

Conclusion. Cutaneous vasculitis is not one specific disease but a manifestation that can be seen in a variety of settings.
Assessment of patients with Takayasu’s arteritis in a routine clinical follow-up with Indian Takayasu Clinical Activity Score (ITAS2010)

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Introduction. ITAS2010 is a new composite index developed to assess clinical activity in Takayasu’s arteritis (TAK), which is weighted for vascular items. We aimed to investigate the effectiveness of ITAS2010 in the routine clinical follow-up of TAK.

Patients. Patients (n = 33, mean age: 40.9 ± 12 years, F/M: 30/3) classified according to ACR criteria for TAK were enrolled. ITAS2010 forms were filled cross-sectionally for baseline, two follow-up visits prospectively, with intervals of at least 4–6 months, by including only new or worsening symptoms within the past 3 months.

Results. ITAS2010 was similar at baseline for both active and inactive patients [12 (5–20) vs. 10 (0–19), respectively]. There was no correlation between ITAS2010 and acute phase reactants (APRs). Similarly, change according to PGA was not reflected in ITAS in the second visit [1.15 (0–6) vs. 1.4 (0–3), respectively]. Only three visit ITAS2010 score was observed to be significantly higher in active [1.62 (0–7)] patients compared to inactives [0.45 (0–3)] (P = 0.001). The total agreement between ITAS2010 and PGA was 60% (kappa: 0.096, P = 0.43) and between ITAS2010 and Kerr et al. [1] was 74% (kappa: 0.18, P = 0.035). The total agreement between PGA and Kerr et al. was 71% (kappa: 0.26, P = 0.005). Twelve patients were evaluated with imaging in the follow-up (four with PET, eight with MR-Angiography). When we added an extra-score on ITAS2010 for high APRs or positive imaging (vascular progression with radiology or increased uptake on vascular structures with PET), the total agreement between ITAS2010 and PGA increased to 74% (kappa: 0.499, P < 0.001), whereas ITAS2010 and Kerr et al. decreased to 51% (kappa: 0.102, P = 0.06).

Conclusion. The agreement between PGA and ITAS2010 was observed to be limited. However, when we combined ITAS2010 with APR or imaging, our results improved. ITAS2010 had a significant discriminatory value according to disease activity in only the third visit in our routine follow-up. These results suggest that ITAS2010 may be valuable in the long-term follow-up, especially if combined with biomarkers and imaging.

Reference


http://dx.doi.org/10.1016/j.lpm.2013.02.065

A randomized trial of mycophenolate mofetil versus cyclophosphamide for remission induction of ANCA-associated vasculitis: ”MYCYC”. On behalf of the European vasculitis study group

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Introduction. Cyclophosphamide (CYC) induction regimens are standard therapy for ANCA-associated vasculitis (AAV) with major organ involvement. However CYC is associated with considerable toxicity. Mycophenolate mofetil (MMF) is a potential alternative to CYC. We performed an international, non-inferiority randomised trial comparing MMF to CYC for remission induction of AAV.

Patients. Eligible patients had newly diagnosed AAV and were randomised to receive up to 6 months of induction with either MMF 2-3 g/day (n = 70) or 6–10 pulses of IV CYC 15 mg/kg (n = 70). Both groups received the same tapering oral prednisolone regimen and azathioprine maintenance therapy. The primary outcome was remission (absence of disease activity for ≥ 4 weeks while adhering to the glucocorticoid regimen). We hypothesized that MMF treatment would result in no more than 12% fewer remissions.

Results. The groups were similar at trial entry. The primary remission endpoint occurred in 46/70 (66%) MMF vs. 48/70 (69%) CYC [risk difference (RD) – 3%, 90% CI –16 to 10%; P = 0.06 for non-inferiority]. Remission induction irrespective of steroid compliance occurred in 61/70 (87%) MMF vs. 54/70 (77%) CYC (RD 10%, 90% CI –1 to 21%; P = 0.01 for non-inferiority). However, glucocorticoid dosing did not differ significantly between groups overall (P = 0.96). Key safety out-