Conférence laurentienne de rhumatologie
Laurentian Conference of Rheumatology

Abstract #: 2403

Category: Présentation de cas clinique / Clinical case presentation
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Title: **Occult Pan-Aortitis in a Patient with Reactive Arthritis**

Objective(s): To review a rare manifestation of reactive arthritis. To stimulate reflection in clinicians presented with similar scenarios.

Method(s): A 62-year-old man was followed for chronic reactive arthritis at a community hospital. He initially presented with inflammatory oligoarthritis, dactylitis and acute anterior uveitis after PCR confirmed chlamydia infection. He did not have inflammatory back pain, psoriasis or inflammatory bowel disease. His disease was controlled on sulfasalazine 500 mg BID and naproxen, though it was discontinued against medical advice after approximately 1 year. Approximately 5 months later, on routine laboratory testing, he developed an unexplained and persistent elevation in his C-reactive protein to 29 mg/L. There were no signs of infection or active rheumatologic disease. Soon afterwards, the patient developed a gradual onset of self-limited retrosternal chest pain while he was out of the country. Upon returning, he was found to have bilateral 2nd toe dactylitis and was reinitiated on sulfasalazine. Then, 2 months later, despite significant improvement in his dactylitis, he developed fatigue, pleuritic chest pain, normocytic anemia and his CRP rose to 125 mg/L. A chest x-ray was performed and was notable for new cardiomegaly. The patient was sent to the emergency room. An initial echocardiogram, and later cardiac MRI showed new aortic regurgitation with associated 50 mm aortic root aneurism and no myocardial edema. A PET scan demonstrated diffuse uptake throughout the thoracic and abdominal aorta, as well as in multiple articular locations (including SI joints). All other investigations for infectious or inflammatory causes of aortitis, including temporal artery ultrasound were negative. He was initiated on high dose prednisone and switched from sulfasalazine to methotrexate. On most recent follow-up the patient is improving clinically and biochemically on tapering steroids.

Result(s): Aortitis and aortic valvopathy are rare, but well-described manifestations of ankylosing spondylitis (1), but scarcely described in reactive arthritis. Brown et al. identified 49 cases of aortic insufficiency attributable to reactive arthritis (2), of which 10 identify an associated aortitis (3-5). However, most reports are of poor quality as they were published prior to modern diagnostic modalities and classification methods. Cases of abdominal aortitis (6) have also been described. There is no consensus for the diagnostic approach or management of these patients. To the best of our knowledge, this is the first case documenting pan-aortitis attributable to reactive arthritis.

Conclusion(s): Clinicians should be aware of aortitis as a potential cause of unexplained biochemical inflammation or chest pain in reactive arthritis.