CASE REPORT

Adult-Onset IgA Vasculitis Presenting with Palpable Purpura and Abdominal Pain Without Renal Involvement: A Case Report

Dr Harsha E Patel[1], Dr Arathi Darshan2*

[1]Junior Resident, Department of General Medicine, Jawaharlal Nehru Medical College (JNMC), Belagavi,

Mail id-harshapatel.e@gmail.com

[2*]Former HOD & Professor, Department of General Medicine, Jawaharlal Nehru Medical college, KLEs Academy of Higher Education, Belagavi, Email- arathidarshan14@rediffmail.com

ABSTRACT

IgA vasculitis, formerly known as Henoch–Schonlein purpura, is an immune complex-mediated small vessel vasculitis predominantly affecting children. Adult-onset disease is uncommon and may present with atypical features or a more severe course. We report a 23-year-old male who presented with multiple non-blanchable purpuric lesions over bilateral lower limbs associated with abdominal pain and arthralgia. Laboratory evaluation showed elevated inflammatory markers and raised serum IgE levels, while renal parameters and ANCA profile were normal. Ultrasonography of the abdomen was unremarkable. A clinical diagnosis of IgA vasculitis was made, and the patient was treated with intravenous methylprednisolone with subsequent improvement. This case highlights the importance of recognising adult-onset IgA vasculitis even in the absence of renal involvement and emphasises the need for close follow-up to detect delayed renal complications.

How to cite this article: Patel HE, Darshan A. Adult-Onset IgA Vasculitis Presenting with Palpable Purpura and Abdominal Pain Without Renal Involvement: A Case Report. Int J Drug Deliv Technol. 2026;16(38s): 830-834. DOI: 10.25258/ijddt.16.38s.87

Source of support: Nil.

Conflict of interest: None

Introduction

IgA vasculitis, previously termed Henoch–Schonlein purpura, is a small vessel vasculitis characterised by IgA1-dominant immune complex deposition in capillaries, venules and arterioles [1]. It is predominantly a paediatric disorder, with the majority of cases occurring before 10 years of age. Adult-onset IgA vasculitis is less common and often associated with a more severe clinical course, particularly with respect to renal involvement [2].

The classical clinical tetrad includes palpable purpura, abdominal pain, arthralgia and renal manifestations [3]. While cutaneous involvement is nearly universal, gastrointestinal and renal manifestations vary in severity. Adults are more likely to develop persistent or progressive renal disease compared to children [4]. The condition can mimic other forms of leukocytoclastic vasculitis, ANCA-associated vasculitis and drug-induced hypersensitivity reactions, making clinical differentiation essential [5].

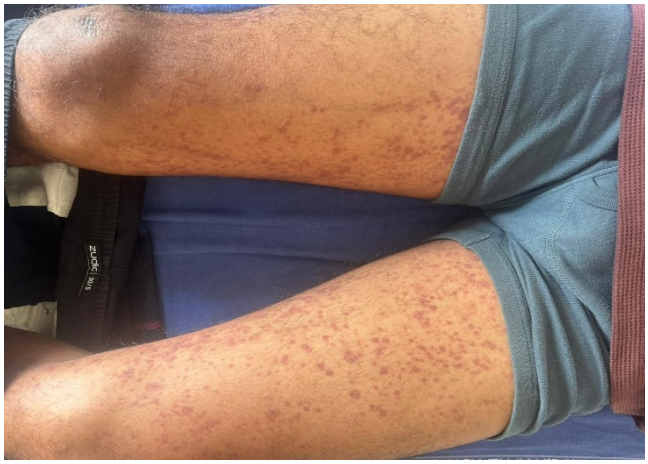
We report a case of adult-onset IgA vasculitis presenting with cutaneous and gastrointestinal manifestations without renal involvement at presentation, underscoring the diagnostic considerations and importance of follow-up.

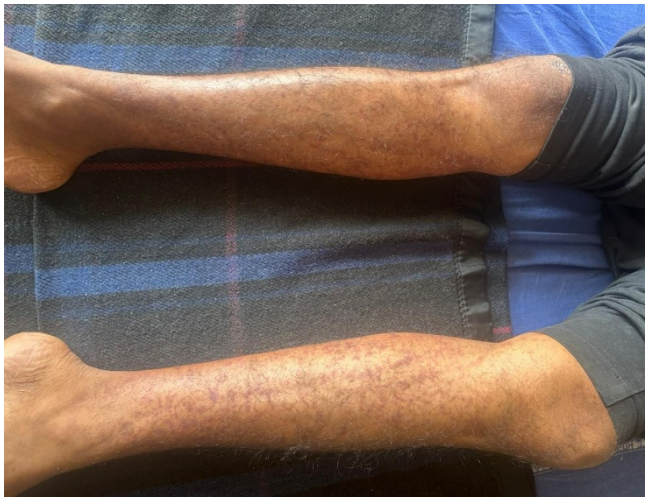
Case Presentation

A 23-year-old male presented with complaints of multiple reddish skin lesions over bilateral lower limbs for one month. The lesions were non-painful initially and progressively increased in number. Three days prior to admission, he developed abdominal pain associated with swelling over both lower limbs. He also reported joint pain. There was no history of fever, weight loss, recent drug intake or bleeding manifestations.

On general examination, he was hemodynamically stable. Blood pressure was 132/86 mmHg and pulse rate was 78 beats per minute. Dermatological examination revealed multiple non-blanchable palpable purpuric lesions distributed symmetrically over bilateral lower limbs. No mucosal involvement was noted. Systemic examination was otherwise unremarkable except for mild abdominal tenderness.

A provisional diagnosis of small vessel vasculitis, likely IgA vasculitis, was considered.





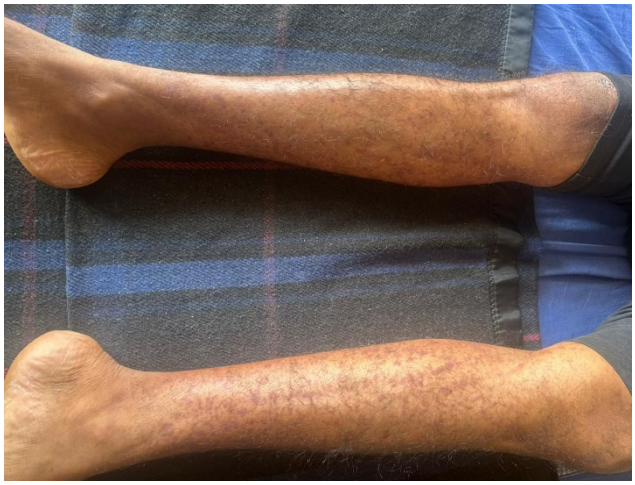


Figure 1: Clinical photograph showing multiple non-blanchable palpable purpuric lesions over bilateral lower limbs.

Figure 2: ANCA immunofluorescence report demonstrating negative p-ANCA and c-ANCA.

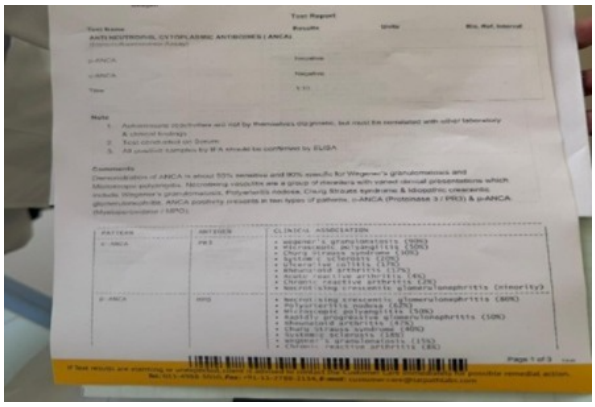


Figure 3: Ultrasonography abdomen report showing no significant pathology.

Investigations

Haematological evaluation revealed haemoglobin of 15.4 g/dL, total leukocyte counts of 12,500/mm³ and platelet count of 2.15 lakh/mm³. Erythrocyte sedimentation rate was 6 mm/hour. C-reactive protein was elevated at 1.5 mg/dL. Renal function tests showed serum creatinine of 0.79 mg/dL and blood urea of 37.5 mg/dL. Liver function tests were within normal limits. Thyroid profile was normal.

Urine routine examination showed no proteinuria or haematuria.

Serum IgE levels were elevated at 280 IU/mL. Antineutrophil cytoplasmic antibody testing revealed negative p-ANCA and c-ANCA.

Ultrasonography of the abdomen and pelvis showed no significant diagnostic pathology.

Table 1: Summary of laboratory investigations at admission. (To include complete blood count, inflammatory markers, renal profile, immunological markers and urine examination.)

Parameter	Result	Reference Range	Interpretation
Complete Blood Count			
Haemoglobin	15.4 g/dL	13–17 g/dL	Normal
Total Leukocyte Count	12,500 /mm³	4,000–11,000 /mm³	Mild leukocytosis
Neutrophils	93%	40–75%	Neutrophilia
Lymphocytes	5%	20–45%	Relative lymphopenia
Eosinophils	2%	1–6%	Normal
Platelet Count	2.15 lakh/mm³	1.5–4.5 lakh/mm³	Normal
ESR	6 mm/hr	0–20 mm/hr	Normal
Inflammatory Marker			
C-Reactive Protein (CRP)	1.5 mg/dL	<0.5 mg/dL	Elevated
Renal Profile			
Blood Urea	37.5 mg/dL	15–40 mg/dL	Normal
Serum Creatinine	0.79 mg/dL	0.6–1.2 mg/dL	Normal
Immunological Markers			
Serum IgE	280 IU/mL	<100 IU/mL	Elevated
p-ANCA	Negative	Negative	Within normal limits
c-ANCA	Negative	Negative	Within normal limits
Urine Examination			
Protein	Absent	Absent	Normal
Red Blood Cells	0–1 /hpf	0–2 /hpf	Normal
White Blood Cells	0–1 /hpf	0–5 /hpf	Normal
Casts	Absent	Absent	Normal

Treatment

The patient was initiated on high-dose intravenous methylprednisolone at a dose of 500 mg once daily. The decision to start pulse corticosteroid therapy was based on the presence of significant gastrointestinal symptoms in the form of persistent abdominal pain and extensive cutaneous involvement. Although renal

parameters were normal at presentation, adult-onset IgA vasculitis is known to have a more aggressive course compared to paediatric cases, and early intervention was considered appropriate to prevent progression.

Supportive management included intravenous fluids to maintain adequate hydration and symptomatic therapy for abdominal pain. Non-steroidal anti-inflammatory drugs were avoided due to the potential risk of gastrointestinal irritation and renal compromise in vasculitis conditions. Blood pressure and urine output were monitored closely during hospital stay.

Dermatology consultation was obtained and a skin biopsy was advised to confirm leukocytoclastic vasculitis with IgA deposition on direct immunofluorescence. The patient was observed for development of haematuria, proteinuria, or any signs of renal impairment during hospitalisation.

Following pulse therapy, a tapering regimen of oral corticosteroids was planned to depend on clinical response and biopsy confirmation. The patient was counselled regarding the importance of adherence to follow-up, monitoring of urine examination, and periodic renal function assessment, as delayed renal involvement may occur even after apparent clinical improvement.

Outcome and Follow-Up

Following corticosteroid therapy, the patient showed improvement in abdominal pain and stabilisation of skin lesions. No new lesions were noted during hospital stay. Renal parameters remained within normal limits throughout admission. The patient was advised regular follow-up with periodic urine examination and renal function monitoring to detect any delayed renal involvement.

Discussion

IgA vasculitis is classified as an immune complex-mediated small vessel vasculitis characterised by predominant IgA1 deposition in vessel walls [1]. Although primarily a childhood disease, adult-onset IgA vasculitis accounts for approximately 10–20% of cases and is associated with increased morbidity, particularly due to renal complications [2].

The hallmark clinical feature is palpable purpura; most commonly distributed over dependent areas such as the lower limbs [3]. In adults, lesions may be more extensive and persistent. Gastrointestinal manifestations occur due to vasculitic involvement of small vessels of the intestinal wall and may present as colicky abdominal pain, gastrointestinal bleeding or, rarely, bowel ischemia [4]. In the present case, abdominal pain preceded hospital admission and raised suspicion for systemic involvement.

Renal manifestations range from microscopic haematuria to rapidly progressive glomerulonephritis. Studies suggest that adults are at higher risk of developing persistent renal impairment compared to children, even when initial renal parameters are normal [2,5]. Therefore, absence of renal involvement at presentation does not exclude the possibility of subsequent nephritic manifestations. Close longitudinal monitoring is strongly recommended.

Differential diagnoses in adults presenting with palpable purpura include ANCA-associated vasculitis, hypersensitivity vasculitis, systemic lupus erythematosus and thrombocytopenic purpura. ANCA-associated vasculitides such as microscopic polyangiitis and granulomatosis with polyangiitis are typically associated with positive ANCA serology and more severe systemic features including pulmonary or renal involvement [6]. In this case, negative p-ANCA and c-ANCA helped narrow the differential diagnosis.

The pathogenesis of IgA vasculitis involves aberrant glycosylation of IgA1 molecules leading to immune complex formation and deposition in vessel walls, triggering complement activation and inflammation [7]. Elevated serum IgE observed in this patient is not a diagnostic criterion but reflects underlying immune activation and has been reported in immune-mediated vasculitic conditions [8].

Corticosteroids remain the mainstay of treatment in moderate to severe IgA vasculitis, particularly in adults with significant gastrointestinal or systemic symptoms [9]. While mild cutaneous disease may resolve spontaneously, systemic involvement warrants active therapy. Pulse intravenous methylprednisolone is often administered in patients with severe abdominal pain or early renal involvement to rapidly control inflammation and reduce risk of complications. Although evidence regarding prevention of renal disease progression is variable, steroids are widely used in clinical practice for symptomatic control and reduction of inflammatory burden [5,9].

Adult IgA vasculitis tends to have a more protracted course compared to paediatric disease. Recurrences are not uncommon and renal involvement may appear weeks after initial cutaneous presentation [2,5]. Therefore, long-term follow-up with periodic urine analysis and renal function testing is crucial.

The present case is clinically significant because adult-onset IgA vasculitis without renal involvement at presentation may be under-recognised, especially when laboratory parameters are largely normal. The combination of palpable purpura, abdominal pain and negative ANCA profile should prompt consideration of IgA vasculitis. Early initiation of corticosteroid therapy in symptomatic patients may lead to rapid improvement and prevent progression.

References

1. Jennette JC, Falk RJ, Bacon PA, Basu N, Cid MC, Ferrario F, et al. 2012 Revised International Chapel Hill Consensus Conference Nomenclature of Vasculitides. Arthritis Rheum. 2013;65(1):1–11.
2. Pillebout E, Thervet E, Hill G, Alberti C, Vanhille P, Nochy D. Henoch–Schönlein Purpura in adults: Outcome and prognostic factors. Medicine (Baltimore). 2002;81(5):381–392.
3. Davin JC, Coppo R. Henoch–Schönlein purpura nephritis in children. Nat Rev Nephrol. 2014;10(10):563–573.
4. Blanco R, Martínez-Taboada VM, Rodríguez-

Valverde V, García-Fuentes M, González-Gay MA. Henoch–Schönlein purpura in adulthood and childhood: Two different expressions of the same syndrome. Semin Arthritis Rheum. 1997;26(6):725–734.
5. Kang Y, Park JS, Ha YJ, Kang MI, Park HJ, Lee SW, et al. Differences in clinical manifestations and outcomes between adult and childhood IgA vasculitis. Clin Rheumatol. 2018;37(6):1617–1624.
6. Watts RA, Scott DG. Epidemiology of the vasculitides. Ann Rheum Dis. 2003;62(5):395–402.
7. Suzuki H, Kiryluk K, Novak J, Moldoveanu Z, Herr AB, Renfrow MB, et al. The pathophysiology of IgA nephropathy. J Am Soc Nephrol. 2011;22(10):1795–1803.
8. Rajagopala S, Parameswaran S, Ajmera JS, Ganesh RN, Kattimani S. Adult Henoch–Schönlein purpura: A case report and review of literature. Indian J Dermatol. 2013;58(6):496.
9. Audemard-Verger A, Pillebout E, Guillevin L, Thervet E, Terrier B. IgA vasculitis (Henoch–Schönlein purpura) in adults: Diagnostic and therapeutic aspects. Autoimmun Rev. 2015;14(7):579–585.