Keratoderma blenorrhagica

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DESCRIPTION

A 15-year-old boy presented with hyperkeratotic papulosquamous skin lesions all over the body associated with fever of 20 days duration (figure 1). No obvious lesions were seen on palms or soles (figure 2). Medical history included backache with asymmetrical oligoarticular arthritis, enthesitis and sacroiliitis progressing over last 4 years. Onychodystrophy affected both the fingernails and toenails. There was no history of urethritis, conjunctivitis and oral or glans lesions. Total leucocyte count, platelet count, erythrocyte sedimentation rate and haemoglobin were 12 400/mm³, 4.5 × 10⁵/mm³, 120 mm/h and 7.9 g/dl, respectively. Urine examination was normal. Tests for HIV, hepatitis B and syphilis were negative. The diagnosis of pustular psoriasis with arthritis was made. Patient showed marked improvement at 1 week with treatment by topical clobetasol propionate and salicylic acid ointments, oral prednisolone (10 mg daily), oral non-steroidal anti-inflammatory drugs (NSAIDs) (naproxen 250 mg twice daily), oral proton pump inhibitor (omeprazole 20 mg/day), oral methotrexate (10 mg/week) and oral folic acid (5 mg/week). This bridging low-dose steroid therapy was started as an adjunct to NSAIDs (for better control of arthritis) along with proton pump inhibitors to prevent gastrointestinal complications. In a patient with joint involvement suggestive of juvenile idiopathic arthritis (enthesitis-related arthritis), the late appearance of keratoderma blenorrhagica should point to the diagnosis of psoriatic arthritis.

Figure 1 Hyperkeratotic papulosquamous lesions on (A) front and (B) back of the body.

Figure 2 No obvious lesions on palms and soles.

Learning points

- ▶ In children suffering from arthritis and keratoderma blenorrhagica, reactive arthritis and psoriatic arthritis should be kept as differential diagnoses. In a case of psoriatic arthritis, usually psoriasis antedates arthritis by years; however, it may follow arthritis in some cases.
- ▶ One should look for the presence of urethritis, conjunctivitis, oral lesions, circinate balanitis, predominance of keratoderma lesions on soles and palms, evidence of gastrointestinal or urogenital infection to differentiate between reactive arthritis and psoriatic arthritis as clinical and histological appearance of keratoderma blenorrhagica is similar in both the conditions.
- ▶ Treatment of psoriatic arthritis should be planned according to severity of skin lesions as well as arthritis. non-steroidal anti-inflammatory drugs have been reported to flare up skin lesions of psoriasis; however, it does not seem to be a major clinical issue.^{1 2}

Competing interests None.

Patient consent Obtained.

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