Dear Editor:

We read in interest Espinosa and García-Valladares’s article entitled ‘Of Bugs and joints’.1 We agree that the epidemiology of reactive arthritis (ReA) is difficult to determine, especially in the absence of any internationally validated diagnostic criteria or guidelines. Whilst the clinical features of a ReA secondary to a sexually transmitted infection (STI) are indistinguishable from those caused by an enteric organism, the management could potentially be different. As was discussed, there is evidence that chlamydia induced ReA may benefit from a prolonged course of combination antibiotics.2,3

We wondered how good clinicians were at identifying the responsible organism? Is sexually acquired ReA (SARA), an under-recognised diagnosis, perhaps due to a reluctance from the rheumatologist to discuss and investigate such matters? We conducted an audit to establish whether patients with suspected ReA were screened for STIs. The first clinic letter of all new referrals <30 years of age to both the general rheumatology and the early arthritis clinics in the preceding 6 months was reviewed. Out of 244 referrals, 42 patients were considered to potentially have ReA and of these only 24% (10/42) were screened for an STI (all negative).

It is not reassuring that no STIs were detected because over three quarters of patients were not tested. STIs are common in the young sexually active population, with chlamydia affecting 5–10% of those under 24 years, and in females especially it can be completely asymptomatic.4 If a patient denies any ‘promiscuous activities’ or appears to be in a stable relationship should they still be screened?

References


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In summary, although induced LE is a rare adverse event seen during anti-TNF treatment, it is important to have in mind because of its varied clinical expression, especially on the skin, and to identify those cases that actually are due to this entity, given the trend that may lead to overdiagnosis.

References


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