Case Report

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A Case of Reiters Syndrome in a Young Patient Presenting to the ED

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Abstract

Introduction: In 1916, Hans Reiter described the classic triad of arthritis, nongonococcal urethritis, and conjunctivitis (Reiters syndrome) in a Prussian soldier with diarrhea, during the first world war.

Reiter's syndrome is defined as a complication of non gonococcal urethritis in which there is arthritis (mainly knees, ankles and feet), conjunctivitis, rashes, cardiac and neurological problems.

Other features include; iritis, keratoderma blenorrhagicum, circinate balanitis, plantar fasciitis, Achilles tendonitis, aortic incompetence.

RS is triggered by bacterial infection that enters via mucosal surfaces usually, (but not always) associated with human leukocyte antigen (HLA)-B27.

Nongonococcal venereal disease (most often *Chlamydia*) and infectious diarrhea usually precede reiter's syndrome. These include infections with: *Shigella flexneri*, Shigella dysenteriae, *Salmonella typhimurium, Salmonella enteritidis, Streptococcus viridans, Mycoplasma pneumonia, Cyclospora, Chlamydia trachomatis, Yersinia enterocolitica, and Yersinia pseudotuberculosis. Campylobacter jejuni . Others include Chlamydia pneumoniæ and Ureaplasma urealiticum.*

Keywords: Urethritis; Tendonitis; Conjunctivitis; Morning Stiffness.

Case Report

A 18 years old male came to ER with H/O lower backache for 7 days followed by involvement of left elbow and right knee along with early morning stiffness with pain and swelling. there was also h/o dysuria/burning micturition. Patient was febrile for 2 days with temperature of upto 101f. patient also complained of redness of eyes, not associated with foreign body sensation, pain or photophobia. There was no h/o rash or orogenital ulcers.

There was no urethral discharge, hematuria or genital ulcer. There was associated discharging of both eyes with redness but no chest symptoms. He had not been transfused with blood in the past and there was history of multiple sexual partners.

On Examination

PULSE-90/M

BP-110/70 MMHG

RR-15/M

RBS-135MG/DL

SPO2-97% IN RA

TEMP- AFEBRILE

HEENT- Bilaterally congested conjunctiva with perilimbal erythema, No pallor , no cyanosis and no JVD

CHEST- b/l vbs and no added sound and no crepitus.

CVS- S1 S2 audible and added sound and no murmur and no pericardial friction rub.

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CNS- GCS15/15, normal higher mental function, no FND and no Neck rigidity and normal motor and sensory examination.

ABDOMEN- soft and no organomegaly and no guarding and no rigidity and normal bowel sound and no pulsatile abdominal mass.

EXTREMITY- Swelling and twnderness noted over left elbow and right knee. Painful active and passive flexion at b/l hip and lower back.

Features suggestive of cardiovascular, nervous and pulmonary involvement were not present in the patient. Such dermatologic manifestations as balanitis circinata, keratoderma, nail changes (onycholysis, ridging and hyperkeratosis) and superficial oral ulcers were absent in the case presented.

Labs Revealed

Tlc 12100, esr 104 mm/hr, crp 28mg/dlchlamidia trachomatis igm negative urine r/m s/o rbc 2-4, leukocytes 10-12.

Patient was managed with a single dose of steroid, nsaids and antibiotics .

Long term follow - up studies suggest that some joint symptoms persist in 30 to 60% of patients with RS. Recurrences of the acute syndrome are common, and as many as 25% cases evolve into chronic illness leading to disability which may make the patient unable to work or forced to change occupation

After 2 days of hospitalisation patient was discharged on a short course of steroid, oral antibiotic and nsaid with advise to follow up in opd.

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