

Is it a Case of Reactive Arthritis?

To the Director: Reactive arthritis (ReA) is a disease that is typically presented by young males in which a suspected or demonstrated microorganism produces an infection (gastrointestinal or urogenital) that, after a short latency period, is followed by a heterogeneous clinical process which is immunologically mediated, that has as a cardinal manifestation the asymmetrical, additive, sudden-onset inflammation of joints (oligoarthritis or polyarthritis), mainly in lower extremities.¹

We present the case of a 42 year old male without any important history that is seen due to recurring episodes of migrating asymmetric oligoarthritis of the knee and ankle, self-limited in nature and without any evidence of mucocutaneous lesions and with no sequel, preceded in the past few months by urinary symptoms. Upon examination there is arthritis without any limitation in the abovementioned joints (arthrocentesis was not carried out). Laboratory showed elevation of acute phase reactants and radiologically he presented enthesopathy in the posterior calcaneum. Four months after the start of these symptoms the patient presents terminal hematuria with blood clots, pneumaturia without fecaluria and dysuria without fever or abdominal pain. Urine culture shows *Escherichia coli*. On simple radiographs there is a well defined, air-filled image in the area of the bladder. After carrying out a barium enema a colon-bladder fistula is found in the context of diverticulosis (confirmed by histopathology) that originated the image and, secondarily, the rest of the clinical problem.

Is there any relationship between the arthritis and the rest of the symptoms that the patient presented? Probably yes.

Can we call it ReA? Also, probably yes. In favor of this diagnosis we would have the characteristic arthropathic pattern as was the clinical picture that preceded it. Nonetheless, we mustn't underestimate the fact that in our country the venereal form of the disease is less frequent than the dysenteric form,² and that dysuria is a very unspecific symptom,³ present in multiple urologic processes, at the same time that *E coli* is not one of the microorganisms that has a causal relationship with this entity, though it is also true that in a large percentage of cases the unleashing microorganism cannot be identified.

On the other hand, the presence of the fistula forces us to make a differential diagnosis with an arthritis related to inflammatory intestinal disease,⁴ even though there are no specific symptoms of this disease. An HLA-B27 could be helpful to increase the force of the relationship, in the same way that a pathologic sacroiliac joint x-ray might be, without forgetting that previous is not a pathognomonic findings nor is the latter present in short term processes. In this manner, the question remains unanswered.

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