Remitting seronegative symmetrical synovitis with pitting oedema following BNT162b2 mRNA COVID-19 vaccination

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SUMMARY
Remitting seronegative symmetrical synovitis with pitting oedema (RS3PE) is a rare inflammatory condition that occurs in older adults. Here, we report a case of an 80-year-old man with no history of rheumatic disease who presented with acute onset of bilateral hand pain, pitting oedema and synovitis after the second dose of the BNT162b2 mRNA COVID-19 vaccine. Laboratory workup revealed elevated inflammatory markers and negative autoantibodies. Significant improvement was noted with prednisolone. This is the first reported case of RS3PE in an elderly patient with no previous rheumatic disease following mRNA COVID-19 vaccination.

BACKGROUND
Since the onset of the COVID-19 pandemic, more than 3 million people have lost their lives. The most effective approach against COVID-19 includes the development and administration of safe vaccines.1 A cross-sectional study among healthcare professionals indicated that BNT162b2 mRNA COVID-19 was associated with vaccination-induced arthritis/arthritis-like in 17% of the population studied.2 Rarely vaccines can trigger a new-onset rheumatic disease; however, data regarding the SARS-CoV-2 vaccines are lacking. In the present study, we report the first case of remitting seronegative symmetrical synovitis with pitting oedema (RS3PE) induced by BNT162b2 mRNA COVID-19 vaccination in a patient with no history of rheumatic disease. Healthcare providers need to be aware of this condition induced by COVID-19 vaccine and appropriately treat it.

CASE PRESENTATION
An 80-year-old Caucasian man presented with a 2-week history of acute onset of bilateral hand swelling and pain, which was worse in the left hand and was associated with paresthesia. The symptoms began 2 days following the second dose of the BNT162b2 mRNA COVID-19 vaccine. The patient’s medical history included hypertension, hyperlipidaemia, atrial fibrillation, ischaemic cardiomyopathy, aortic valve stenosis, COPD, sleep apnoea and without any previous history of any rheumatic disorder. Physical examination revealed symmetrical pitting oedema in the dorsum of both hands and synovitis (figure 1).

INVESTIGATIONS
Laboratory investigations revealed an elevated erythrocyte sedimentation rate of 55 mm/hour (normal <20) and C reactive protein level of 120 mg/L (normal <5), with negative antinuclear antibodies rheumatoid factor and anticyclic citrullinated peptide antibodies (table 1). The full blood count, renal and liver function tests were normal. Hepatitis B and C antibodies, parovirus B19 were negative. The hand radiographs did not show any evidence of erosion or chondrocalcinosis. Chest radiograph was normal.

DIFFERENTIAL DIAGNOSIS
The differential diagnosis included crystal-induced arthritis, such as gout or calcium pyrophosphate deposition disease, but the absence of chondrocalcinosis and the persistent nature of the patient’s symptoms. An additional consideration was late-onset rheumatoid arthritis; however, the autoantibodies were negative, and the dorsal hand pitting oedema is not a classic manifestation of rheumatoid arthritis.

Given the abrupt onset of symptoms, the puffy oedematous hands and significant response to glucocorticoids, the patient was diagnosed with RS3PE.

TREATMENT
The patient took paracetamol without symptomatic relief. He was prescribed prednisolone 15 mg daily and had a remarkable improvement in his symptoms (figure 2). In addition, the patient also underwent physical therapy and used topical NSAIDs.

OUTCOME AND FOLLOW-UP
Three months following the onset of his symptoms, a trial to wean off prednisolone was unsuccessful, and the patient stills require prednisolone 5 mg daily. The repeated erythrocyte sedimentation rate
was 36 mm/hour (normal <20) and C reactive protein level of 3 mg/L (normal <5). We discussed the option to add a disease modifying antirheumatic drug, such as methotrexate, but the patient was reluctant to take the medication.

**DISCUSSION**

RS3PE is a rare rheumatic syndrome affecting elderly males and it is characterised by acute onset of symmetrical pitting oedema and small joint synovitis involving mainly the hands and, less often, the feet. The pathogenesis of RS3PE remains largely unknown. Elevated serum levels of VEGF facilitate increased capillary permeability and synovial angiogenesis, leading to subcutaneous oedema and tenosynovitis, may be an important pathogenic mechanism in RS3PE. Although most cases are idiopathic, RS3PE has been associated with other rheumatic conditions, malignancies, parvovirus infection, installation of the intravesical BCG and more recently with immunotherapies.

Proposed diagnostic criteria include the following: bilateral pitting oedema of both hands, sudden onset of polyarthritis, age over 50 years and seronegative for rheumatoid factor. Further, dramatic response to low dose glucocorticoids, and attainment of remission in most patients, support the diagnosis of RS3PE.

In our case, the patient fulfilled the criteria mentioned above and the kinetics of symptom onset (2 days after the second dose of the vaccine) strongly suggests that the RS3PE was triggered by the vaccination. A previous case series study described an 83-year-old patient with history of polymyalgia rheumatica who developed RS3PE, 7 days after the first dose of the BNT162b2 mRNA vaccine. The patient had a prompt response to treatment and resolution of his symptoms.

**References**


**Learning points**

- This case underlines that RS3PE can be induced by vaccinations such as the BNT162b2 mRNA COVID-19 vaccine.
- The administration of low dose of glucocorticoid led to a rapid and excellent symptom response.

**Patient's perspective**

‘I am a farmer, and the joint pain deeply affected my quality of life and it impacted my ability to drive my tractor. The steroid is a miracle drug’.

**Table 1** Laboratory studies

<table>
<thead>
<tr>
<th>Laboratory studies</th>
<th>Results</th>
<th>Reference range</th>
</tr>
</thead>
<tbody>
<tr>
<td>White cell count</td>
<td>8.8</td>
<td>4.0–10.0 x 10⁹/L</td>
</tr>
<tr>
<td>Haemoglobin</td>
<td>13.1</td>
<td>12.0–16.0 g/L</td>
</tr>
<tr>
<td>Platelet</td>
<td>230</td>
<td>150–350 x 10⁹/L</td>
</tr>
<tr>
<td>Sedimentation rare</td>
<td>55</td>
<td>&lt;20 mm/hour</td>
</tr>
<tr>
<td>C reactive protein</td>
<td>120</td>
<td>&lt;5 mg/L</td>
</tr>
<tr>
<td>Creatinine</td>
<td>0.9</td>
<td>0.6–1.2 mg/dL</td>
</tr>
<tr>
<td>Alanine aminotransferase</td>
<td>32</td>
<td>7–55 U/L</td>
</tr>
<tr>
<td>Aspartate aminotransferase</td>
<td>27</td>
<td>8–48 U/L</td>
</tr>
<tr>
<td>Alkaline phosphatase</td>
<td>79</td>
<td>45–115 U/L</td>
</tr>
<tr>
<td>Parvovirus B¹ igM</td>
<td>Negative</td>
<td>Negative</td>
</tr>
<tr>
<td>Parvovirus B¹ igG</td>
<td>Negative</td>
<td>Negative</td>
</tr>
<tr>
<td>Antinuclear antibodies</td>
<td>Negative</td>
<td>Negative</td>
</tr>
<tr>
<td>Rheumatoid factor</td>
<td>10</td>
<td>&lt;14 IU/mL</td>
</tr>
<tr>
<td>Cyclic citrullinated peptide</td>
<td>6</td>
<td>&lt;20 IU/mL</td>
</tr>
</tbody>
</table>

**Contributors** Both authors, KP and MC had substantial contribution to the conception or design of the work; the acquisition, analysis or interpretation of data for the work; and drafted the work and revised it critically for important intellectual content; and final approval of the version to be published; and agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

**Funding** The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

**Competing interests** None declared.

**Patient consent for publication** Obtained.

**Provenance and peer review** Not commissioned; externally peer reviewed.

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**REFERENCES**
