Case report

An unusual case of Reiter's disease

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SUMMARY A 72-year-old man was admitted to hospital after a syncopal attack. Investigations showed anaemia and adenocarcinoma of the colon. After tumour resection with end to end anastomosis he had a urinary catheter in situ for two days, but otherwise his recovery was unremarkable, until 13 weeks after operation when he developed classical Reiter's disease.

Investigations did not reveal any known trigger factor but it is postulated that the process may have been initiated by urinary catheterisation or bowel surgery.

Key words: urinary catheterisation, colonic neoplasms/surgery, adenocarcinoma.

Case report

A 72-year-old man was admitted to hospital after a syncopal attack.

Subsequent investigations showed positive faecal occult bloods, haemoglobin of 6.1 g/dl, and microcytic hypochromic indexes. Barium enema showed a stricture at the hepatic flexure with no evidence of colitis. The patient had no previous bowel upset. Before operation he received six units of blood, and after one of these transfusions he had an urticarial rash. The tumour was resected and an end to end anastomosis performed. Histology showed an adenocarcinoma. A urinary catheter was inserted post-operatively for the first two days. Diarrhoea was noted for the week after operation, but no faecal cultures were taken.

He was discharged four weeks later after a satisfactory recovery.

At an outpatient clinic six weeks after discharge he was well and an erythrocyte sedimentation rate (ESR) of 15 mm in the first hour was noted. At review three weeks later he complained of pain and swelling of the left knee and severe dysuria for the previous two weeks. He admitted when questioned to persistent mild dysuria after his catheterisation.

Investigations at this time showed an ESR of 51

mm/h; alkaline phosphatase and serum uric acid were normal; rheumatoid factor was negative; mid-stream urine was sterile but with 80 white cells/high power field. 40 ml of clear fluid was aspirated from his knee and this was sterile.

On follow up two weeks later he had swelling of both his knee joints and right ankle. He had bilateral conjunctivitis, early keratoderma blennorrhagica lesions on the soles of his feet, a mucopurulent urethral discharge, and circinate balanitis.

He was admitted for investigations and treatment. Subsequent manifestations were keratoderma lesions in the pubic and axillary regions, and a right anterior uveitis also developed.

Investigations: Haemoglobin 9.4 g/dl, ESR 120 mm/h, urethral smear – polymorphs + + + +, culture for gonorrhoea was negative, chlamydia studies could not be performed, x-rays of involved joints and sacroiliac joints were normal, stool culture was negative, Widal's test was negative, yersinia titre was 0, electrocardiogram was normal, HLA-B27 was positive.

He did not give any history of previous similar episodes. There was no family history of autoimmune disease. His last sexual intercourse with his wife was one month before his original admission, and neither he nor his wife admitted to any extramarital sexual contact.

After discharge from hospital after treatment for his Reiter's disease he resumed sexual contact with

his wife who was untreated and did not have any evidence of urethritis six months later.

Discussion

This man undoubtedly had Reiter's disease as witnessed by the association of urethritis, circinate balanitis,¹ which is said to be pathognomic of this condition, asymmetric arthritis, conjunctivitis, anterior uveitis, and keratoderma blennorrhagica. He did not have any recognised trigger factor, i.e., sexually transmitted urethritis or dysentery. Although he had diarrhoea for the first post-operative week, this is considered quite normal after such an operation.

Unusual features about this case were:

- (1) The age of onset. In Kousa's series published in 1978² the eldest patient at onset of 178 cases was 58 years with a mean age of 29.
- (2) Although he had no history of sexually transmitted disease, he had a urinary catheterisation after which he had urinary discomfort until the onset of his definite

urethritis. We can find no reference to onset of Reiter's disease after catheterisation.

- (3) He had an adenocarcinoma with bowel resection but no episode of infective dysentery. No reference to onset of Reiter's associated with bowel surgery or carcinoma of the bowel could be found.

It may well be that this man had a latent urethritis, which his catheterisation triggered into an acute flare up, but the history is not suggestive of this, as he did not develop urethritis again after intercourse with his untreated wife.

We put this case forward as that of Reiter's disease with no known trigger factor, though involvement of urethra and bowel by previously unreported trigger mechanisms could be inferred.

References

- 1 Alassus A, Tiiilikainen A, Stubb S, Reunala T, Johansson E. Circinate erosive balanitis - HLA B27. *Acta Derm Venereol (Stockh)* 1975; **55**: 199-201.
- 2 Kousa M. Clinical observation on Reiter's disease with special reference to the venereal and non-venereal aetiology. *Acta Derm Venereol [Suppl] (Stockh)* 1978; **58** (Suppl 81).