Worcestershire Acute Hospitals NHS Trust

Henoch-Schönlein Purpura (HSP) (PIP)

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The following guidance is taken from the Partners In Paediatrics (PIP)

HENOCH-SCHÖNLEIN PURPURA (HSP)

RECOGNITION AND ASSESSMENT

- Vasculitic condition of unknown aetiology
- Typical age group aged 2–8 yr

Symptoms and signs

Rash

- Purpuric, raised on extensor surfaces of legs, buttocks and arms, with surrounding erythema

Gastrointestinal tract

- Abdominal pain mostly non-specific typically resolves in 72 hr
- if severe or persistent, exclude intussusception, testicular torsion or pancreatitis (rare)
- Nausea and vomiting
- Intestinal haemorrhage: haematemesis, melaena, bloody stools (rare)

Joints

- Arthralgia and swelling of large joints, especially ankles and knees. Pain typically resolves in 24–48 hr

Renal

- Microscopic haematuria (common)
- Proteinuria can present 4–6 weeks after initial presentation
- Hypertension
- Nephritic syndrome: haematuria with ≥1 of following:
- raised urea and creatinine
- hypertension
- oliguria
- Nephrotic syndrome: proteinuria +/- oedema and hypoalbuminaemia
- Oedema of hands, feet, sacrum and scrotum

Neurological

- Headache (common)
- Seizures, paresis, coma (rare)

Differential diagnosis

- Purpuric rash:
- meningococcaemia – clinical diagnosis
- thrombocytopenia – FBC (rash looks different, ITP not vasculitic)
- rarer vasculitides – more difficult to exclude; differentiation requires review over a period of time
- Pancreatitis – suspect in abdominal pain

Investigations

All patients

- BP
- Urine dipstick
- if proteinuria, send urine for early morning protein:creatinine ratio
- if haematuria, send urine for microscopy

Additional investigations

- Blood tests if urinalysis abnormal or diagnosis uncertain
- FBC + film
- U&E
- Albumin
- If fever, blood culture and ASO titre
- Coagulation
- Throat swab

IMMEDIATE TREATMENT/SUBSEQUENT MANAGEMENT

Indications for admission

- Orchitis
- Moderate or severe abdominal pain
- Arthritis involving >2 joints
- Proteinuria
- Clear evidence of gastrointestinal bleeding
- Inability to ambulate

Joint pain

- NSAIDs (ibuprofen 1st line. Use with caution if renal involvement or patient asthmatic)

Abdominal pain

- Give prednisolone 1 mg/kg/day for 2 weeks
- Renal involvement not a contraindication
- If severe and persists, exclude pancreatitis, intussusception or spontaneous bowel perforation

MONITORING

Uncomplicated HSP (e.g. urine analysis ≤1+ blood and protein, and normal BP)

- No hospital follow-up required but GP follow-up in 1–2 weeks. Monthly BP for 6 months and weekly urine dipsticks at home until urine clear

HSP with haematuria or proteinuria >1+ and normal renal function

- As above + routine follow-up in children's outpatients

Refer to nephrologist if:

- Urinalysis blood or early morning protein >1+ after 6 months
- Macroscopic haematuria or heavy proteinuria at presentation
- Hypertension (see **Hypertension** guideline)
- Significant proteinuria (early morning urine protein:creatinine ratio >100 g/mmol or 3+ proteinuria for 3 days)
- Impaired renal function

Refer to rheumatologist if:

- Atypical or rapidly evolving rash

DISCHARGE AND FOLLOW-UP

- Inform parents condition may fluctuate for several months but recurrence rare once settled properly
- Very rare risk of renal failure, hence importance of monitoring urine
- Seek medical advice if child develops headache, PR bleeding or severe abdominal pain

Uncomplicated HSP

- GP follow-up as above
- Discharge from GP follow-up if urine analysis **and** BP normal 6 months after onset