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Erythematous patches with keratotic annular borders on the glans penis

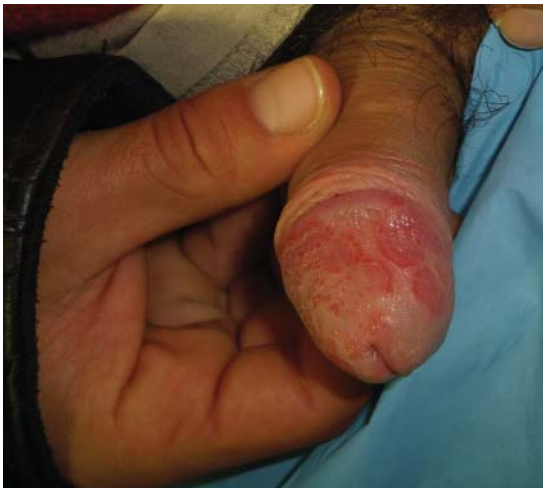

FIGURE 1. Circinate balanitis: erythematous patches with slightly raised keratotic annular borders.

A 31-year-old man presented to the emergency department with meatal inflammation, dysuria, and mucopurulent penile discharge, diagnosed as urethritis and treated empirically with levofloxacin. He was referred to the genitourinary medicine clinic for a full screening for sexually transmitted disease. The results were negative.

Two months later, he returned with pain and redness in his left eye and inflammatory lumbar pain. The glans penis had small pustules that ruptured, leaving painless superficial erosions that coalesced to form a serpiginous pattern (**Figure 1**). Radiography and magnetic resonance imaging revealed features of grade 3 bilateral sacroiliitis (**Figure 2**): subchondral sclerosis of both sacral and iliac articular margins (predominantly on the iliac side), erosions, reduced articular space, widening of the joint space, and incipient ankylosis. A diagnosis of reactive arthritis was made based on the presence of urethritis, ocular symptoms, circinate balanitis, and radiologic evidence of sacroiliitis. In addition, the chronic inflammatory back pain and bilateral sacroiliitis indicated developing ankylosing spondylitis according to the modified New York criteria.

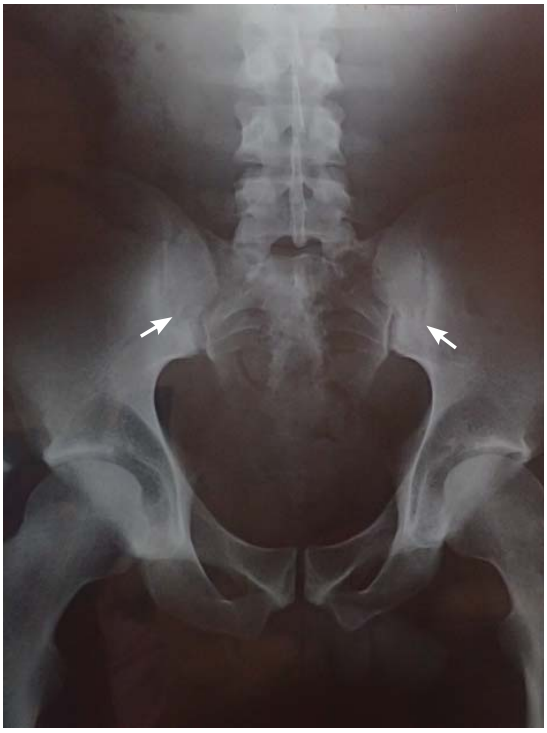

FIGURE 2. Radiography showed grade 3 bilateral sacroiliitis: subchondral sclerosis of both sacral and iliac articular margins (predominantly on the iliac side), erosions, reduced articular space, widening of the joint space, and incipient ankylosis (arrows).

The circinate balanitis resolved with hydrocortisone cream; nonsteroidal anti-inflammatory drugs improved the joint symptoms

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Our patient's circinate balanitis resolved with hydrocortisone cream, and treatment with a nonsteroidal anti-inflammatory drug brought improvement of the joint symptoms.

THE MANY FEATURES OF REACTIVE ARTHRITIS

The American Rheumatology Association diagnostic criteria for reactive arthritis include asymmetric arthritis that lasts at least 1 month and at least one of the following symptoms: urethritis, inflammatory eye disease, mouth ulcers, circinate balanitis, and radiographic evidence of sarcoiliitis, periostitis, or heel spurs.[1,2] Keratoderma blennorrhagicum is another extra-articular manifestation. These symptoms typically start within 1 to 6 weeks after urogenital infection with *Chlamydia trachomatis* or gastrointestinal infection with *Salmonella*, *Shigella*, *Yersinia*, or *Campylobacter* species.[1–3]

There is great variation in the severity, number, and timing of clinical features in reactive arthritis. The diagnosis can be difficult because only about one-third of patients show the complete classic triad (conjunctivitis, urethritis, arthritis). HLA-B27 positivity is associated with more frequent skin lesions and axial involvement.[4,5]

REFERENCES

1. **Wu IB, Schwartz RA**. Reiter's syndrome: the classic triad and more. J Am Acad Dermatol 2008; 59:113–121.
2. **Koga T, Miyashita T, Watanabe T, et al**. Reactive arthritis which occurred one year after acute chlamydial urethritis. Intern Med 2008; 47:663–666.
3. **Carter JD**. Treating reactive arthritis: insights for the clinician. Ther Adv Musculoskelet Dis 2010; 2:45–54.
4. **Willkens RF, Arnett FC, Bitter T, et al**. Reiter's syndrome: evaluation of preliminary criteria for definite disease. Arthritis Rheum 1981; 24:844–849.
5. **Bakkour W, Chularojanamontri L, Motta L, Chalmers RJ**. Successful use of dapsone for the management of circinate balanitis. Clin Exp Dermatol 2014; 39:333–335.

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