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Multiple arthritis: three in one

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DESCRIPTION

The authors describe a first report of three types of arthritis in the same patient: rheumatoid arthritis, psoriatic arthritis and gouty arthritis. A male patient, 56-year-old, Caucasian, with a known history of essential hypertension and gout was presented. The diagnosis of gout was made by isolation of monosodium urate crystals in synovial liquid when he was 45-years-old. He was diagnosed with psoriasis when he was 32-years-old, initially with extensive cutaneous and nail involvement (scalp, trunk and limbs). Associated with psoriatic changes, he had thickening of both legs skin with multiple nodules of hard consistency (figure 1). The patient presented with joint complaints that included inflammatory, bilateral and asymmetric polyarthritis of the wrists, metacarpal-phalangeal joints and conditioning articular deformity (figure 2). He also had tophi in forearms, hands, feet and ears (figure 3). Blood tests performed showed a serum uric acid level of 4.5 mg/dl, elevated inflammatory markers (erythrocyte sedimentation rate 56 mm/h and C reactive protein 2.8 mg/dl), positive antinuclear antibody titres of 1/320, positive rheumatoid factor of 53 and anticitrullinated protein antibody weakly positive – 25 U/ml. Hands radiography revealed exuberant joint destruction predominantly in carpal and proximal interphalangeal joints, juxta-articular new bone formation and enthesitis (figure 4). A biopsy of a cutaneous nodule was compatible with a rheumatoid nodule.

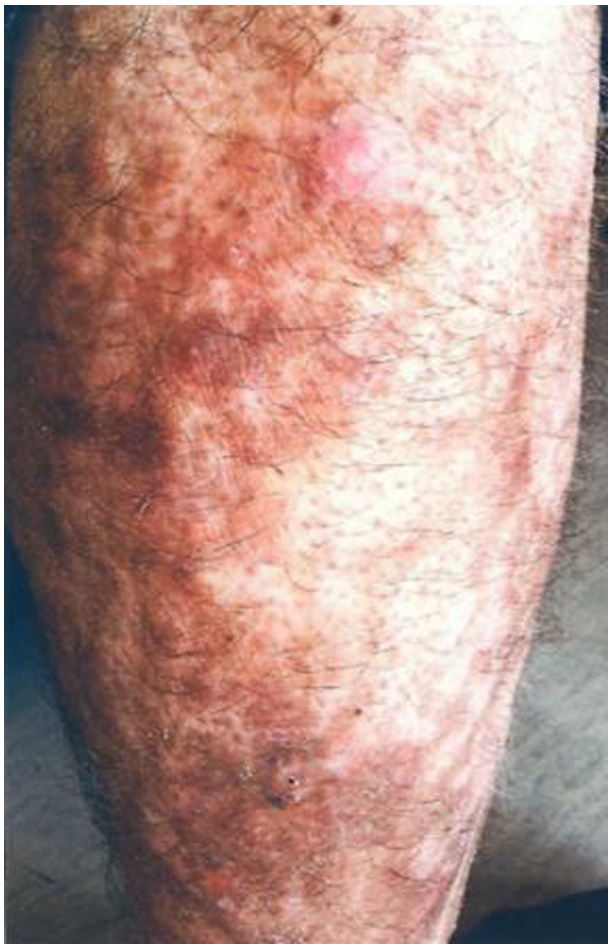

Figure 1 Rheumatoid nodules; thickening of both legs skin with multiple nodules of hard consistency.

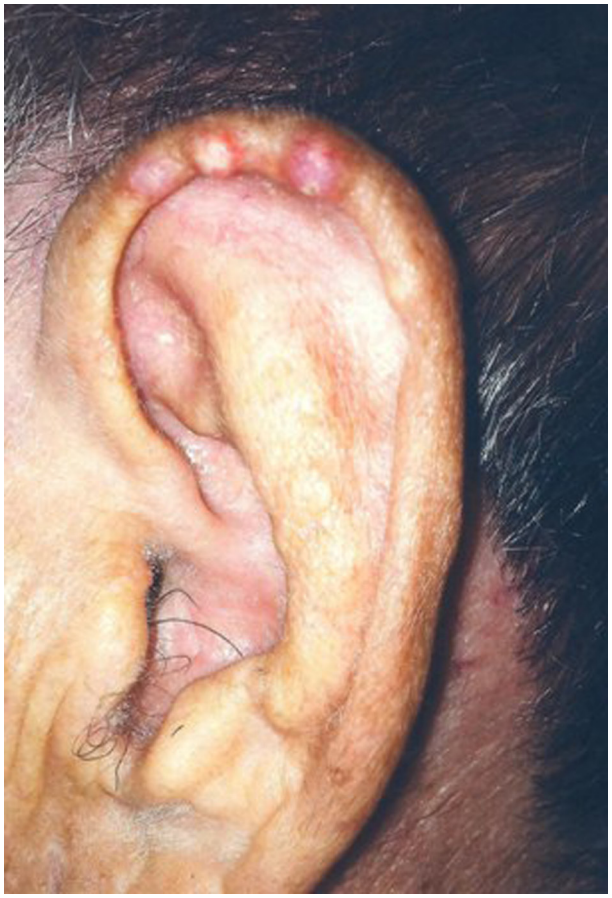

Figure 3 Multiple tophi in the curved ridge along the edge of the outer ear.

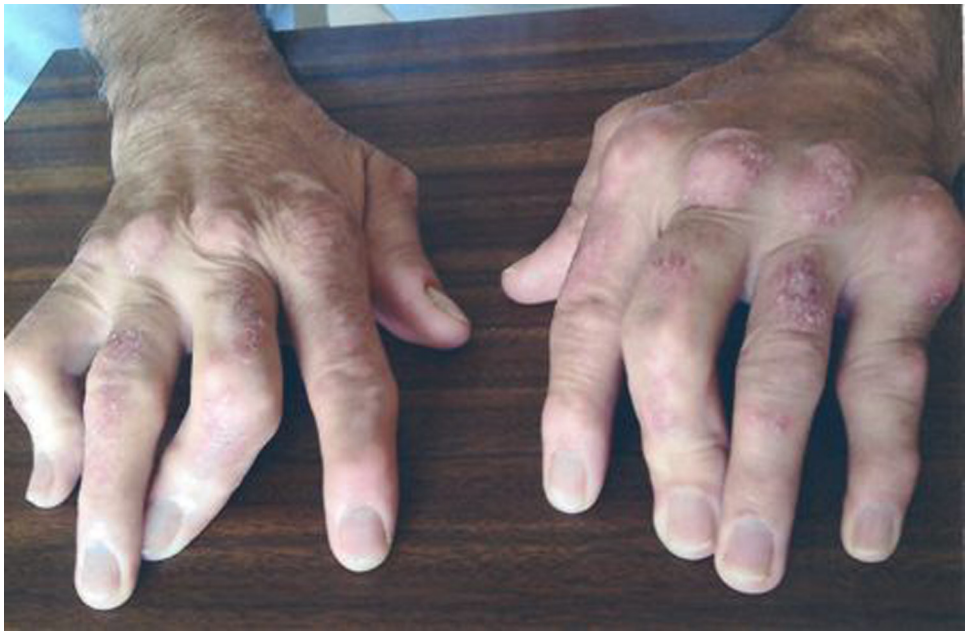

Figure 2 Exuberant articular deformity of both hands; multiple juxta-articular nodules in metacarpophalangeal joints.

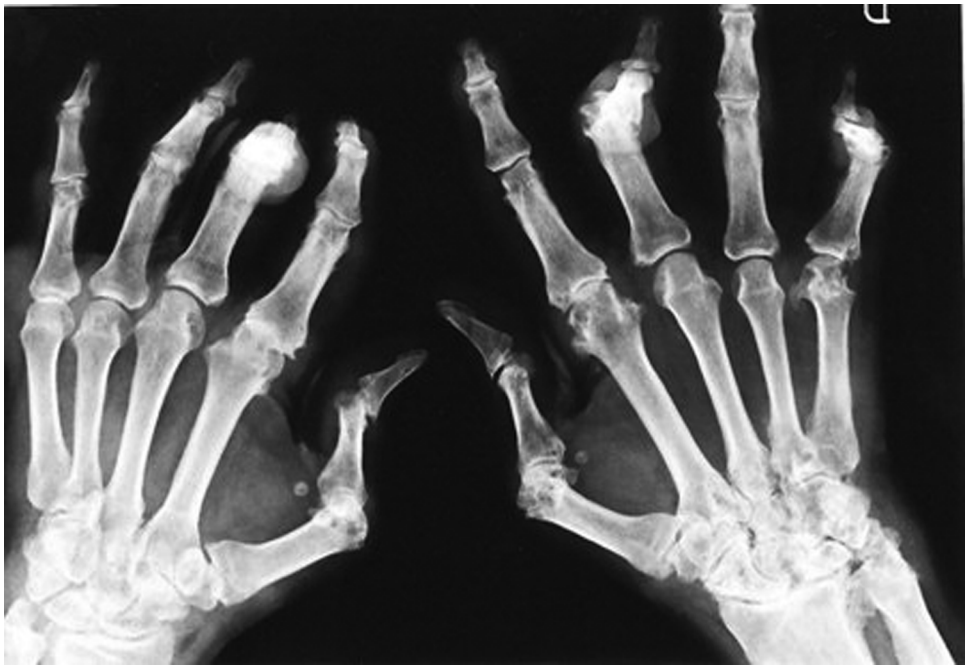

Figure 4 Hands radiography revealing exuberant joint destruction in carpal and proximal interphalangeal joints, juxta-articular new bone formation and enthesitis.

Given these data, beyond gouty arthritis, it was possible to include this patient in another two distinct autoimmune entities, according to the criteria of current classification – psoriatic arthritis (PA) (CASPAR criteria 2006) and rheumatoid arthritis (RA) (ACR criteria/EULAR 2010).[1 2] The classification in overlap syndromes and the distinction between primary and secondary diseases reveal the immunological common basis of the autoimmune diseases (ADs). Clinically, it is useful to define overlap syndromes to clarify prognosis and facilitate disease management.[3] Certain drugs (particularly antitumour necrosis factor α) can successfully treat an AD (for example RA or PA) and paradoxically exacerbate others, including psoriasis (for which conditions are known to be effective).[4] In this context the early identification and classification of an overlap AD is of the utmost importance.

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Learning points

- The presence of more than one type of arthritis can have a prognostic significance, conditioning, in some cases a more aggressive clinical course.
- The coexistence of ADs should be identified early, given that the therapeutic approach may be more complex, considering that some of the drugs used to treat an AD can be unexpectedly harmful in another AD.

Competing interests None.

Patient consent Obtained.

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