

A Case Report of Juvenile Male with Inflammatory Bowel Disease with Grade I Hemorrhoids with Enteropathic Arthritis.

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Abstract: Enteropathic arthritis (EA) is a spondyloarthritis (SpA) which occurs in patients with inflammatory bowel diseases (IBDs) and other gastrointestinal diseases. Diagnosis is generally established on the medical history and physical examination. It was, generally, made according to the European Spondyloarthropathy Study Group (ESSG) criteria. Rheumatic manifestations are the most frequent extraintestinal findings of IBD with a prevalence between 17% and 39%.

I. Introduction

Enteropathic arthritis or enteroarthritis (EA) is a spondyloarthritis (SpA) which occurs in patients with inflammatory bowel diseases (IBDs) and other gastrointestinal diseases, such as Whipple's disease (WD), celiac disease (CD), and intestinal bypass surgery [1, 2].

Bargen et al. [3], in 1929, and Hench [4], in 1935, described a peripheral arthritis involvement in patients with IBD and also reported the arthritis tendency to flare with exacerbation of the colitis and to recede with the remission of bowel symptoms. Finally, in 1964, the American Rheumatism Association classified arthritis associated with IBD as independent clinical form [5], and, later, Wright and Moll included enteroarthritis definitively among SpA group [6].

II. Case Report

We report a case of a 17 year old male who presented with the chief complaints of: Low back ache, Morning stiffness, Pain in the gluteal region, Joint deformities of both knees and small joints of both hands, Recurrent abdominal pain, Loose stools. The complaints had been present for the last 3 months. The patient was a non-smoker and had no history of any other chronic illnesses. The family history was non-remarkable. There was no history of intake of any drugs.

On examination the patient had:

Swelling of the Left 1st metacarpophalangeal joint (MCP) Flexion deformity of bilateral 2nd and 3rd distal interphalangeal joints (DIP) Flexion deformity of Left Proximal (PIP) and Distal Interphalangeal (DIP) Joints Valgus deformity of left elbow Swelling and Valgus deformity of both knee joints. General and systemic examinations were unremarkable. Blood investigations were suggestive of microcytic hypochromic anemia with neutrophilic leukocytosis. Renal and Liver profile were normal. Blood culture did not reveal any pathogens. Urine routine was normal. RA factor and Anti-CCP were negative and CRP was strongly positive. Colonoscopic examination was reported as Hemorrhoids Grade-I. X Ray imaging of Sacroiliac joints revealed Sacroiliitis of the right sacroiliac joint. Patient's immunologic profile showed positivity for HLA-B27.

III. Discussion

The enteropathic arthropathies are a group of rheumatologic conditions that share a link to gastrointestinal (GI) pathology. However, the term typically refers to the inflammatory spondyloarthropathies associated with inflammatory bowel disease (IBD) and to reactive arthritis caused by bacterial (eg, Shigella, Salmonella, Campylobacter, Yersinia, Clostridium difficile) and parasitic (eg, Strongyloides stercoralis, Giardia lamblia, Ascaris lumbricoides, Cryptosporidium species) infections.

Rheumatic manifestations are the most frequent extraintestinal manifestation in IBD patients with a prevalence ranging between 17% and 39% [7, 8]. Interestingly, articular alterations can be diagnosed before, simultaneously, or after the diagnosis of IBD. The joint involvement observed in IBD is usually classified in two subsets: axial (including sacroiliitis with or without spondylitis) and peripheral. The axial involvement is found to be present in 2%–16% of IBD patients, with a higher prevalence in CD patients than in UC ones. Moreover,

the prevalence of sacroiliitis (asymptomatic and symptomatic) is between 12% and 20% and association with HLA-B27 ranged from 3.9% to 18.9%. Recently, some studies showed that the prevalence of axial joint involvement was higher than those reported previously, as already described by Scarpa et al. in 1992 [9]. In fact, in these studies, based on the ESSG criteria for SpA [10], the authors detected a frequency ranging between 10%–25% for spondylitis and 30%–36% for sacroiliitis [11,12,13].

The peripheral involvement is a common complication in both CD and UC and its prevalence has been reported in a wide range (0.4%–34.6%) of patients with IBD. It is reported to be more frequent in CD than UC (20% and 10%, resp.) and it predominantly affects the joints of the lower limbs. Women show more frequently a peripheral joint involvement, whereas men tend to have an axial involvement [14, 15]. In our case the patient had findings suggestive of both axial and appendicular skeleton involvement in association with gastrointestinal symptoms. The diagnosis of Enteropathic arthritis was made according to European Spondyloarthropathy Study Group (ESSG) criteria and confirmed with X ray imaging of sacroiliac joints, Immunological profile and IBD on the basis of biopsy.

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