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AN INTERESTING CASE REPORT OF DYSENTERY PRESENTING WITH PALPABLE PURPURA IN AN ADULT WOMAN

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ABSTRACT

Dysentery in adults is commonly attributed to infectious etiologies; however, the presence of palpable purpura, arthralgia, and renal abnormalities may suggest an underlying small- vessel vasculitis. We report the case of a 35-year-old woman who presented with fever, abdominal pain, vomiting, and bloody stools accompanied by a rapidly progressive purpuric rash involving all four limbs and trunk, predominantly in lower limb and back region. Laboratory evaluation revealed neutrophilic leukocytosis, markedly elevated in ammatory markers, positive stool occult blood, mild proteinuria, and elevated D-dimer. Dermatologic examination identi ed multiple palpable purpura, vesicles, and bullae. The constellation of symptoms raised suspicion for IgA vasculitis or leukocytoclastic vasculitis (LCV) with gastrointestinal involvement. This case highlights the need for early recognition of vasculitic manifestations in adults presenting with dysentery-like symptoms.

KEYWORDS: Dermatologic examination identi ed multiple palpable purpura, vesicles, and bullae.

INTRODUCTION

Palpable purpura in association with gastrointestinal symptoms raises concern for small- vessel vasculitides such as IgA vasculitis (Henoch-Schönlein purpura) or leukocytoclastic vasculitis (LCV). Although IgA vasculitis is more common in children, adult-onset disease may be severe and often presents with extensive skin involvement, abdominal pain, and renal abnormalities. Gastrointestinal manifestations such as hematochezia or dysentery may complicate the initial presentation and obscure the diagnosis. Here, we present an adult woman with presumed dysentery whose evaluation revealed features suggestive of systemic vasculitis.

Case Presentation

A 35-year-old female catering worker from Tenkasi who is a known case of Type 2 Diabetes Mellitus (DM) and Hypothyroidism (HTN) presented with a 10-day history of low-grade, intermittent fever followed by three days of progressive abdominal pain, vomiting, and passage of blood and mucus in stools. The abdominal pain was colicky and di use. She also reported multiple erythematous skin lesions over the upper and lower limbs, predominantly in lower limb and back that progressed over ten days. Knee pain developed concurrently.

The patient denied chills, rigors, cough, hemoptysis, hematemesis, chest pain, weight loss, shortness of breath, visual disturbances, oral ulcers, photosensitivity, or urinary symptoms. There was no history of recent drug exposure. She had applied neem paste over the lesions. Past medical history included type 2 diabetes mellitus (poorly controlled) and hypothyroidism on thyroxine 100 µg. Family and menstrual history were unremarkable.

Married for 15 years with no children; one second trimester abortion 10 years back.

Examination

She was conscious, oriented, and afebrile on admission. Mild pallor was noted. No icterus, clubbing, cyanosis, pedal edema, or lymphadenopathy was found. Vital signs

were stable (pulse 84/min, BP 130/70 mmHg, RR 16/min, SpO_2 98%).

Systemic examination revealed di use abdominal tenderness without guarding or rigidity. Cardiovascular, respiratory, and neurologic examinations were within normal limits.

Investigations

Laboratory Results

Table 1: Baseline hematological and biochemical investigations Additional ndings.

Test	Value
Hemoglobin	12.8 g/dL
Total Count	13,300 cells/cumm
Platelet Count	633,000
Urea	19 mg/dL
Creatinine	0.55 mg/dL
Sodium	139 mEq
Potassium	3.9 mEq
Total Bilirubin	0.80 mg/dL
Direct Bilirubin	0.2 mg/dL
SGOT	26.5 U/L
SGPT	33.8 U/L

Additional findings

- Peripheral smear: Neutrophilic leukocytosis with left shift
- ESR (Erythrocyte Sedimentation Rate): 100 mm/hr
- CRP (C-Reactive Protein): 85 mg/L
- LDH (Lactate Dehydrogenase): 347 U/L
- Stool occult blood: Positive
- D-dimer: 2600 ng/mL
- Coagulation pro le: Normal
- ANA (Antinuclear Antibody) and rheumatoid factor: Negative
- Viral markers (HIV, HBsAg, HCV): Negative
- C3 complement: 180.50 mg/dL
- C4 complement: 39.30 mg/dL
- IgA: 618 mg/dL (Normal values: 70-400 mg/dL)

Urine Examination

- Trace albumin
- 24-hour urine protein: 447 mg
- Urine PCR: 0.42
- Urine sugar: ++
- No dysmorphic RBCs (Red Blood Cells)

Radiological Investigations

- Ultrasound (USG) Abdomen and pelvis: Grade 1 fatty liver
- Computed Tomography (CT) Abdomen plain and contrast: Mild hepatosplenomegaly
- Esophagogastroduodenoscopy (OGD): Antral gastritis

Histopathology Study

Punch Biopsy from purpuric macula over left arm

Gross Description

Received specimen of one skin-attached soft tissue fragment measuring 0.3 × 0.3 cm.

Microscopic Description

Sections studied show thinned out epidermis; underlying collagenized dermis shows compressed adnexal structures, perivascular edema, and perivascular in ltration of fragmented neutrophils and extravasated RBCs.

Impression

Features consistent with leukocytoclastic vasculitis (LCV).

Skin Findings

Multiple well-de ned palpable purpura of varying sizes were present over both legs, thighs, abdomen, and gluteal region. Vesicles, bullae, crusted erosions, and di use hyperpigmentation were noted over the extremities. Palms, soles, scalp, hair, and nails were normal.

DISCUSSION

The patient presented with fever, bloody diarrhea, abdominal pain, palpable purpura, arthralgia, and mild renal involvement—features classically associated with IgA vasculitis. Although dysentery may explain the abdominal symptoms, the presence of di use palpable purpura, vesicles, and bullae strongly supports a diagnosis of small-vessel vasculitis, most likely IgA vasculitis or leukocytoclastic vasculitis.

IgA vasculitis typically manifests with a tetrad of palpable purpura, abdominal pain, arthralgia, and renal involvement. Adults tend to experience more severe disease with increased risk of gastrointestinal bleeding and renal complications. In the present case, the presence of bloody stools and severe abdominal pain may represent vasculitic involvement of the gastrointestinal tract rather than pure infectious dysentery.

The elevated ESR, CRP, leukocytosis, and D-dimer support a systemic in ammatory process. The lack of autoantibodies and the presence of skin lesions favor small-vessel vasculitis.

Mild proteinuria without hematuria suggests early renal involvement.

Con rmatory diagnosis requires skin biopsy with direct immuno uorescence, which typically reveals leukocytoclastic vasculitis with IgA deposition in IgA vasculitis. Stool cultures and abdominal imaging may further di erentiate between primary gastrointestinal infection and vasculitic involvement.

CONCLUSIONS

This case highlights the diagnostic challenges in adults presenting with dysentery-like symptoms accompanied by extensive skin involvement. The presence of palpable purpura, abdominal pain, arthralgia, and renal abnormalities should raise strong suspicion for IgA vasculitis or other small-vessel vasculitides. Early dermatologic evaluation and skin biopsy are essential to establish a de nitive diagnosis and guide management, especially since adult-onset IgA vasculitis may have a more severe course.

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