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STUDY OF THE EFFECTIVENESS OF BASIC THERAPY IN VARIOUS CLINICAL FORMS OF HEMORRHAGIC VASCULITIS

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ABSTRACT

Systemic Hemorrhagic vasculitis (Henoch–Schönlein purpura) is an immune-mediated small-vessel vasculitis characterized by multisystem involvement, including skin, joints, gastrointestinal tract, and kidneys. The clinical course and prognosis of the disease largely depend on the predominant clinical form and severity of organ involvement. Basic therapy remains the cornerstone of treatment; however, its effectiveness varies among different clinical presentations.

This article analyzes the effectiveness of basic therapeutic approaches in patients with different clinical forms of hemorrhagic vasculitis. The effectiveness of treatment was evaluated based on the dynamics of clinical symptoms, laboratory parameters, duration of hospitalization, and development of complications. The results demonstrated higher treatment effectiveness in skin and skin–joint forms, while abdominal and renal forms required longer and more intensive therapy and were associated with a higher risk of complications. These findings highlight the importance of early clinical classification and individualized treatment strategies to improve outcomes in patients with hemorrhagic.

Introduction

Hemorrhagic vasculitis, also known as Henoch–Schönlein purpura, is an immune-mediated small-vessel vasculitis characterized by the deposition of IgA-containing immune complexes in the walls of capillaries, venules, and arterioles. This leads to inflammatory damage of the vascular endothelium and results in multisystem clinical manifestations. Although the disease is more common in children, adult patients often experience a more severe course and a higher risk of complications, particularly renal involvement, which significantly affects long-term prognosis.

Clinically, hemorrhagic vasculitis presents with a wide spectrum of manifestations, including palpable purpura, arthralgia or arthritis, abdominal pain with possible

gastrointestinal bleeding, and glomerulonephritis. Based on the predominance of organ involvement, several clinical forms are distinguished: skin, skin–joint, abdominal, renal, and mixed forms. Each form differs not only in symptom severity but also in response to treatment and risk of adverse outcomes.

Basic therapy remains the primary approach in the management of hemorrhagic vasculitis and typically includes bed rest, hypoallergenic diet, antiplatelet agents, antihistamines, and, in moderate to severe cases, systemic glucocorticoids. However, the effectiveness of these therapeutic measures is not uniform across different clinical forms, and standardized treatment protocols may not adequately address individual patient needs.

Therefore, evaluating the effectiveness of basic therapy in relation to specific clinical forms of hemorrhagic vasculitis is of significant clinical importance. Understanding these differences may contribute to earlier identification of high-risk patients, optimization of treatment strategies, and prevention of severe complications, particularly renal damage. This study aims to assess and compare the outcomes of basic therapy in patients with different clinical forms of hemorrhagic vasculitis.

Aim of the Study

To evaluate the effectiveness of basic therapy in patients with different clinical forms of hemorrhagic vasculitis and to determine the relationship between clinical presentation and treatment outcomes.

Materials and Methods

The study included patients diagnosed with hemorrhagic vasculitis who were treated in a hospital setting. Diagnosis was established based on clinical features, laboratory findings, and exclusion of other causes of vasculitis. Patients were divided into five groups according to clinical form: skin, skin–joint, abdominal, renal, and mixed forms.

All patients received standard basic therapy, including bed rest, hypoallergenic diet, antiplatelet drugs, antihistamines, and systemic glucocorticoids in moderate and severe cases. Laboratory investigations included complete blood count, urinalysis, and inflammatory markers. Treatment effectiveness was assessed based on regression of clinical symptoms, normalization of laboratory parameters, duration of hospitalization, and development of complications.

Results

The study included a total of 60 patients diagnosed with hemorrhagic vasculitis. Patients were classified according to the predominant clinical manifestation into skin, skin–joint, abdominal, renal, and mixed forms.

Distribution of patients by clinical form is presented in Table 1 and Figure 1.

Table 1. Distribution of patients by clinical form

Clinical form	Number of patients (n)	Percentage (%)
Skin	22	36.8
Skin–joint	14	23.3
Abdominal	10	16.7
Renal	8	13.3
Mixed	6	10.0

Systemic glucocorticoids (GCS) were administered to 28 patients (46.7%), mainly in abdominal, renal, and mixed forms. The remaining 32 patients (53.3%) received basic therapy without glucocorticoids.

Table 2. Antiplatelet therapy used in patients

Drug	Number of patients (n)	Percentage (%)
Dipyridamole	20	33.3
Pentoxifylline	12	20.0
Both drugs	28	46.7

Patients with skin and skin–joint forms showed rapid regression of purpura and joint symptoms within 5–7 days of therapy, with normalization of inflammatory markers. Patients with abdominal form required longer treatment, and some demonstrated signs of gastrointestinal bleeding. Renal and mixed forms were associated with persistent urinary abnormalities and longer hospitalization.

Overall, treatment effectiveness was significantly higher in mild clinical forms, while severe forms required prolonged therapy and closer monitoring.

Discussion

The findings indicate that the effectiveness of basic therapy is significantly influenced by the clinical form of hemorrhagic vasculitis. Skin and skin–joint forms respond well to standard treatment, while abdominal and renal forms represent more severe disease requiring intensive and individualized management.

Early identification of patients at risk for renal involvement is essential to prevent chronic kidney damage. Tailoring treatment intensity based on clinical form may improve outcomes and reduce complication rates.

Conclusion

Basic therapy is effective in mild clinical forms of hemorrhagic vasculitis; however, patients with abdominal and renal involvement require more aggressive and prolonged treatment. Clinical classification at disease onset is crucial for selecting optimal therapeutic strategies and improving prognosis.

Conclusion

Basic therapy is effective in mild clinical forms of hemorrhagic vasculitis; however, patients with abdominal and renal involvement require more aggressive and prolonged treatment. Clinical classification at disease onset is crucial for selecting optimal therapeutic strategies and improving prognosis.

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