CORRESPONDENCE

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

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Response to the commentary on a rare co-occurrence of anti CCP-positive rheumatoid arthritis with sacroiliitis by Dalal A. IJRCI. 2020;8(1):C1

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I thank Dr. Dalal for the detailed review and appreciate his commentary.

The patient had clinically diagnosed anti-CCP-positive rheumatoid arthritis (RA) and she responded well to DMARDs. She had a low back pain of acute onset during the treatment for RA, which impaired her routine activities. Previous X-rays of the pelvis and LS spine were not available with the patient. An MRI was done to rule out disc lesion /SI joint pathology. I fully agree with the comment that the chronicity should be determined by the clinical symptoms and not by MRI. But the presentation of low back pain in females is atypical and many a time, the symptom cannot fit in as a criterion. Even in spondyloarthritis (SpA) with peripheral features as predominant manifestation, 25% can have asymptomatic sacroiliitis.

The pain subsided in the current patient after receiving treatment with steroids/NSAIDs. This was similar to the response noted in acute synovitis/flare in RA. She is still undergoing regular treatment and has attained remission.

She might fit into the Assessment of SpondyloArthritis International Society (ASAS) classification criteria, but I have a different view. I wanted to highlight that the synovial component of the SI joint can also be involved in AS, similar to the synovial involvement noted in RA. Though this involvement is frequently seen in clinical practice, it has been scantily explored.

I strongly believe that the underlying pathology in both peripheral joints and sacroiliac joints is the same. The disease cannot be CD4-mediated at one site (synovial) and CD8-mediated (entheses, ligament and capsule) at other sites. Even though HLA- B27 is associated with SpA, it was not considered in the present case. As far as treatment is considered, the down-stream effects of cytokines are the same in both RA and SpA. The patient's response was better to the treatment and did not warrant the use of biologics at any point of time.

Psoriasis can explain peripheral arthritis, SI joint involvement and anti-CCP positivity. But the present patient clinically complies with the criteria specified for early RA.

In certain clinical scenarios, strict compliance to such classification criteria is highly challenging and are often interpreted according to the clinician's convenience. I strongly feel that the sacroiliitis in RA is underreported and needs to be further evaluated.

Conflicts of Interest

The author declares that he has no conflict of interest.

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