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# VASCULITIC ULCERS IN RHEUMATOID ARTHRITIS

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Six patients with rheumatoid arthritis (RA) and vasculitis presented to us with chronic ulcers (6 months duration). 50% had RA for 10 years or more and majority had solitary ulcer on the lower limbs. All had significant elevations in the ESR and most had a strongly positive rheumatoid factor. They needed streoid ± immunosuppressants for the ulcer and preliminary attempts at skin grafting prior to the control of the disease failed in 3 patients.

**Key Words : Vasculitic ulcers, Rheumatoid vasculitis**

## Introduction

Chronic non-healing ulcers have always been a diagnostic and therapeutic challenge, to the physicians and surgeons. They pose the same problems to a rheumatologist. The causes of ulcers in a rheumatoid arthritis (RA) patient vary from vasculitis, immobility, complication of steroid therapy and intercurrent problem. In a survey done in the Bath Health District (U.K.), RA was the fifth most common diagnosis seen in all skin ulcers found in the hospitals on a single day census.[1] There is a shortage of Indian literature on this subject. In this article, we have made an attempt to analyse our data of vasculitic ulcers in RA patients. Over a 5 year period we had 12 patients of RA with vasculitis, of whom 6 had non-healing ulcers, which persist for more than 6 months inspite of treatment.

## Result

Over the last 5 years we have seen 12 patients with rheumatoid arthritis and vasculitis. 7 had history of ulcers during the course of the illness amongst whom, 6 had non-healing ulcers for at least 6 months. Their demographic data, clinical features and laboratory parameters are depicted in table 1.

Majority of the patients were females in the third and fourth decades. 50% had RA for at least 10 years. Rheumatoid nodules were seen in 3 patients, while 4 had significant synovitis and deformities of the joints. Of the 6 patients 2 had more than 1 ulcer and in the majority the ulcers were in the lower limbs near the malleoli. These ulcers varied in size from few centimeters to as large as 10 centimeters in diameter. Most had a pale necrotic base and under-mined edges. Extra articular features apart from the ulcers were seen in 3 patients. The ESR was raised (> 100 mm/hr) in 4 patients while, rheumatoid factor was positive in 5. Skin grafting was attempted in 3 prior to adequate control of vasculitis and was unsuccessful. In 4 patients healing was achieved after adequate treatment with steroids and disease modifying drugs (2 Azathioprine, 1 Inj. Gold, 1 Methotrexate). 1 is on steroids still and showing improvement and 1 has been lost to follow up.

## Comments

Cutaneous manifestations are one of the most common clinical features of rheumatoid vasculitic. These include nail fold, nail edge and digital infarcts. Cutaneous ulcers occur in 50 to 60% of such cases. The usual sites are lower limbs or sacrum.[2]

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It is important to realise that vasculitic ulcers could be large enough to simulate bed sores.[3] The fact that they may be present in the non-pressure areas and at times their genesis from a nodule may help to differentiate them from bed sores. Their recognition is important since they seem to respond adequately to steroids and disease modifying drugs.

Debridement and skin grafting may be of value in recalcitrant vasculitic ulcers. Autologous grafts for small ulcers and freeze-dried porcine grafts for large ulcers have been recommended. Even if the graft fails there is often increased granulation in the ulcer so that subsequent grafting may be successful.[4] However, if the vasculitic process is very active these grafts could fail as it did in 3 of our patients.

One can conclude that in the absence atherosclerosis, hypertension, ven insufficiency and infection, the typ ischaemic ulcer in the setting of RA is usu an evidence of vasculitis.[5]

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