CORRESPONDENCE

Commentary: A rare co-occurrence of anti CCP-positive rheumatoid arthritis with sacroiliitis

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A commentary on
A rare co-occurrence of anti CCP-positive rheumatoid arthritis with sacroiliitis *by Haridas V, Haridas K. IJRCI. 2019;7(1):CS1*

Dear editor,

I have read the case report titled, 'A rare co-occurrence of anti CCP-positive rheumatoid arthritis with sacroiliitis' written by Haridas *et al.* with great interest![1] The authors have highlighted (though rare) the need to consider the involvement of sacroiliac joints (SIJs) in patients diagnosed with rheumatoid arthritis (RA), which can be considered as an atypical joint involvement of RA from their experience with this case. However, there certain clarifications are needed for the common readers, which I would like to highlight in this commentary.

Firstly, the presented case had 3-months history of polyarthritis involving small joints of hands and feet. There was no back pain at time of first encounter, as per case history presented. Afterwards, the pain and swelling in the small joints were subsided with the medication given for seropositive RA, but mild lower back pain (LBP) aggravated over a period of 6 weeks and interfered with the routine activities. As per the authors, the magnetic resonance imaging (MRI) of SIJs had confirmed chronic bilateral sacroiliitis.[1]

In my opinion, especially in rheumatology field, chronicity is to be documented as per time period, since symptoms/ signs present (inflammatory back pain (IBP) in this case) and not from the radiological techniques. In case of SIJs, plain radiograph actually gives information on grading of sacroiliitis (damage due to inflammation), while MRI gives information on active inflammation/ damage due to inflammation of SIJs.[2, 3] In this particular case presented, it seems to be acute LBP (6 weeks duration) rather than chronic!

Secondly, authors also mentioned that although the patient experienced tenderness in the SIJs, ankylosing spondylitis (AS) was not suspected, as she was negative for Schober's test![1]

AS is the prototype disease of the spodyloarthritis (SpA) group. It is characterized by the presence of axial symptoms resulting in both spinal mobility limitation and radiological sacroiliitis. The modified New York criteria have been widely accepted both in clinical practice and in clinical trials to classify patients with AS.[4] They work well in established disease, however, very limited in early disease. In addition, they focus mainly on the spine and SIJs and do not include extra-articular features.[2] Authors have mentioned that mild LBP interfered with the routine activities, which mean that there would be limitation of spine mobility and stiffness (suggest IBP). This leads to the presence of at least one clinical criterion to suspect AS or even axial SpA!

Thirdly, nothing was mentioned about plain radiograph of SIJs in case of suspected IBP, so we have to assume that it was not done and direct MRI was performed, which showed chronic bilateral sacroiliitis.

The MRI description of sacroiliitis would be more informative then the mention of chronicity in this particular case, as discussed above. Recently, the Assessment of SpondyloArthritis international Society (ASAS)/OMERACT MRI group putforth the definition for MRI sacroiliitis after reaching a consensus. As per the defintion, bone marrow edema (BMO) (on STIR) or osteitis (or T1 post Gd) must be clearly present in subchondral/ periarticular with

sufficient signal (defined as >1 BMO lesion on a single slice or only one BMO lesion on two consecutive slices).[3] This definition should be applied for 'active sacroiliitis by MRI' in the new ASAS classification criteria for axial SpA because BMO can also arise from mechanical stress, insufficiency fractures or malignant tumours.[2, 3]

Finally, the authors mentioned about HLA-B7 positive sacroiliitis with concurrent early anti-CCP positive RA and concluded that since the possibility for SpA had been excluded in current patient, the presence of sacroiliitis can be considered as an atypical joint involvement of RA.[1]

However; in my opinion, the history of IBP, raised inflammatory markers, bilateral active sacroiliitis on MRI, and back pain not responding to RA treatment, but to NSAIDs, all these were actually fulfilling ASAS axial SpA criteria along with ACR/EULAR 2010 RA criteria.[5,6] The ASAS criteria for axial SpA are a step forward in the SpA arena and help diagnosing early non-radiographic axial SpA as well as established SpA. MRI by detecting active inflammation in the spine and SIJs is an invaluable tool in early diagnosis. Early diagnosis enables the institution of treatment before permanent structural damage occurs and possibly alters the disease course. However, it is worthy to point out that criteria are designed primarily for classification and research purposes. There are no diagnostic criteria for SpA, so in daily clinical practice one has to adopt a more flexible approach.[2]

On concluding the commentary, in my opinion, the current patient must be seen as having clear overlap between RA and axial SpA (probable AS) rather than attributing sacroiliitis to atypical joint involvement of RA even in the absence of HLA B27. RA and AS (prototype SpA) are chronic, progressive, and most common inflammatory rheumatic diseases leading to joint damage. Even though the etiopathogenesis of both diseases has not been completely understood, it is thought to be different including their symptomatology and nowadays there are no major diagnostic difficulties in differentiating these diseases, thanks to modern laboratory tests and imaging. However, a problem may arise when the same patient has the symptoms typical of both diseases simultaneously. The cases of co-existence of RA with AS (or axial SpA) are considered rare.[7] However, the true co-existence of two or even more inflammatory joint diseases in the same patient can result in modification of the clinical image and an inadequate response to the treatment.[7] In RA, synthetic disease-modifying antirheumatic drugs (DMARD) should be applied as soon as possible, while in the axial form of AS without peripheral joint inflammation, drugs from this group do not apply.[8] While in both diseases, high efficacy of biological DMARD such as TNF inhibitors has been confirmed.[7]

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It may be possible that the rarely observed RA and SpA co-existence may be more prevalent than it was thought and is actually missed and/or unrecognized. This was also recently highlighted by Adam *et al.* in a retrospective study (presented in IRACON 2018) describing patients with clinical diagnosis of this overlap.[9] Whether these two rheumatic diseases develop in the same patient by chance or some individuals are predisposed to such an overlap, which I would call 'Rheumankylosis' is definitely a matter of further studies.

Competing interests

The author declares that he has no competing interests.

Citation

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