

pain and/or jaundice are not responding to moderate ceiling analgesics and multi agent chemotherapy early enough especially in a low resource setting.

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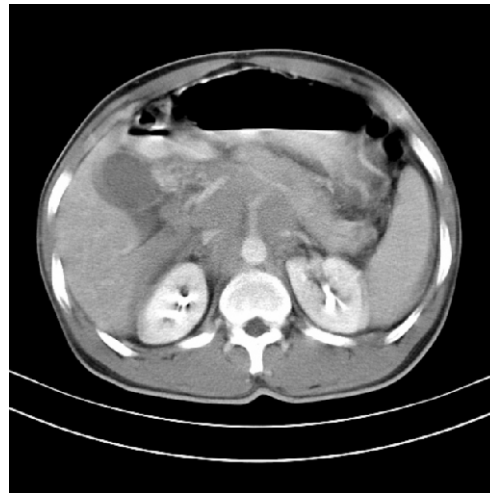


Fig I. CT section showing an hypodense solid mass arising from the region of the head of the pancreas, note the encasing of the abdominal aorta

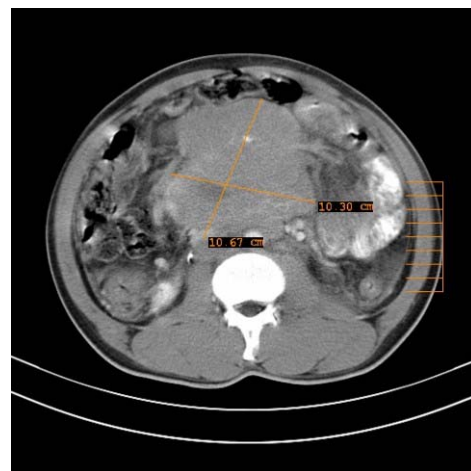


Fig II. CT axial cuts demonstrating the extensive nature of the mass, note measurements of the mass at its widest diameters

CASE REPORT

Psoriatic Arthropathy In A Black African A Case Report

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Abstract

We report the case of a 40 year old Military Officer with psoriatic skin lesions who developed arthropathy a complication said to be rare in the Black race. He was successfully managed with psoralen and methotrexate and the case is reported to increase the awareness of practitioners to the occurrence of the complication in blacks

Key Words: Psoriasis, Black, HLA antigen, Joint deformity, Methotrexate.

Introduction

Psoriasis is a chronic recurrent disease of variable severity that affects between 1-4% of the population¹. It is associated with an inflammatory sero-negative arthritis- Psoriatic arthritis in approximately 5-7% of psoriatic patients¹. The key histological features of psoriasis are epidermal keratinocyte hypoproliferation, dermal vascularity, and an inflammatory infiltrate².

Over the last few years, the role of some genes, for example HLA-CW6 and the role of the immune system in the development of psoriasis have become more defined³. It has been demonstrated that innate immunity plays a key role in the development of psoriasis, especially through the production of cytokines, the most important of which is TNF alpha³. Environmental triggers known to induce psoriasis include beta- haemolytic streptococcal infection, Human Immunodeficiency Virus (HIV), and drugs such as beta-blockers and stress.

Although rarely life-threatening, psoriasis causes considerable psychological disability and impairment of quality of life for those it afflicts. Most cases present before the age of forty years (type 1 psoriasis) with a second peak of onset between 55 and 60 years (type 11 psoriasis). Clinically, there is little to distinguish type 1 from type 11 disease. As a general observation, type 1 psoriasis is familiar, severe and has a strong association with HLA-CW6⁴. Type 11 psoriasis is neither familiar nor associated with HLA-CW6⁴. Psoriasis is associated

with psoriatic arthropathy which is classified as spondyloarthritides (SPA)⁵. Psoriatic spondylitis is associated with HLA- B27.

The treatment modalities include non-steroidal anti-inflammatory drugs (NSAIDS) and topical steroids. Disease modifying agents, such as methotrexate and sulfasalazine are used in active joint disease not responsive to NSAIDS. Newer classes of drugs are leflunomide and anti-TNF alpha agents⁶.

Case report

A 40 year old military officer presented with joint swelling involving the distal and proximal interphalangeal joints of the hands, the wrists and the ankles of two years duration. The swelling of the wrist joints was associated with early morning stiffness of the fingers of less than ten minutes duration. There were no associated subcutaneous nodules.

He however admitted to the presence of certain skin lesions on his back dated to six years prior to the onset of the arthritis. He had been on various skin ointments for the skin lesions and several NSAIDS (non-steroidal anti-inflammatory drug) for the arthritis without any significant improvement.

When examined, he had psoriatic plaques on his back (fig 1). There were however no nail changes. The medial four fingers bilaterally were tender with flexor deformity of the distal interphalangeal joints (fig 2). He also had tender and swollen wrists (fig 2) and bilateral tenderness in the ankles. There was no tenderness at the tendon insertions and the sacroiliac joints. Other systems were essentially normal.

A diagnosis of psoriatic arthritis was made. Laboratory results revealed normal full blood count with elevated ESR (55MM/HR), negative rheumatoid factor and anti-nuclear antibody. HLA antibody was however not done. No radiological changes were noted.

The patient was placed on NSAIDS, methotrexate, and psoralen. He made significant improvement in both skin and joint manifestations. He is still presently attending the out-patient clinic for follow-up.

Discussion

About 5-8% of patients with psoriasis do develop psoriatic arthritis. It occasionally develops in the absence of detectable psoriasis but tends to occur at higher frequencies when skin involvement is florid⁷. It is commoner in the white than black race⁸. Most commonly the skin lesions of psoriasis precede arthritis. However in 15-20% of patients, arthritis appears before the skin psoriasis. The latter case is associated with hereditary pattern. Skin lesions presumably preceded arthritis for 6 years in this patient⁹.

The course of psoriasis is usually characterized by flares and remissions. The variety of clinical manifestations was defined by Moll and Wright in 1973¹⁰. Five patterns of psoriatic arthritis are identified⁵. This patient has symmetrical polyarthriti type. This rheumatoid like pattern seen in this patient has been recognized as one of the most common types. It is generally milder than rheumatoid arthritis. The hands, wrists, ankles, and the feet are affected in this patient.

Other identified patterns of psoriatic arthritis include asymmetrical oligoarticular arthritis, distal joint arthropathy arthritis mutilans, and psoriatic spondylitis⁵. The commonest pattern seen is the asymmetrical oligoarticular type.

The presence of psoriatic skin lesion in this patient made the diagnosis of psoriatic arthritis easy. When there is little or no skin or nail lesions, there could be diagnostic confusion between psoriatic arthritis and other causes of polyarthriti.

Rheumatoid arthritis was however eliminated in this patient on the grounds of involvement of the distal interphalangeal joints, absence of subcutaneous nodules, and a negative test for rheumatoid factor¹¹. Systemic Lupus Erythematosus (SLE) was ruled out because of absence of malar rash, discoid rash, recurrent sore throat, photosensitivity, normal full blood count result, and negative test for anti-nuclear antibody¹².

This patient sought medical attention because he was not responding to various NSAIDs. The initial treatment of psoriatic arthritis is usually based on NSAIDs but most patients will eventually need disease modifying anti-rheumatic drugs (DMARD). In clinical practice, the most widely used DMARD are methotrexate, sulfasalazine and cyclosporin¹³. Leflunomide (inhibitor of pyrimidine synthesis) has recently been shown in a randomized controlled trial (RCT) to be effective in the treatment of psoriasis

and psoriatic arthritis, but no data on its action on radiographic progression has been presented¹⁴.

The most recent agents are the biologic therapies, examples of which are etanercept and infliximab¹⁵. These agents have been investigated less extensively in the psoriatic arthritis than in rheumatoid arthritis, but a number of research and clinical studies suggest that they may also be beneficial and able to inhibit joint damage in psoriatic arthritis⁶.

Advent of TNF blockers is a singular advance in the therapy of psoriatic arthritis, but the long-term outcome of these agents is a cause for concern. The cost and availability of the agents are the limiting factors to their use in our environment.

This write-up is to heighten the presence of this uncommon condition in Blacks in our environment.

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FIG I Photograph showing skin lesions of psoriasis at the back.



FIG II - Black arrows- showing flexor deformity of the distal interphalangeal joints. Red arrows----showing swollen wrist joints.