SELF - ASSESSMENT PROGRAMME

A 33 year old accountant presented with the history of extensive thick scaly plaques of 8 years' duration as well as pain and swelling of large and small joints associated with fever for 4½ months. The skin lesions started as papules on the trunk and had gradually transformed into scaly plaques with pustulation at the edge. The lesions had subsequently spread to other parts of the body. The patient used to be relatively well in summer and was completely free of skin lesions for 2 years at one stage.

Joint pains and swelling associated with fever had set in 4½ months before the hospital visit; starting from the right ankle followed successively by the right knee, left ankle, left knee and the back which had become painful and stiff. There were circinate lesions on the glans penis. Palms and soles were free. There was no history of premarital or extramarital exposure, urethral discharge or dysentry.

Patient had been treated with systemic corticosteroids and other anti - inflammatory agents without relief either in the skin lesions or joint pains.

(1) Which of the following diagnoses is likely ?

A. Psoriasis with arthritis

B. Reiter's syndrome

(2) Which of the following investigations will be helpful ?

A. Skin biopsy

B. X - ray examination of the joints

C. HLA antigen typing

D. Urethral scrapings for Chlamydia culture.

Skin biopsy was compatible with pustular psoriasis; HLA B 27 was detected in the serum; urethral scrapings did not yield any chlamydia.

(3) Which of the following treatment would be helpful ?

A. Systemic steroids

B. Methotrexate

C. Non-steroidal anti-inflammatory agents

D. Tetracyclines

(4) What is the prognosis of this patient ?

A. Relapsing and remitting

B. Self - limiting

C. Progressive but benign

D. Fatal

ANSWERS

1. From the total clinical profile of this patient, a diagnosis of psoriasis with arthropathy would seem most likely. Admittedly this patient had some features that would fit in with Reiter's disease; but a history of skin lesions for 8 years preceding the onset of joint pain would weigh strongly against a diagnosis of Reiter's disease. Absence of urethritis or ocular lesions would be additional points against a diagnosis of Reiter's disease.

2. None of the investigations listed is going to conclusively prove the diagnosis one way or other. Were Chlamydia isolated from the urethral scrapings it would have favoured a diagnosis of Reiter's disease. Association of HLA - B_{27} with Reiter's disease has frequently been reported[1], but so is the case when psoriasis has associated arthropathy involving the spine[2,3]. X - ray of the spine was compatible with ankylosing spondylitis but shoulders and knees did not show any osseous abnormalities. Skin biopsy was compatible with a diagnosis of pustular psoriasis - a picture not infrequently seen in Reiter's skin lesions.

3. Non - steroidal anti - inflammatory agents should have been given an initial trial. In view, however, of the severity of the disease patient was given corticosteroids and methotrexate with some relief. Tetracyclines were not indicated in the absence of any evidence of urethritis.

4. The patient is likely to continue with relapses and remissions, though complete recovery is unlikely even under steroid and anti - metabolite treatment.

Comment

The present patient posed a difficult diagnostic problem of differentiation between psoriasis with arthropathy and Reiter's disease. Were it not for an 8 year history of preceding skin lesions, the differentiation could have become well nigh impossible. Absence of the history of an overt urethritis and lack of isolation of Chlamydia would tend to weigh against the diagnosis of Reiter's disease. Apart from that the cutaneous lesions and the joint involvement including the spinal involvement could occur in either of these two conditions. One wonders if these two diseases are not so closely interlinked as to make differentiation between these in certain situations purely academic. The relationship between psoriasis and Reiter's disease perhaps merits further study[4,5].

References

1. Morris RI, Metzger AH, Bluestone R et al: HLA-W_{27}-a clue to the diagnosis and pathogenesis of Reiter's syndrome. N Engl J Med 290: 554-556, 1974.

2. Metzger AL, Morris RI, Bluestone R et al: HLA W_{27} in psoriatic arthropathy. Arthritis Rheum 18: 111-115, 1975.

3. Brewerton DA, Caffrey M, Nicholls A et al: HL-A_{27} and arthropathies associated with ulcerative colitis and psoriasis. 1: 956-957, 1974.

4. Wright V and Reed WB: The link between Reiter's syndrome and Psoriatic arthritis. Ann Rheum Dis 23: 12-20, 1964.

5. Lawrence JS: Family survey of Reiter's disease. Brit J Vener Dis 50: 140-145, 1974.

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AN APPEAL

Dear Colleague

I am addressing this brief appeal to you requesting you to become a member of the International Society of Tropical Dermatology which is the chief organizaion looking after Dermatology in the Tropics and Tropical Dermatology which indeed are our problems. This entitles all members to receive the International Journal of Dermatology which has, as you might already know, excellent review and other articles invaluable for Continuing Medical Education. I would be happy to send you the application forms and sponsor your membership. I look forward to hear from you,

Yours sincerely,
L. K. Bhutani, M.D.,
President, I.A.D.V.L.