

CASE REPORT

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A case of Henoch-Schönlein purpura triggered by wild bee sting

Cihangir Akgün, Nihat Demir, Lokman Üstyol, Sinan Akbayram, Oguz Tuncer
Department of Pediatrics, Yuzuncu Yil University School of Medicine, Van, Turkey

Correspondence Address:

Nihat Demir
Hospital of the Yuzuncu Yil University, 65250 Van
Turkey

Abstract

Henoch-Schönlein purpura (HSP) is defined as a vasculitis with predominantly IgA deposits in the walls of small vessels in the skin, gastrointestinal tract and kidney associated with arthralgias or arthritis. The etiology is unknown, but HSP follows an upper respiratory infection. Infection agents, some medications and some toxins were reported as a trigger for Henoch-Schönlein purpura. We report a 6-year-old boy with typical clinical and pathologic features of this disease that was developed after wild bee sting and our case is an example of insect bite as a trigger agent for Henoch-Schönlein purpura.

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Full Text

Introduction

Henoch-Schönlein purpura (HSP), also known as anaphylactoid purpura, is characterized by nonthrombocytopenic purpura, arthritis and arthralgia, abdominal pain and gastrointestinal hemorrhage, and glomerulonephritis. [1] HSP often occurs between 3 and 15 years of age, and is more common in boys than girls. [2] Drugs and toxins, including vaccinations, insect bites, and food allergies also may be the primary predisposing factors for HSP. [3]

Case Report

A 6-year-old boy was admitted to pediatric emergency room with the complaint of severe diffuse abdominal pain. He had a 5-day history of ankle pain, and swelling and a non-blanching purpuric rash on his lower extremities. Except a history of wild bee bite 10 days before, the personal and family history was unremarkable. Moreover, recent history of infectious disease or vaccination was not described. Physical examination revealed multiple palpable purpuric lesions that were

concentrated on the buttocks and lower extremities and mild to moderate abdominal tenderness with palpation. He had pain and swelling of his both ankles and generalized swelling of his lower extremities on the periarticular regions. On admission, the laboratory examinations revealed hemoglobin 11.07 g/ dl, white blood cell count 10,080/ μ l, platelet count 481,000/ μ l, and C-reactive protein 15.8 mg/dl (0-5 mg/dl). Serum electrolytes, blood culture, liver enzymes, blood coagulation tests, antinuclear antibody, rheumatoid factor, antistreptolysin O, serum IgA, and urinalysis were within normal levels. On skin punch biopsy, capillaries and venules of the dermis were affected by a leukocytoclastic vasculitis with vessel wall necrosis and perivascular accumulation of polymorphonuclear leukocytes and mononuclear cells. Immunofluorescence microscopy was positive for IgA. Occult blood was absent in the stool. There was no evidence for invagination on abdominal ultrasonography and pediatric surgery consultation. Considering the complete clinical examination and investigations, a final diagnosis of HSP was made according to EULAR/PreS criteria for the classification of the childhood vasculitides. [4] Antihistaminic and nonsteroid anti-inflammatory drugs were initiated for pruritus and arthritis, respectively. The patient got relieved of abdominal pain without any treatment. He is now on the 7th month of follow-up and has fully recovered without any relapse and renal or systemic involvement of HSP.

Discussion

HSP is a small vessel vasculitis with multiorgan involvement including skin, gastrointestinal tract, joints, and kidneys, with variable clinical expression. The etiology of HSP is primarily unknown, and antecedent upper respiratory tract infection that is usually viral has been reported and streptococcal infection has been emphasized as an important triggering factor. The disease is also shown to be triggered by drugs, cold, insect bite, or some foods. [5],[6],[7] On the other hand, it is known that IgA plays an important role in the pathogenesis of the disease. The IgA immune complexes deposit in the vascular walls of affected organs, triggering a typical inflammatory response by both complement pathways and direct cell activation, causing endothelial destruction and invasion by leukocytes. [8] In the literature, there are several reports on the occurrence of immunologic conditions after insect sting, particularly bee sting. Namdev et al. reported a case of Idiopathic Thrombocytic Purpura (ITP), which was triggered by a honeybee bite. [9] Tasic reported a 2-year-old boy who developed nephrotic syndrome after a bee sting. [10] Cuoghi et al. presented three nephrotic syndrome patients who were in remission and developed relapse after bee stings. [11] Allergy has been regarded by some authors to be the basis for development of HSP after insect bites and exposure to drug and dietary allergens. [1] To our knowledge, in the literature, there are only two reports on the occurrence of HSP after insect bite, [12],[13] and because of the rarity of HSP in association with bee sting, we wanted to share our clinical experiences in this case and would like to emphasize the possibility of wild bee sting being a trigger agent of HSP.

References

- 1 Cassidy JT, Petty RE. Leukocytoclastic vasculitis. In: Textbook for Paediatric Rheumatology, 5th ed. In: Cassidy JT, Petty RE, Laxer RM, Lindsley CB, editors. Philadelphia: Elsevier, Saunders Company; 2005. p. 496-511.
- 2 Saulsbury FT. Epidemiology of Henoch-Schönlein purpura. Cleve Clin J Med 2002;69:87-9.
- 3 González LM, Janniger CK, Schwartz RA. Pediatric Henoch-Schönlein purpura. Int J Dermatol 2009;48:1157-65.
- 4 Ozen S, Ruperto N, Dillon MJ, Bagga A, Barron K, Davin JC, *et al.* EULAR/PreS endorsed consensus criteria for the classification of childhood vasculitides. Ann Rheum Dis 2006;65:936-41.
- 5 Chen O, Zhu XB, Ren P, Wang YB, Sun RP, Wei DE. Henoch Schonlein Purpura in children: Clinical analysis of 120 cases. Afr Health Sci 2013;13:94-9.
- 6 Sohagia AB, Gunturu SG, Tong TR, Herten HI. Henochschönlein purpura-a case report and review of the literature. Gastroenterol Res Pract 2010;597648:1-7.
- 7 Reamy BV, Williams PM, Lindsay TJ. Henoch-Schönlein purpura. Am Fam Physician 2009;80:697-704.
- 8 Sinclair P. Henoch -Schönlein Purpura - A review. Curr Allergy Clin Immunol 2010;23:116-20.
- 9 Namdev R, Dutta SR, Singh H. Acute immune thrombocytopenic purpura triggered by insect bite. J Indian Soc Pedod Prev Dent 2009;27:58-61.
- 10 Tasic V. Nephrotic syndrome in a child after a bee sting. Pediatr Nephrol 2000;3-4:245-7.
- 11 Cuoghi D, Venturi P, Cheli E. Bee sting and relapse of nephrotic syndrome. Child Nephrol Urol 1988-1989;9:82-3.
- 12 Sharan G, Anand RK, Sinha KP. Schönlein-Henoch syndrome after insect bite. Br Med J 1966;5488:656.
- 13 Burke DM, Jellýnek HL. Nearly fatal case of Schoenlein-Henoch syndrome following insect bite. AMA Am J Dis Child. 1954;6:772-4.

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