

Through the Lens: Cryoglobulinemia

A 51-year-old lady presented with episodic discoloration of lower extremities associated with severe pain of 2 years' duration. She was a nonsmoker, nondiabetic, and normotensive. On examination, she had gangrene involving the left great toe [Figure 1]. Evaluation revealed hepatitis C virus (HCV) RNA copies – 1.4 million copies/mL, genotype – 3, cryoglobulins – present, rheumatoid factor – positive and thrombocytopenia. Color Doppler involving lower limb vessels and two-dimensional echocardiography were normal. Histopathology of the skin showed fibrinoid deposits and thrombus formation in dermal capillaries without active vasculitis. Diagnosis of HCV-associated cryoglobulinemic vasculitis was made. She was treated with tablet sofosbuvir 400 mg and daclatasvir 60 mg once a day along with tablet prednisolone 40 mg once a day. She responded favorably to treatment, and review at 3 months showed resolution of skin lesions [Figure 2].

Cryoglobulinemic vasculitis develops in approximately 15% patients with HCV infection, while circulating cryoglobulins are detected in 40–60% of the patients.^[1] Viral clearance is important for the treatment of vasculitis as clinical remission is closely linked with viral clearance. Pegylated interferon α with ribavirin with or without rituximab is the standard of care for the management of cryoglobulinemic vasculitis, but 30–40% patients do not respond to this combination.^[2] With the availability of direct-acting antiviral agents, treatment of this condition has changed dramatically.^[3] In an open label multicentre study, sofosbuvir 400 mg per day and daclatasvir 60 mg per day for 12 weeks resulted in complete clinical response in 90% patients.^[4]

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Figure 1: Gangrene involving the left great toe



Figure 2: Complete resolution of the gangrene with post-inflammatory pigmentation on the left great toe after 12 weeks

Conflicts of interest

There are no conflicts of interest.

References

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