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Chronic polyarthritis with diarrhoea, oedema and skin lesions

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DESCRIPTION

A 20-year-old man presented to our outpatient with a history of diarrhoea since the last 40 days. Stools were 3–4 times/day, watery and not containing mucous or blood. Patient had arthritis involving hips, knees and shoulders intermittently for 6 years which flared up again after his recent episodes of diarrhoea. He also observed skin lesions that were first noted on the scalp about 5 years ago and were now present on trunk, abdomen, thighs and soles since the last 3 months. Patient had recently also noted that he had puffiness around his eyes and swollen feet. He did not have any diagnosis or specific treatment in the past.

On physical examination, he appeared cachectic and had periorbital puffiness and pedal oedema. He had fixed flexion deformities in both knees (figure 1), along with restricted motion and swelling in both hips and right shoulder. He had skin lesions which were multiple, discrete to confluent well-defined scaly plaques with heaped up crusting present on the trunk and limbs (figures 2–4). There were

Figure 1 Fixed flexion deformities of both knees.

Figure 2 Keratoderma blenorrhagicum.

Figure 3 Skin lesion on trunk.

Figure 4 Skin lesion on limb.

Figure 5 Circinate balanitis.

Figure 6 Acanthosis and elongation of rete ridges and diminution of granular layer.

Figure 7 Spongiiform pustule beneath the para keratotic cornified layer.

Figure 8 Renal biopsy suggestive of amyloidosis.

well-defined glazed erythematous patches present on the glans penis and prepuce in a circinate pattern (figure 5). Slit lamp examination of the eyes was normal.

His investigations revealed hypoalbuminemia (serum albumin 1.5 g/dl) 4+ albuminuria and 5–6 pus cells. USG abdomen showed enlarged kidneys and cystitis. On skin biopsy, histopathological findings were consistent with spongiiform pustule of Reiter's disease (figures 6 and 7). Renal biopsy revealed positive congo red stain confirming amyloid involvement of kidney (figure 8). Patient was offered antibiotics imidazoles and quinolones in standard doses as well as antisecretory agents like rabeprazole for diarrhoea. Non-steroidal anti-inflammatory drugs, methotrexate and physiotherapy for arthritis and symptomatic treatment for skin lesions. He gradually started improving. His skin lesions started regressing, his diarrhoea subsided and his joint pains started decreasing.

DISCUSSION

Our patient had predominant symptoms of severe deforming chronic polyarthritis with relatively recent onset of psoriasisiform skin lesions that had a striking resemblance

macroscopically and microscopically to keratoderma blenorrhagicum. Reactive arthritis previously termed Reiter's syndrome has a reported incidence of arthritis around 50–60% and keratoderma blenorrhagicum to the tune of 10%.¹

Our patient didn't have any history of preceding urethritis but had pus cells in urine and ultrasound suggestive of cystitis that could suggest presence of urethral inflammation earlier and this is possibly consistent with the diagnostic criteria proposed for reactive arthritis.²

Our patient had nephrotic syndrome due to secondary amyloidosis that was again a result of the chronic inflammation associated with his arthritis. This association though rare has been reported earlier in the literature.³

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Competing interests None.

Patient consent Obtained.

REFERENCES

1. **Prakash S**, Mehra NK, Bhargava S, *et al*. Reiter's disease in northern India. A clinical and immunogenetic study. *Rheumatol Int* 1983;**3**:101–4.
2. **Kingsley G**, Sieper J. Third International Workshop on Reactive Arthritis. 23–26 September 1995, Berlin, Germany. Report and abstracts. *Ann Rheum Dis* 1996;**55**:564–84.
3. **Sayal SK**, Sanghi S, Prasad GK. Reiter's syndrome with secondary amyloidosis. *Indian J Dermatol* 2001;**46**:106–8.

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