Clinical image description

A 55-year-old male presented with inflammatory polyarthritis of one month duration. He had history of inflammatory low back pain for 25 years, and intermittent inflammatory arthritis of various joints for 12 years, with each episode occurring every two years, involving one or two joints and lasting for about three weeks. He was using intermittent analgesics for back pain, and alternative therapy during arthritis episodes. He underwent left hip replacement for osteoarthritis in 2012, and right total hip replacement for femur neck fracture in 2015. In 2019 zoledronic acid was started for osteoporosis. On examination bilateral wrist and left elbow were tender and swollen. Bilateral mid foot joints and all Metatarsophalangeal (MTP) were also tender. All cervical and lumbar movements were restricted. Serum uric acid was normal, erythrocyte sedimentation rate was elevated and radiograph was suggestive of ankylosing spondylitis (AS) (Figure 1). Considering peripheral arthritis of spondyloarthritis, indomethacin and sulfasalazine were initiated. Ten days later he had acute onset excruciating pain at right first MTP joint, which was warm, tender and swollen with overlying erythema (Figure 2). Septic arthritis was ruled out as leucocyte count was normal and patient was afebrile. Though crystals were absent in synovial fluid from left elbow, a diagnosis of polyarticular gout with AS was made on clinical grounds. Dramatic response was seen with five days of 30 mg oral prednisolone and colchicine.

Although the coexistence of gout and AS is thought to be rare and only few cases are reported, results from a recent case control study by Gonen et al [1], suggested that prevalence of gout in AS is not less than general population. Thus, physicians should keep gout in mind as a possible diagnosis when managing peripheral arthritis in AS patients, as treatment strategies are different for both the diseases.

References