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KERATODERMA BLENORRHAGICUM IN A PATIENT WITH REITER SYNDROME

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ABSTRACT

Reiter syndrome is a systemic disorder, originally defined as a triad of arthritis, urethritis and conjunctivitis. This symptoms complex usually follows an episode of either urethritis or dysentery. Skin and mucosal involvement is observed in about 10% of the cases. We present a case of Reiter's syndrome in a 55-year-old man who developed the typical skin lesions - keratoderma blenorrhagicum. The disease started with a severe asymmetric oligoarthritis a month after the patient had urethritis. Two weeks after the onset of the arthritis red patches on the palms and plants appeared, which transformed quickly in harder and elevated plaques.

Key words: Syndroma Reiter, Keratoderma blenorrhagicum

INTRODUCTION

Reiter syndrome, also known as reactive arthritis, is a disease in which a non-suppurative polyarthritis lasting more than one month follows closely a lower urogenital or enteric infection. Classically it includes the triad arthritis, urethritis, and conjunctivitis. Approximately 80% of patients are positive for the histocompatibility antigen called human leukocyte antigen (HLA)-B27; therefore, Reiter syndrome is strongly associated with HLA-B27. The disease is classified as type of seronegative spondyloarthropathy. Dermatologic manifestations are common, including keratoderma blenorrhagicum, circinate balanitis, nail changes and oral lesions.

CASE REPORT

History

We present a 55-year-old man admitted at a rheumatology department regarding a severe asymmetric oligoarthritis. The complaints appeared a month after outpatient was treated for urethritis. Two weeks after the onset of the acute arthritis the patient developed red patches on the palms and soles, which transformed quickly in harder and elevated plaques. The condition required a dermatological consultation. There were no data of internal diseases, enteral or respiratory infections. Family history was clear.

Physical examination

Physical examination in a dermatologic department a week after the appearance of the skin lesions revealed erythematous, confluent, hyperkeratotic papules and pseudopustules on the palms, soles, fingers and toes, and diffuse yellowish hyperkeratotic plaques on the soles (fig 1). Swelling and restricted movement of the left ankle and of the right wrist were observed (fig 2). There were no mucosal lesions, nail changes and other pathology from the physical examination including eye involvement.

Lab and imaging studies, histopathological findings

The laboratory tests showed the following abnormalities: leukocytosis, elevated ESR and CRP, positive Chlamidia trachomatis antibodies (IgA (+) > 1:8; IgG (+) - 1:64). E. faecalis was isolated from the urine culture. RF was negative and the HLA-B27 positive. HIV was negative.

Hand and wrist X-ray did not show any abnormal findings. Abdominal sonography revealed hepatic steatosis and calculus in the right kidney.

Histopathology examination of the skin biopsy showed psoriasiform changes - hyper- and parakeratosis, acanthosis, elongation of the rete ridges in the epidermis and mixed inflammatory infiltrate in the upper dermis.

Diagnosis

The diagnosis Reiter syndrome was made according to the typical history, clinical symptoms and the findings of the above-mentioned laboratory tests. In this context the described skin lesions were interpreted as keratoderma blenorrhagicum.

Differential diagnosis

Differential diagnosis of the articular involvement includes other seronegative arthritides - psoriatic arthritis, ankylosing spondylitis, gonococcal arthritis, rheumatoid arthritis. Skin involvement must be differentiated from pustular psoriasis, erythema multiforme, hyperkeratotic eczema of the palms and soles.