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DIGITAL ARTERITIS AS A SKIN MANIFESTATION OF VASCULITIS IN RHEUMATOID ARTHRITIS

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Rheumatoid arthritis (RA) is a long-term autoimmune systemic disease of connective tissue with unknown etiology. RA characterized by inflammatory and destructive joint damage and extra-articular manifestations. Various organs and systems (including skin) involve in the pathological process. Thus, cutaneous rheumatoid vasculitis (RV) is a systemic manifestations of RA. RV in patients with RA is generally associated with longstanding disease, has an important impact on a patient's well being, and markedly influences patient life expectancy. RV may develop due to immune complex deposition on the vascular walls. Male sex, high titers of rheumatoid factor, the presence of other extra-articular manifestations and smocking are predisposing factors for the development of RV in patients with RA. Several studies have reported high morbidity and mortality rates in patienrs with RV. The overall mortality rates are similar and high, with 1-year mortality rate 12-14%, and 5-year mortality rate 26% (Mackol A. et al., 2016). According to S. Kobak (2014) about 90% of patients with RV have skin lesions. Digital arteritis (DA) is one of the most common skin manifestations of RV in patients with RA. The classic form of DA is manifested in the picture of tissue necrosis of periungual area. DA is never isolated. It is combined with other extra-articular manifestations of RA, in particular - with rheumatoid nodes, polyneuropathy, diffuse atrophy of the muscles, lymphadenopathy etc. High clinical activity of the inflammatory process in patients with RA and DA correlates with an increase in the values of laboratory signs of inflammatory and immunological disorders. Anaemia, increased erythrocyte sedimentation rate and C-reactive protein is noted. High levels of immune complexes and circulating autoantibodies, particularly RF, are often present in patients with RV and were noted in >80% of the patients.

The presence of vasculitis in patients with DA is confirmed by histological examination of the skin biopsy specimens taken out of the lesion from the lower third of the forearm. Signs of productive vasculitis with lymphohistiocytic and lymphomacrophageal infiltration of vessels, thrombosis of vessels, perivascular edema, fibrinoid deposition observed in biopsy samples. By macroscopic examination, infarctions of periungual area look like a trail of splinters. They usually heal up completely or leave superficial scar. However, with the transformation of DA in obliterating endarteritis of large arteries may develop gangrene of the finger. In this case, the need for amputation of the phalanges may occur.DA should be seen as a negative prognostic factor RA course. Special treatment is required over DA only at occurrence of trophic ulcers at the site of tissue necrosis. In order to prevent the transformation from DA to trophic ulcer in

the first place aggressive treatment of RA (glucocorticoids, cytostatics, anticoagulants) requires. Debridment wound with antiseptics/ antibiotics and collagenolytic enzymes required in the case of formation of trophic ulcers. Unguent streptolaven or iruksol can be used for these purpose.

Thus, skin lesions are an integral part of a complex pattern of violations throughout the body. In the case of RA, the skin lesions reflect RV and occupy an important place in the practice of a dermatologist, family doctor and rheumatologist. The correct evaluation and interpretation of skin lesions, especially DA, in patients with RA is very important in diagnosis, treatment and prognosis of disease outcome.