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.
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 spongiform 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 racecadotril 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 psoriasiform 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.

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