Amber N. Fiutko, MD; Joseph S. Palter, MD

0196-0644/$-see front matter

https://doi.org/10.1016/j.annemergmed.2018.07.013

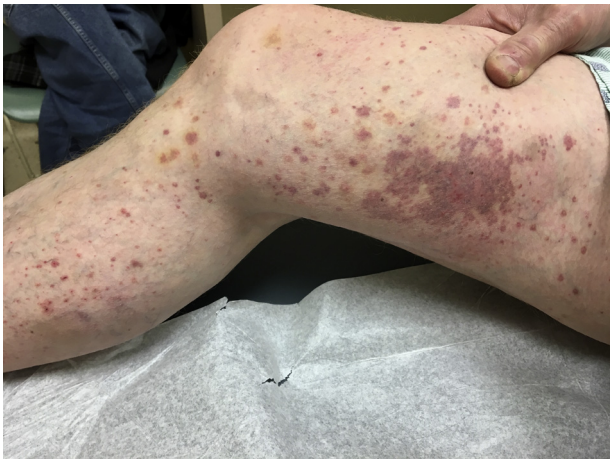

Figure 1. Rash on right leg.

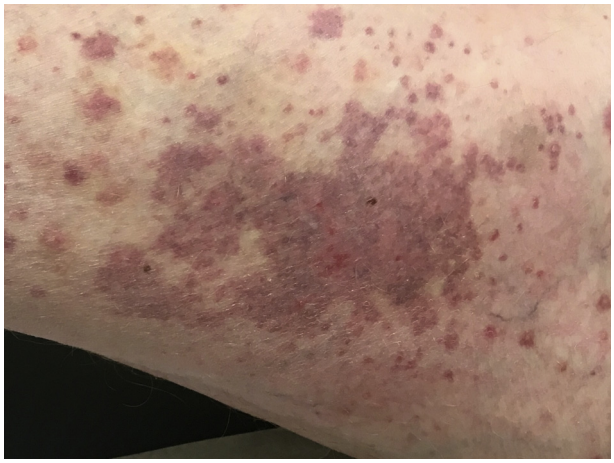

Figure 2. Close-up of raised rash on right thigh.

[Ann Emerg Med. 2019;73:91.]

A 55-year-old man with a history of hypertension presented to the emergency department (ED) with complaints of a bilateral lower extremity rash for 1 week (Figures 1 and 2). The patient initially noticed a spotted rash around his sock line, which he attributed to "ringworm." During the course of the next week, the lesions spread proximally and coalesced into a palpable rash. He denied preceding illness or use of any new soap or detergents. On review of systems, he did note a red tint to his urine but denied abdominal or joint pain. Laboratory analysis confirmed the presence of hematuria and revealed normal renal function.

For the diagnosis and teaching points, see page 93.
To view the entire collection of Images in Emergency Medicine, visit www.annemergmed.com

and welcome opportunities to be present in their lives outside the hospital, even if that is a casual encounter on the street. Instead of letting our paths diverge once again that day, I could have spent a brief moment building community, showing him that he is not forgotten. I could have pulled over, reintroduced myself, and asked about the man's health and how he was coping. At the very least, I could have purchased a newspaper that day.

We cannot take it upon ourselves to resolve every individual's troubles, but I enter residency with the determination to place each medical encounter in the context of the patient's greater life narrative. I will not only acknowledge the immediate suffering of their emergency but also the suffering preceding and following my time with them. In this way, I will equip myself to meet their needs more completely. Though at times I may feel there are no more tools in my toolbox, that is never true. What I failed to offer the gentleman—both in the hospital and on the corner—were my time and presence. Even with no medical care to extend, we can create community. And wherever community exists, there is the potential for healing.

The author acknowledges Brian C. Drolet, MD, for his critical comments on the article.

Author affiliations: From the Department of Emergency Medicine, University of North Carolina, Chapel Hill, NC.

IMAGES IN EMERGENCY MEDICINE

(continued from p. 91)

DIAGNOSIS:

Henoch-Schönlein's purpura. Henoch-Schönlein's purpura is an immunoglobulin A–mediated vasculitis that commonly presents in children after a viral illness. Diagnosis consists of palpable purpura (a mandatory finding) in addition to at least one of the following: diffuse abdominal pain, skin biopsy with immunoglobulin A deposition, acute joint pain, or renal impairment including hematuria or proteinuria.[1] Although common in children, affecting approximately 15 per 100,000 annually, the incidence in adults is far less common, ranging from 0.5 to 5.1 per 100,000 patients.[2,3] It is important to accurately diagnosis Henoch-Schönlein's purpura in adults because nonpediatric populations are at higher risk for disease sequela. Older than 50 years is a strong predictor of severe renal impairment.[2]

Henoch-Schönlein's purpura was suspected in our patient with hematuria and palpable purpura, although his renal function during his ED visit was normal. The patient was referred to rheumatology and dermatology, where skin biopsy confirmed immunoglobulin A–mediated vasculitis. At subsequent visits, the rash had nearly resolved and the patient's renal function remained normal.

Author affiliations: From the Department of Emergency Medicine, Cook County Health and Hospitals System, Chicago, IL.

REFERENCES

1. Ozen S, Ruperto N, Dillon MJ, et al. EULAR/PReS endorsed consensus criteria for the classification of childhood vasculitides. *Ann Rheum Dis*. 2005;65:936-941.
2. Pillebout E, Thervet E, Hill G, et al. Henoch-Schonlein purpura in adults: outcome and prognostic factors. *J Am Soc Nephrol*. 2002;13:1271-1278.
3. Hočevar A, Rotar Z, Ostrovršnik J, et al. Incidence of IgA vasculitis in the adult Slovenian population. *Br J Dermatol*. 2014;171:524-527.