Reiter's cramp

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Abstract

We report the occurrence of writer's cramp in a 31 year old B27 positive man with a recent past history of Reiter's syndrome. Although aware of the close linguistic relation between the pen and the penis, we have not previously encountered the two diseases in a single patient.

Case report

In August 1986 the patient, a freelance journalist, developed dysuria and a mild urethral discharge subsequent to a casual sexual encounter while on holiday in Turkey. Coincidental to this he experienced three days of severe bloody diarrhoea and received a short course of oral antibiotics, after which his diarrhoea resolved.

Two weeks later, having returned to the United Kingdom, he developed a swollen tender right ankle. His urethral symptoms were more prominent with a continuation of his discharge. His left eye had by now become red and sore.

He presented himself to the rheumatology outpatient clinic and on examination he had conjunctivitis of his left eye and synovitis of his right ankle, right knee, and both elbows. Non-gonococcal urethritis was confirmed by genitourinary examination. No evidence of *Chlamydia trachomatis* infection could be found by either chlamydial serology or enzyme linked immunosorbent assay (ELISA) for chlamydial antigen performed on a urethral specimen. Stool culture was sterile and serological tests for common Gram negative gut pathogens were negative.

He was a sexually active promiscuous man having had several bisexual contacts over the previous three months, including two new sexual partners while on holiday in Turkey. In the past he had been treated for both gonorrhoea and non-gonococcal urethritis on several occasions.

Arthroscopic synovial examination and biopsy of the knee joint confirmed an acute synovitis. He had a raised erythrocyte sedimentation rate of 42 mm/h, normal full blood count, and negative rheumatoid factor, antinuclear antibody, and HIV serology. Tissue typing was positive for HLA-B27.

It was unclear whether the episode of sexually acquired non-gonococcal urethritis or the brief but dramatic episode of diarrhoea had provided the trigger for the development of his reactive arthritis.

He was treated with a course of minocycline for his non-gonococcal urethritis and indomethacin to relieve his joint symptoms, with good effect. His Reiter's syndrome resolved completely over the next six months.

He next attended the rheumatology clinic on 8 November 1988 complaining of the gradual onset of pain and stiffness in his fingers over the previous two months. His symptoms were aggravated by writing, an activity essential to his job as a journalist. The only abnormal finding was of mild tenderness over his left lateral epicondyle. He experienced 'tension' during a test period of handwriting, coinciding with an increase in his hand symptoms. He held his pen clenched with abnormal force between his thumb and index finger, which blanched white with the pressure. As he wrote so his right scapula moved, with increased tone in his sternomastoid and rotator cuff muscles. In the light of these characteristic findings a diagnosis of writer's cramp was made and reassurance given. His symptoms have since gradually improved.

Discussion

We report the occurrence of these two rheumatological conditions in a single individual, though we do not believe that they have any aetiological connection. A search of published work shows no previous report of their co-occurrence, nor does it show a relation between HLA-B27 and writer's cramp.

There is a risk of recurrence of either Reiter's syndrome or writer's cramp in this man. Overactivity of the pen on the one hand, or the penis (or bowel) on the other, may lead to exacerbation of the relevant associated condition. In view of his job as a journalist and his promiscuous lifestyle there is a strong possibility of either. He has therefore been advised to avoid extensive use of both instruments in the future.

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