Ashford and St. Peter's Hospitals
NHS Foundation Trust

Henoch-Schonlein Purpura Guideline

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Guideline History		
Date	**Comments**	**Approved By**
May 2018	First ratified	
Sept 2023	Reviewed by Dr Emily Taylor and Dr Day – no significant changes.	Dr Claire Mitchell

Henoch Schonlein Purpura Guideline

Age indication: 0 -18 years

Initial management of newly diagnosed HSP

Aim
The aim of this guideline is to provide clear guidance to all staff caring for children and young people with Henoch – Schonlein Purpura (HSP).

Epidemiology
HSP is the commonest vasculitis of childhood and is self-limiting in the majority of cases. It is a multisystem disorder affecting mainly the skin, joints, gastro-intestinal tract and kidneys. Involvement of other organs (pulmonary haemorrhage and CNS involvement) is rare.

It is immune mediated and is caused by the deposition of IgA containing immune complexes with subsequent complement activation. The aetiology is unknown but the history often identifies a preceding throat/URTI infection and some bacteria and viruses have been implicated.

It has an incidence of 13.5-21.7/100,000 per year. It occurs in all age groups from few months to late adulthood. The peak age incidence is 2-11yrs. (50% under 5yrs, 80% under 10yrs)
It affects Males > Females in a ratio of 2:1. Caucasians are often more affected than other ethnic groups

Definition
The agreed criteria for HSP diagnosis is:

- Palpable purpura (mandatory) usually in the presence of at least 1 of the following;
- Diffuse abdominal pain
- Acute arthritis or arthralgia
- Renal involvement (haematuria +/or proteinuria)
- Biopsy showing predominant IgA deposition

Clinical Features:
The classical rash is the sign that usually leads to diagnosis but it can be preceded by other symptoms by up to two weeks.

Skin (100%): 50% at onset / 100% during course

- Palpable purpura distributed symmetrically over extensor surfaces of limbs and buttocks
- Erythematous macules developing into purple, non-blanching, non-pruritic urticarial, palpable purpuric lesions
- Rarely: haemorrhagic bullae and vesicles which desquamate
- In <3 year old, subcutaneous oedema of the scalp, ears, periorbital area, dorsi of the hands, feet and genitalia

Joints (50-80%): 25% at onset / 60 – 85% during course

- Arthralgia typically affects the larger joints (knees, ankles) with pain, swelling and reduced range of movement.
- Swelling is usually periarticular oedema
- Synovial effusions are usually absent.
- Joint involvement can be debilitating but does not typically result in permanent damage.
- Less commonly affects wrists/fingers/elbows

Gastrointestinal (60%): 30% onset / 85 % during course /90% of those with renal involvement

Abdominal pain may precede rash in 14-36% of patients
Varies from colicky abdominal pain, nausea and vomiting to GI haemorrhage
5% of patients develop intussusception
Rarely, pancreatitis, hydrops of the gallbladder and protein losing enteropathy (PLE).
Significant bleeding is rare.

Renal (20-60%): 80 % by 4 weeks / 97 % by 6 months

- Renal involvement is often absent at presentation and may only be apparent weeks or months later
- Renal involvement has a wide range of signs and symptoms:
- Microscopic haematuria - transient of persistent
- Macroscopic haematuria
- Proteinuria
- Nephrotic syndrome
- Mixed Nephritic / Nephrotic syndrome
- Hypertension
- Renal impairment
- Hypertension may be associated with nephritis or be an isolated finding. Most patients with renal involvement will have mild disease that recovers well.
- 5% will have long term morbidity.

Other Features:

- Cerebral -Headache, seizures, encephalopathy, coma, stroke, GBS
- Lung - Interstitial disease, Haemorrhage
- Cardiac - Carditis, chest pain
- Genital - Testicular pain / orchitis /necrosis, cord haematoma, ecchymotic induration of scrotum
- Other- Parotitis

Differential Diagnosis

- Sepsis- meningococcal disease
- Idiopathic Thrombocytopenia Purpura (ITP)
- Leukaemia / other malignancies
- Other causes of a low platelets
- Connective tissue disease / vasculitis (SLE/GPA/polyarteritis nodosa)
- Non Accidental Injury (NAI)

Investigations

Diagnosis is usually on clinical grounds.
Bloods are needed to rule out other diagnoses and in assessing the extent of organ involvement.

All patients:

- Weight, Height, BP (+ centile),
- Urine dipstick
- FBC & film - to rule out thrombocytopenia / leukaemia
- Blood Culture, CRP, clotting - if concerned about sepsis
- U&E, Albumin, calcium, phosphate
- Clotting - if macroscopic haematuria
- Urine microscopy +/- culture, red cell casts
- Early Morning Urine Protein : Creatinine ratio (PCR) – if 2+ or more of proteinuria

If the diagnosis is in doubt- consider the following additional investigations after discussion with the on call consultant (+/- tertiary nephrology)

- ASOT, Anti-DNAse B
- Complement (C3,C4)
- Immunoglobulins
- Autoimmune profile: ANA, dsDNA, pANCA, cANCA
- Abdominal / Renal USS

Treatment

Generally supportive - hydration and simple analgesia is all that is required.

Criteria for Admission

- Diagnosis unclear
- Severe joint pain/swelling limiting ability to weight bear and mobilize
- Severe abdominal pain +/or GI Haemorrhage
- Evidence of nephritis/nephrotic syndrome
- Hypertension or renal impairment
- Neurological symptoms

Specific Symptom management:

Joint symptoms:

- Usually respond to rest and NSAIDS (only if renal function normal)
- Steroids have also been used in severe cases (avoid use of NSAIDS and steroids together).

Abdominal pain:

- Usually settles within 72hrs and simple analgesia is adequate.
- For more severe GI disease, systemic steroids have been used – after discussion with Paediatric Consultant / Gastroenterology.
- Prednisolone – 1mg/kg for 5-7 days then wean gradually over 1 – 2 weeks
- If abdominal pain is acute, severe and/or associated with blood in the stool - consider Intussusception and request USS and surgical opinion.

Skin:

- Manifestations are generally benign.
- Severe cases have been treated with Oral Colchicine or Dapsone.
- Seek Dermatology opinion in these cases.

Renal:

Treatment in HSP Nephritis is debatable and in cases of significant findings the opinion of a Paediatric Nephrologist is required. **Please discuss ANY renal complications with the local renal team in the first instance and consider follow up locally in the renal clinic for ongoing surveillance.**

Indications for referral to a Tertiary Paediatric Nephrologist:

- Acute nephritic syndrome - haematuria, proteinuria, oedema, hypertensive, renal impairment, oliguria
- Macroscopic haematuria for 5 days
- Persistent Microscopic haematuria
- Hypertension
- Proteinuria
- Nephrotic syndrome at any time
- Urine protein/creatinine ratio > 200 with normal plasma albumin concentration for 1 month
- Urine protein/creatinine ratio 100 to 200 for 3 months
- Urine protein/creatinine ratio 25 to 100 for 6 months

Prognosis:

- HSP is usually self-limiting and symptoms resolve within 6 weeks in most cases.
- 33% will have relapses/recurrence of symptoms, more likely in patients with renal disease.
- Mortality is very low (<1%).
- Long term morbidity is usually related to the renal complications and occurs in 5%.
- Overall, 1% progress to end-stage renal failure.
- HSP accounts for 2 – 5% of all patients with end- stage renal failure (previously 15%).

Persistent purpura (>1month), severe abdominal pain and bloody stools are risk factors for significant renal involvement. Renal manifestations generally present in the first 6 months but occasional cases take up to 12 months. Therefore, prolonged monitoring is required. Urinalysis which is normal at presentation, and remains so at 6 months is unlikely to progress and the patient can be discharged. **Otherwise ongoing follow up is required until urinalysis is normal on 2 occasions, 6 months apart.**

Follow up:

See algorithm below (appendix 1)

Straightforward cases should be shared between GP (see algorithm) and hospital Outpatient clinic (4 weeks and 3months). Follow up should be in RAC / Attending consultant's clinic unless discussed otherwise.

Note: In cases of HSP relapse, follow up should occur from the most recent symptoms, not the initial presentation. Refer to algorithm

Discharge:

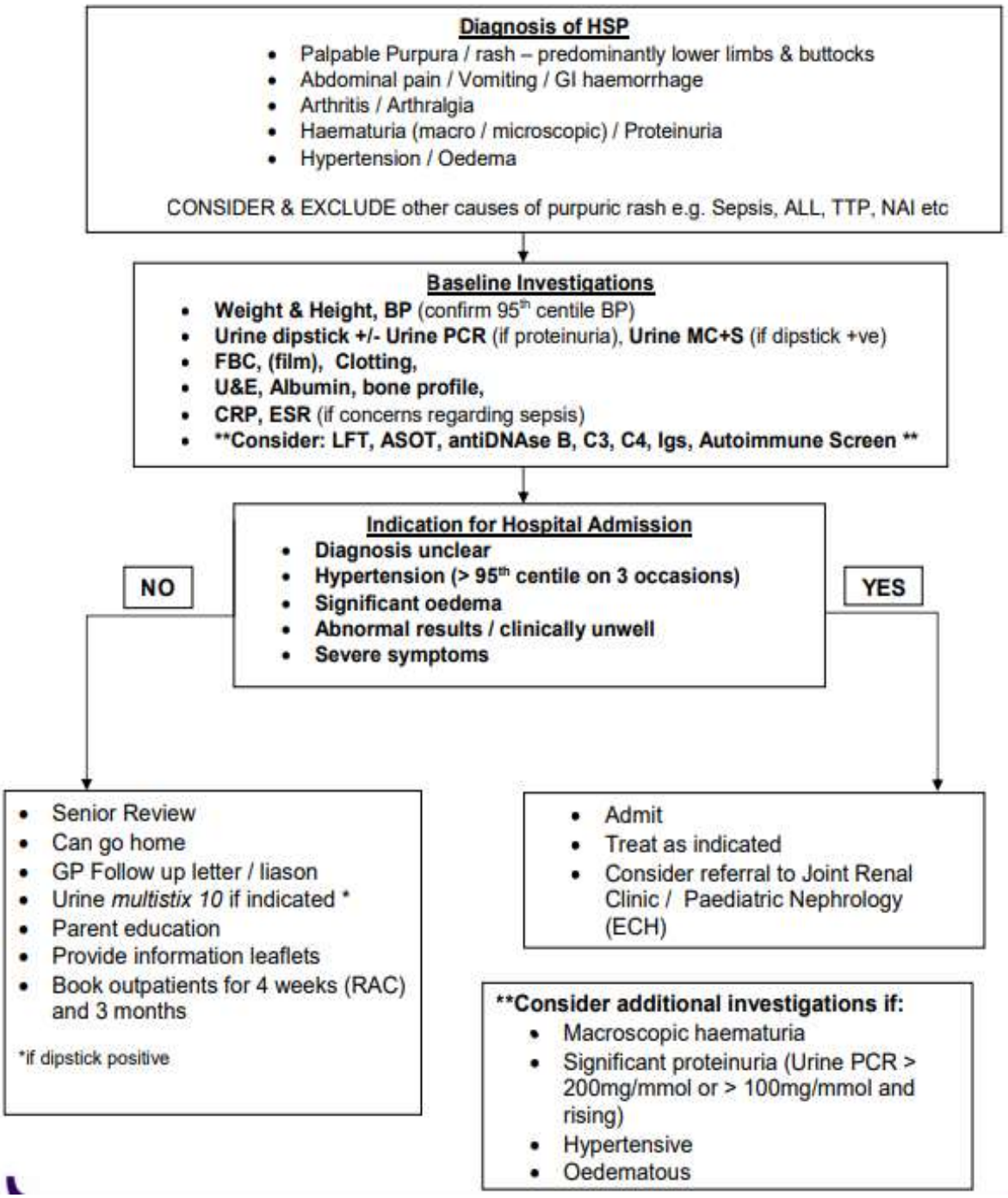
- Give parent / child GP letter and follow up record sheet – Appendix 2+3
- Give parent / child the information leaflet on discharge – on intranet
- Prescribe urine dipsticks – multistix 10 (available in A&E) and educate on use
- Contact GP & confirm follow up plan & that they agree to shared care
- Include the systolic BP (95th centile for height) – Appendix 4 (boys) Appendix 5 (girls)

Ensure GP / Family know what to monitor and how to escalate any concerns

Appendix 1

Patient Pathways

1. Initial management of newly diagnosed HSP



2. General Paediatric Review (Clinic / A&E)

- **History & examination**
- **EarlyMorning Urine Dipstick +/- uPCR**
- **Blood Pressure measurement**
- **Review of previous symptoms**
- **Review of investigations**

- Clinically well
- Normal urinalysis
- Normal Blood pressure
- No new symptoms

- Ensure GP follow up in progress
- Complete Ratient Record
- Ensure parent education up to date
- Schedule follow up as per plan

- Macroscopic haematuria
- Significant Proteinuria *
- SBP > 95th Centile (3 occasions)
- Oedema
- Microscopic Haemtauria >12 months

If Yes to any of above:

- Confirm ASOT, ANA, ds DNA, ANCA, C3, C4. Igs has been checked
- Check FBC, U&E,
- Send early morning Urine PCR
- Renal USS
- Plan for more frequent hospital follow up if indicated
- Consider referral to joint renal clinic +/or discussion with Evelina Renal Team

- **1/3 of patients will have recurrence of symptoms**
  - They should be managed as for primary episode
- **If BP & urinalysis are normal at 6 – 12 months they can be safely discharged**
- **Patients with HSP Nephritis should have lifelong follow up – annual BP / urinalyis**
- **Risk of long term renal involvement**
  - Isolated haematuria & proteinuria 1.6 %
  - If nephritic / nephrotic syndome 19.5 %

***Significant Proteinuria**

- If >2+ on dipstick check uPCR
- If uPCR > 200 mg / mmol or >100mg / mmol & rising up to 6 months post diagnosis
- If uPCR > 50 mg/ mmol at 12 months from diagnosis

Paediatric Nephrology Indications

- **Hypertension**
- **Abnormal Renal Function**
- **Macroscopic Haematuria for > 5 days**
- **Nephrotic Syndrome**
- **Acute Nephritic Syndrome**
- **Persistent proteinuria**
  - **uPCR > 250 mg/mmol for 4 weeks**
  - **u PCR > 100 mg / mmol for 3 months**
  - **u PCR > 50 mg/mmol for 6 months**
- **Persistent Microscopic Haematuria for 12 months**

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Appendix 2: GP Letter

Dear Doctor,

Patient Details:

Your patient has been diagnosed with Henoch Schonlein Purpura (HSP) and requires monitoring of the following:

- **Blood pressure**
- **Early morning urine dipstick** – for proteinuria and haematuria

We would be extremely grateful if you would be able to facilitate shared care with us. The monitoring needs to occur at defined intervals as directed on the patient record sheet. Essentially this will be weekly for the first month, 2 weekly for the next 2 months and if all remains well, at 3, 4, 6 and 12 months. Your patient will be seen routinely in paediatric outpatients at 4 – 6 weeks and 3 - 6 months but we will provide remote care if required.
One third of patients with HSP will have relapse / recurrence of symptoms. In these instances, the follow up from a renal point of view should start again from week 1.

Concerning findings which warrant referral to the paediatric team acutely include:

- **Urine dipstick of 2+ or more Proteinuria**
- **Macroscopic haematuria**
- **Blood pressure >95th centile for age/sex**
  (This value has been recorded on the patient record sheet)

Patients with microscopic haematuria are less concerning but if their findings persist at 12 months this will need referral to children's' outpatients although they may well already be under follow up.

Refer to Paediatric Outpatients if:
Persistent proteinuria at 3 months (**if not already under f/up**)
Persistent microscopic haematuria at 12 months
Any other concerns

Should you have any other concerns, or would like to discuss this further, please contact the paediatric team at ASPH via the on call Registrar bleep (5315) or via Switch Board. Alternatively you can contact Paediatric A&E on 01932 72 3624 or the Paediatric Secretaries on 01932 72 2722 / 3494 to leave a message for the Attending Consultant. *Ongoing hospital follow up determined by symptoms

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Appendix 3: Henoch-Schonlein Purpura (HSP) Follow up Patient Record

Name: _____

DOB: _____

Hospital No:_____

Address:_____

Your child has been diagnosed with HSP. It is very important that we continue to monitor the possible kidney involvement of this disease. Blood pressure and an early morning urine sample (i.e. first urine passed that day) will be tested at regular intervals as directed below. There may be additional tests performed depending upon the presentation and illness course. These screening tests will primarily be undertaken at your GP surgery with paediatric follow up scheduled for 4 – 6 weeks and 3 months initially (or more frequently as required). In the meantime; if you or your GP have any concerns, they can be discussed with the registrar on call via switchboard. (01932 87 2000 and ask to bleep the paediatric registrar).

Named Consultant:

95th Centile BP Limit for patient:

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Henoch-Schonlein Purpura – Follow up Schedule

Patient Name:

Week	Place of Review	Date	Urine Protein	Urine Blood	Blood Pressure
1	GP				
2	GP				
3	GP				
4	Outpatients (ASPH) / GP				
6	GP / Outpatients (ASPH)				
8	GP				
10	GP				
12	Outpatients (ASPH)				
4 months	GP				
6 months	GP / Outpatients				
12 months **(if required)**	GP / Outpatients				

Please keep this document safe and updated. Please bring it to any reviews.

Appendix 4: Height matched Blood Pressure centiles for Boys

Blood Pressure Levels for Boys by Age and Height Percentile

Age (Year)	BP Percentile ↓	Systolic BP (mmHg) ← Percentile of Height →							Diastolic BP (mmHg) ← Percentile of Height →						
		5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
1	50th	80	81	83	85	87	88	89	34	35	36	37	38	39	39
	90th	94	95	97	99	100	102	103	49	50	51	52	53	53	54
	95th	98	99	101	103	104	106	106	54	54	55	56	57	58	58
	99th	105	106	108	110	112	113	114	61	62	63	64	65	66	66
2	50th	84	85	87	88	90	92	92	39	40	41	42	43	44	44
	90th	97	99	100	102	104	105	106	54	55	56	57	58	58	59
	95th	101	102	104	106	108	109	110	59	59	60	61	62	63	63
	99th	109	110	111	113	115	117	117	66	67	68	69	70	71	71
3	50th	86	87	89	91	93	94	95	44	44	45	46	47	48	48
	90th	100	101	103	105	107	108	109	59	59	60	61	62	63	63
	95th	104	105	107	109	110	112	113	63	63	64	65	66	67	67
	99th	111	112	114	116	118	119	120	71	71	72	73	74	75	75
4	50th	88	89	91	93	95	96	97	47	48	49	50	51	51	52
	90th	102	103	105	107	109	110	111	62	63	64	65	66	66	67
	95th	106	107	109	111	112	114	115	66	67	68	69	70	71	71
	99th	113	114	116	118	120	121	122	74	75	76	77	78	78	79
5	50th	90	91	93	95	96	98	98	50	51	52	53	54	55	55
	90th	104	105	106	108	110	111	112	65	66	67	68	69	69	70
	95th	108	109	110	112	114	115	116	69	70	71	72	73	74	74
	99th	115	116	118	120	121	123	123	77	78	79	80	81	81	82
6	50th	91	92	94	96	98	99	100	53	53	54	55	56	57	57
	90th	105	106	108	110	111	113	113	68	68	69	70	71	72	72
	95th	109	110	112	114	115	117	117	72	72	73	74	75	76	76
	99th	116	117	119	121	123	124	125	80	80	81	82	83	84	84
7	50th	92	94	95	97	99	100	101	55	55	56	57	58	59	59
	90th	106	107	109	111	113	114	115	70	70	71	72	73	74	74
	95th	110	111	113	115	117	118	119	74	74	75	76	77	78	78
	99th	117	118	120	122	124	125	126	82	82	83	84	85	86	86
8	50th	94	95	97	99	100	102	102	56	57	58	59	60	60	61
	90th	107	109	110	112	114	115	116	71	72	72	73	74	75	76
	95th	111	112	114	116	118	119	120	75	76	77	78	79	79	80
	99th	119	120	122	123	125	127	127	83	84	85	86	87	87	88
9	50th	95	96	98	100	102	103	104	57	58	59	60	61	61	62
	90th	109	110	112	114	115	117	118	72	73	74	75	76	76	77
	95th	113	114	116	118	119	121	121	76	77	78	79	80	81	81
	99th	120	121	123	125	127	128	129	84	85	86	87	88	88	89
10	50th	97	98	100	102	103	105	106	58	59	60	61	61	62	63
	90th	111	112	114	115	117	119	119	73	73	74	75	76	77	78
	95th	115	116	117	119	121	122	123	77	78	79	80	81	81	82
	99th	122	123	125	127	128	130	130	85	86	86	88	88	89	90

Blood Pressure Levels for Boys by Age and Height Percentile (Continued)

Age (Year)	BP Percentile ↓	Systolic BP (mmHg) ← Percentile of Height →							Diastolic BP (mmHg) ← Percentile of Height →						
		5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
11	50th	99	100	102	104	105	107	107	59	59	60	61	62	63	63
	90th	113	114	115	117	119	120	121	74	74	75	76	77	78	78
	95th	117	118	119	121	123	124	125	78	78	79	80	81	82	82
	99th	124	125	127	129	130	132	132	86	86	87	88	89	90	90
12	50th	101	102	104	106	108	109	110	59	60	61	62	63	63	64
	90th	115	116	118	120	121	123	123	74	75	75	76	77	78	79
	95th	119	120	122	123	125	127	127	78	79	80	81	82	82	83
	99th	126	127	129	131	133	134	135	86	87	88	89	90	90	91
13	50th	104	105	106	108	110	111	112	60	60	61	62	63	64	64
	90th	117	118	120	122	124	125	126	75	75	76	77	78	79	79
	95th	121	122	124	126	128	129	130	79	79	80	81	82	83	83
	99th	128	130	131	133	135	136	137	87	87	88	89	90	91	91
14	50th	106	107	109	111	113	114	115	60	61	62	63	64	65	65
	90th	120	121	123	125	126	128	128	75	76	77	78	79	79	80
	95th	124	125	127	128	130	132	132	80	80	81	82	83	84	84
	99th	131	132	134	136	138	139	140	87	88	89	90	91	92	92
15	50th	109	110	112	113	115	117	117	61	62	63	64	65	66	66
	90th	122	124	125	127	129	130	131	76	77	78	79	80	80	81
	95th	126	127	129	131	133	134	135	81	81	82	83	84	85	85
	99th	134	135	136	138	140	142	142	88	89	90	91	92	93	93
16	50th	111	112	114	116	118	119	120	63	63	64	65	66	67	67
	90th	125	126	128	130	131	133	134	78	78	79	80	81	82	82
	95th	129	130	132	134	135	137	137	82	83	83	84	85	86	87
	99th	136	137	139	141	143	144	145	90	90	91	92	93	94	94
17	50th	114	115	116	118	120	121	122	65	66	66	67	68	69	70
	90th	127	128	130	132	134	135	136	80	80	81	82	83	84	84
	95th	131	132	134	136	138	139	140	84	85	86	87	87	88	89
	99th	139	140	141	143	145	146	147	92	93	93	94	95	96	97

BP, blood pressure

* The 90th percentile is 1.28 SD, 95th percentile is 1.645 SD, and the 99th percentile is 2.326 SD over the mean.

For research purposes, the standard deviations in Appendix Table B–1 allow one to compute BP Z-scores and percentiles for boys with height percentiles given in Table 3 (i.e., the 5th,10th, 25th, 50th, 75th, 90th, and 95th percentiles). These height percentiles must be converted to height Z-scores given by (5% = -1.645; 10% = -1.28; 25% = -0.68; 50% = 0; 75% = 0.68; 90% = 1.28%; 95% = 1.645) and then computed according to the methodology in steps 2–4 described in Appendix B. For children with height percentiles other than these, follow steps 1–4 as described in Appendix B.

Appendix 5: Height matched Blood Pressure centiles for Girls

Blood Pressure Levels for Girls by Age and Height Percentile

Age (Year)	BP Percentile ↓	Systolic BP (mmHg) ← Percentile of Height →							Diastolic BP (mmHg) ← Percentile of Height →						
		5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
1	50th	83	84	85	86	88	89	90	38	39	39	40	41	41	42
	90th	97	97	98	100	101	102	103	52	53	53	54	55	55	56
	95th	100	101	102	104	105	106	107	56	57	57	58	59	59	60
	99th	108	108	109	111	112	113	114	64	64	65	65	66	67	67
2	50th	85	85	87	88	89	91	91	43	44	44	45	46	46	47
	90th	98	99	100	101	103	104	105	57	58	58	59	60	61	61
	95th	102	103	104	105	107	108	109	61	62	62	63	64	65	65
	99th	109	110	111	112	114	115	116	69	69	70	70	71	72	72
3	50th	86	87	88	89	91	92	93	47	48	48	49	50	50	51
	90th	100	100	102	103	104	106	106	61	62	62	63	64	64	65
	95th	104	104	105	107	108	109	110	65	66	66	67	68	68	69
	99th	111	111	113	114	115	116	117	73	73	74	74	75	76	76
4	50th	88	88	90	91	92	94	94	50	50	51	52	52	53	54
	90th	101	102	103	104	106	107	108	64	64	65	66	67	67	68
	95th	105	106	107	108	110	111	112	68	68	69	70	71	71	72
	99th	112	113	114	115	117	118	119	76	76	76	77	78	79	79
5	50th	89	90	91	93	94	95	96	52	53	53	54	55	55	56
	90th	103	103	105	106	107	109	109	66	67	67	68	69	69	70
	95th	107	107	108	110	111	112	113	70	71	71	72	73	73	74
	99th	114	114	116	117	118	120	120	78	78	79	79	80	81	81
6	50th	91	92	93	94	96	97	98	54	54	55	56	56	57	58
	90th	104	105	106	108	109	110	111	68	68	69	70	70	71	72
	95th	108	109	110	111	113	114	115	72	72	73	74	74	75	76
	99th	115	116	117	119	120	121	122	80	80	80	81	82	83	83
7	50th	93	93	95	96	97	99	99	55	56	56	57	58	58	59
	90th	106	107	108	109	111	112	113	69	70	70	71	72	72	73
	95th	110	111	112	113	115	116	116	73	74	74	75	76	76	77
	99th	117	118	119	120	122	123	124	81	81	82	82	83	84	84
8	50th	95	95	96	98	99	100	101	57	57	57	58	59	60	60
	90th	108	109	110	111	113	114	114	71	71	71	72	73	74	74
	95th	112	112	114	115	116	118	118	75	75	75	76	77	78	78
	99th	119	120	121	122	123	125	125	82	82	83	83	84	85	86
9	50th	96	97	98	100	101	102	103	58	58	58	59	60	61	61
	90th	110	110	112	113	114	116	116	72	72	72	73	74	75	75
	95th	114	114	115	117	118	119	120	76	76	76	77	78	79	79
	99th	121	121	123	124	125	127	127	83	83	84	84	85	86	87
10	50th	98	99	100	102	103	104	105	59	59	59	60	61	62	62
	90th	112	112	114	115	116	118	118	73	73	73	74	75	76	76
	95th	116	116	117	119	120	121	122	77	77	77	78	79	80	80
	99th	123	123	125	126	127	129	129	84	84	85	86	86	87	88

Blood Pressure Levels for Girls by Age and Height Percentile (Continued)

Age (Year)	BP Percentile ↓	Systolic BP (mmHg) ← Percentile of Height →							Diastolic BP (mmHg) ← Percentile of Height →						
		5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
11	50th	100	101	102	103	105	106	107	60	60	60	61	62	63	63
	90th	114	114	116	117	118	119	120	74	74	74	75	76	77	77
	95th	118	118	119	121	122	123	124	78	78	78	79	80	81	81
	99th	125	125	126	128	129	130	131	85	85	86	87	87	88	89
12	50th	102	103	104	105	107	108	109	61	61	61	62	63	64	64
	90th	116	116	117	119	120	121	122	75	75	75	76	77	78	78
	95th	119	120	121	123	124	125	126	79	79	79	80	81	82	82
	99th	127	127	128	130	131	132	133	86	86	87	88	88	89	90
13	50th	104	105	106	107	109	110	110	62	62	62	63	64	65	65
	90th	117	118	119	121	122	123	124	76	76	76	77	78	79	79
	95th	121	122	123	124	126	127	128	80	80	80	81	82	83	83
	99th	128	129	130	132	133	134	135	87	87	88	89	89	90	91
14	50th	106	106	107	109	110	111	112	63	63	63	64	65	66	66
	90th	119	120	121	122	124	125	125	77	77	77	78	79	80	80
	95th	123	123	125	126	127	129	129	81	81	81	82	83	84	84
	99th	130	131	132	133	135	136	136	88	88	89	90	90	91	92
15	50th	107	108	109	110	111	113	113	64	64	64	65	66	67	67
	90th	120	121	122	123	125	126	127	78	78	78	79	80	81	81
	95th	124	125	126	127	129	130	131	82	82	82	83	84	85	85
	99th	131	132	133	134	136	137	138	89	89	90	91	91	92	93
16	50th	108	108	110	111	112	114	114	64	64	65	66	66	67	68
	90th	121	122	123	124	126	127	128	78	78	79	80	81	81	82
	95th	125	126	127	128	130	131	132	82	82	83	84	85	85	86
	99th	132	133	134	135	137	138	139	90	90	90	91	92	93	93
17	50th	108	109	110	111	113	114	115	64	65	65	66	67	67	68
	90th	122	122	123	125	126	127	128	78	79	79	80	81	81	82
	95th	125	126	127	129	130	131	132	82	83	83	84	85	85	86
	99th	133	133	134	136	137	138	139	90	90	91	91	92	93	93

BP, blood pressure

* The 90th percentile is 1.28 SD, 95th percentile is 1.645 SD, and the 99th percentile is 2.326 SD over the mean.

For research purposes, the standard deviations in Appendix Table B–1 allow one to compute BP Z-scores and percentiles for girls with height percentiles given in Table 4 (i.e., the 5th,10th, 25th, 50th, 75th, 90th, and 95th percentiles). These height percentiles must be converted to height Z-scores given by (5% = -1.645; 10% = -1.28; 25% = -0.68; 50% = 0; 75% = 0.68; 90% = 1.28%; 95% = 1.645) and then computed according to the methodology in steps 2–4 described in Appendix B. For children with height percentiles other than these, follow steps 1–4 as described in Appendix B.

2. Supporting References

HSP Guideline - PAEDIATRIC INNOVATION, EDUCATION & RESEARCH NETWORK (piernetwork.org)

Clinical Practice Guidelines : Henoch-Schönlein purpura (rch.org.au)

3. Supporting relevant trust guidelines

Parent information HSP for Parents Jan 2019.pdf

Haematuria Mar 2018 (ashfordstpeters.net)

2. Guideline Governance

a. Scope

This guideline is relevant to all staff caring for all children from 0-18 years old across the emergency department, inpatient ward and outpatient department.

b. Purpose

i. This guidelines aims to facilitate a common approach to the management of children. At times deviation from the guideline may be necessary, this should be documented and is the responsibility of the attending consultant.

ii. This guideline is subject to regular review to ensure ongoing evidence based practice.

c. Duties and Responsibilities

All healthcare professionals responsible for the care of all children 0-18years should be aware of practice according to this guideline.

d. Approval and Ratification

This guideline will be approved and ratified by the Paediatric Guidelines Group.

e. Dissemination and Implementation

i. This guideline will be uploaded to the trust intranet 'Paediatric Guidelines' page and thus available for common use.
ii. This guideline will be shared as part of ongoing education within the Paediatric Department for both medical and nursing staff.
iii. All members of staff are invited to attend and give comments on the guideline as part of the ratification process.

f. Review and Revision Arrangements

a. This policy will be reviewed on a 3 yearly basis by the appropriate persons.
b. If new information comes to light prior to the review date, an earlier review will be prompted.
c. Amendments to the document shall be clearly marked on the document control sheet and the updated version uploaded to the intranet. Minor amendments will be ratified through the Paediatric Guidelines Group. A minor amendment would consist of no major change in process, and includes but is not limited to, amendments to documents within the appendices.

g. Equality Impact Assessment

Background • Who was involved in the Equality Impact Assessment
Author and the supervising consultants.
Methodology • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) • The data sources and any other information used • The consultation that was carried out (who, why and how?)
All groups of staff and patients were taken into consideration and there is no bias towards or against any particular group.
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups
There is no evidence of discrimination.
Conclusion • Provide a summary of the overall conclusions
There is no evidence of discrimination.
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified • Describe the plans for reviewing the assessment
This guideline is appropriate for use.

h. Document Checklist

To be completed (electronically) and attached to any document which guides practice when submitted to the appropriate committee for approval or ratification.

Title of the document: Henoch-Schonlein Purpura Guideline

Policy (document) Author: Dr Emily Taylor

Executive Director: N/A

		Yes/No/ Unsure/NA	Comments
1.	**Title**		
	Is the title clear and unambiguous?	**Y**	
	Is it clear whether the document is a guideline, policy, protocol or standard?	**Y**	
2.	**Scope/Purpose**		
	Is the target population clear and unambiguous?	**Y**	
	Is the purpose of the document clear?	**Y**	
	Are the intended outcomes described?	**Y**	
	Are the statements clear and unambiguous?	**Y**	
3.	**Development Process**		
	Is there evidence of engagement with stakeholders and users?	**N/A**	
	Who was engaged in a review of the document (list committees/ individuals)?		**Dr Taylor and Dr Day**
	Has the policy template been followed (i.e. is the format correct)?	**Y**	
4.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	**Y**	

		Yes/No/ Unsure/NA	Comments
	Are local/organisational supporting documents referenced?	**Y**	
5.	**Approval**		
	Does the document identify which committee/group will approve/ratify it?	**Y**	
	If appropriate, have the joint human resources/staff side committee (or equivalent) approved the document?	**N/A**	
6.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	**Y**	
	Does the plan include the necessary training/support to ensure compliance?	**N**	
7.	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?	**N**	
8.	**Review Date**		
	Is the review date identified and is this acceptable?	**Y**	
9.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	**Y**	
10.	**Equality Impact Assessment (EIA)**		
	Has a suitable EIA been completed?	Y	

Committee Approval (Paediatric Guidelines Group)			
If the committee is happy to approve this document, please complete the section below, date it and return it to the Policy (document) Owner			
Name of Chair	**Dr Claire Mitchell**	**Date**	**23/11/2023**
Ratification by Management Executive (if appropriate)			
If the Management Executive is happy to ratify this document, please complete the date of ratification below and advise the Policy (document) Owner			
Date: n/a			