Churg Strauss Syndrome: a Review

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Abstract

**Background:** Churg Strauss syndrome is a medical condition of unknown aetiology characterized by asthma, eosinophilia and finally vasculitis involving small vessels in the limbs and nasal sinuses and the lungs. The purpose of this review is to highlight the natural history of this condition, the pathogenesis, clinical features and treatment modalities available and the prognosis.

**Methods:** Literature on the subject was reviewed using manual library search, articles in journals, internet search and conference abstracts.

**Result:** Churg Strauss syndrome has been reported to be predominantly common in middle aged individuals in their middle age of life with a history of new onset or worsened asthma. The condition has a male predisposition. Prior to the advent of steroid therapy this condition invariably leads to death, but since the introduction of prednisolone therapy and other immunosuppressive therapy, the outlook has improved for sufferers and long term survival has been seen.

**Conclusion:** Suspicion of this condition should be based on a good history, physical examination and laboratory investigations and diagnosis based on the criteria that has been drawn by the American College of Rheumatology.

**Keywords:** Asthma, Churg Strauss syndrome, Eosinophilia, Vasculitis.

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Introduction

Churg Strauss syndrome is an extremely rare condition which results from vasculitis of vessels. The inflammation leads to systemic organ damage chief among them being the skin, lungs, kidneys, nerves, nasal sinuses, joints, intestinal tract and the heart. There is almost always a history of asthma and allergic rhinitis. The inflammation is accompanied by peripheral blood eosinophilia and tissue invasion by eosinophils. These changes are seen along with granulomatous lesions that appears as vasculitis on tissue biopsy. The vasculitis can present either as weakening of the blood vessels leading to formation of aneurysm and bleeding or to narrowing of vessels to the point of obliterating such vessels with resultant blockage and organ damage.

Although CSS is a rare disease, it is however often seen in clinical practice. Misdiagnosis is due to the clinician failure to have a high index of suspicion. This has resulted in many high profile patients seeking treatment overseas.

Historical perspective

This condition was first described by Dr Jacob and Dr Lotte Strauss in 1951. They described it as a syndrome consisting of asthma, eosinophilia, fever and an accompanying vasculitis involving several organ systems. CSS shares several clinical and pathological features with another type of vasculitis known as polyartheritis nodosa (PAN). Churg and Strauss were able to identify that this clinical entity differs from PAN by the presence of granulomas and peripheral blood eosinophilia. CSS is also known as allergic granulomatosis.

Etiology/pathogenesis

The cause of CSS is unknown. It is not a form of malignant condition nor is it contagious. There is no evidence that CSS is contagious nor for a familiar inheritance. Evidence from the laboratory has shown that the immune system plays a key role in the pathogenesis. An over reactive immune system due to an unknown stimulus results in immense production of eosinophils. The granule content of the eosinophils finally leads to vasculitis which leads to damage of blood vessels. Recent finding has linked the CSS to the presence of the antineutrophilic cytoplasmic antibody (ANCP) and the characteristic vasculitis. However the association with asthma and eosinophilia remains unexplained.
Epidemiology
CSS can occur in all age groups from childhood to the elderly. The average age of patients at the time of diagnosis is between 35-50 years old. There is a male predominance in this disorder.

Clinical features
The typical patient with CSS presents with asthma in 100% of patients. Asthma symptoms may begin long before the onset of vasculitis which may be many years before any other symptom of CSS arising. Other early symptoms and signs include nasal polyps and allergic rhinitis in 61% of patients. There may be anorexia with loss of weight, fever and myalgias in 50-70% of cases.

Morphological changes
The changes affecting various organs in CSS usually include the nose, lungs, skin kidney, gastrointestinal tract, heart and the nerves. In the nose, sinusitis including allergic rhinitis and nasal polyps are the main findings. Involvement of the nerve may result in the devastating medical condition known as mononeuritis multiplex which induces severe tingling sensation, numbness, shooting pains and muscle wasting/ power loss in the hands or feet in 78% of patients.

Laboratory investigations
In addition to a good and detailed history a careful physical examination will be able to elicit some of the changes involving various organ systems. Full blood counts will reveal an increase in the eosinophil count (see figure 3 below), all other cells may remain normal or within limit. Chest x-ray and other imaging techniques may help to show other changes in the lung. Nerve conduction studies and tissue biopsy from skin, lung and nerve may contribute to the diagnosis. The ESR is invariably increased in 90% of individuals and may be accompanied with mild anaemia. Majority of patients with CSS appears to have positive antineutrophil cytoplasmic antibody (ANCA). An increased level of IgE is indicative of disease severity.

Diagnosis
In order to arrive at a diagnosis, the American College of Rheumatology has established certain criteria that must be satisfied before classifying anybody as having CSS. These criteria are designed to differentiate CSS patients from those having other forms of vasculitis for example PAN. Not all patients meet all the criteria. Some may have only 2 or 3 of the criteria and they may be classified as having CSS. In order to avoid this pitfall, the American College of Rheumatology selected 6 disease features to help in making a diagnosis and differentiating CSS from other vasculitides. In order to make a diagnosis a patient must have at least 4 of the following criteria:

1. Asthma
2. Eosinophilia> 10% of differential WBC count
3. Mononeuropathy
4. Transient pulmonary infiltrates on chest x-ray
5. Paranasal sinus abnormalities
6. Biopsy of a vessel containing extravascular eosinophils

Treatment and prognosis
Treatment depends on severity symptoms and the involvement of organ damage. In patients with mild disease, systemic corticosteroid may be sufficient. When major organs are involved with necrotizing
vasculitis, cytotoxic therapy must be undertaken with cyclophosphamide as the drug of choice, although there are data that appear to suggest that the use of high dose intravenous steroid therapy may result in remission in more than 90% of patients. Relapse can occur in 26% of patients and even with aggressive treatment death has been described in 25% of patients. The cause of death in most patients with CSS was vasculitis related primarily, affecting the cardiac and mesenteric vessels.

In general, CSS usually respond to prednisolone. Initially high doses of oral prednisolone are given in order to produce remission as quickly as possible. This will entail giving a start dose of 40–60 mg daily in divided doses form a period of about a month and then tapering the dose in the subsequent month depending on the response of this initial dose. Other immunosuppressive drugs which may help in the control of this condition include Azathioprine, Cellcept, Methotrexate or Cyclophosphamide either as single dose or in combination. In addition to the regimen above, intravenous steroid such as methylprednisolone and plasmapheresis may be used in patients that did not respond to prednisolone or other immunosuppressive regimen.

Prior to the advent of prednisolone, CSS was often a fatal disease the majority of patients dying from rampant uncontrolled disease. With present therapy constitutional symptoms begin to recede quickly with gradual improvement in cardiac and renal functions as well as improvement in the pain that results from peripheral involvement. The course of therapy may last for 1–2 years, although the length and type of treatment depend on the severity of disease and organ involved. The patient's response to treatment and continuation of disease control during lowering of prednisolone dose are the primary determinate on how long therapy is continued. Laboratory monitoring of blood tests is very helpful in gauging the activities of disease. Some of the most useful laboratory tests are the erythrocyte sedimentation rate and the WBC count and differentials.

However the five year survival ranges from 62–79% with mortality strongly associated with cardiac, gastrointestinal and renal involvement. Nevertheless, after treatment with corticosteroids, relapses are frequent in 25% of cases even after recovering from vasculitis most patients (95%) still have asthma requiring corticosteroid therapy.

**Conclusion**

With the advent of prednisolone CSS, which in the past carried a dismal prognosis has now been brought under control. However the benefits of steroid and other immunosuppressive therapy will not mean much if a proper diagnosis is not reached before the onset of organ damage. Therefore it is incumbent on physicians to have a high index of suspicion when the physical examination and the white cell count are suggestive of CSS and to institute early treatment.
Churg Strauss Syndrome: Borke ME, *Nwagu M U, **Obaseki D, ***Bazuaye N O

References