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Editorial Open Access

A Brief note on Inflammatory Arthritis

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Editorial

Inflammatory arthritis can lead to erosions and destruction of the joints. There could be various causes of inflammatory arthritis including but not limited to rheumatoid arthritis, psoriatic arthritis and systemic lupus erythematosus and ankylosing spondylitis. Longstanding and generally untreated arthritis can progress to arthritis mutilans characterized by bone resorption and collapse of soft tissues. One of the rare disease entities that should be always is in the differential of inflammatory arthritis and arthritis mutilans is known as Multicentric Reticulohistiocytosis (MRH).

MRH is a rare non-Langerhans histiocytosis of unknown etiology with the predisposition for joints and skin. It manifests as inflammatory arthritis and nodules on the skin. The mean age of disease onset is around 50 years of age and is more common in women [1]. The arthritis of MRH is symmetric polyarthritis involving interphalangeal joints (76%) frequently DIP of the fingers. Other involved joints include knee (73%), shoulders (64%), wrist (64%), hips (61%), ankles and spine. Early and severe atlanto-axial joint involvement has also been noticed. Skin lesions are typically firm, 1mm to 2 cm flesh colored reddish brown papulonodules. These tumefactions when located along the proximal nailfolds have been described as coral beads and are very characteristic of the disease. They are most commonly located on the face (94%) and hands (91%). Other areas of distribution include forearm, pinna, scalp ear, neck and shoulders. Mucosa and internal organ involvement with these nodules have also been reported. They can be differentiated from rheumatoid nodules in the distribution which usually involves the extensor surfaces and the areas of friction rub. They also need to be differentiated from gouty tophi which would be usually larger in size and at times be associated with white chalky discharge [2].

The association with malignancy has been reported in about 25% of the cases. Xanthelasma and hyperlipidemia is also seen in about 30% of the cases. Therefore, it is prudent for patients to undergo age appropriate screening when they are diagnosed with MRH.

NSAIDs are recommended for mild symptoms. Disease Modifying Anti- rheumatic drugs including methotrexate have also been used with some success. Case reports exist with success of TNF-inhibition and cytotoxic agents like cyclophosphamide have been used in resistant cases.

References

1. Barrow MV, Holubar K (1969) Multicentric reticulohistiocytosis. A review of 33 patients. Medicine 48: 287-305.
2. Codriansky KA, Rünger TM, Bhawan J, Kantarci A, Kissin EY (2008) Multicentric reticulohistiocytosis: a systemic osteoclastic disease? Arthritis Rheum 59: 444-448.