

PSORIATIC ARTHRITIS (PsA):

A DIAGNOSTIC AND THERAPEUTIC DILEMMA IN A LOW RESOURCE SETTING;

The Case of A 35 year old woman in Bafut, North West Province, Cameroon, West Africa.

Mbuagbaw L.C.E. MD General Practitioner, Mbuagbaw J.N., MD Internal Physician/

Dermatologist, Okwen P.M., MD General Practitioner, Douala M. S., MD Internal Physician/

Rheumatologist.

Key words: Psoriatic arthritis, Arthritis mutilans, Sub-Saharan Africa

Includes 3 photos.

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We report here the case of a 36-year-old female of the Bororo tribe, married and mother of two children. Her past medical history revealed that her symptoms started 17 years ago with well-circumscribed scaly patches over the anterior surface of her right thigh, which we assume to be the initial psoriatic lesion. She sought traditional medicine to no avail. Then she noticed joint stiffness four years later. Her symptoms seemed to recede during her two pregnancies. She could not ascertain if anybody in her family had similar disease.

When she was brought to us she presented with a diffuse scaly pruritic eruptions covering the whole skin surface, including the scalp and sparing most of her face. Her nails were also affected, with hyperkeratosis, pitting and oncholysis. She had asymmetrical interphalangeal joint malformations (arthritis mutilans and sausage joints), left elbow and bilateral knee ankylosis. She was in severe pain.

Uric acid level was 5.2mg/dl (normal), Rheumatoid factor was negative, Haemoglobin level was 9.7g/dl (mild anaemia) and the white blood cell count was 9000cells/dl (normal). She was HIV seronegative. No X-rays were done. Our findings permitted us to define psoriatic arthritis using the Bennett, Mc Gonagle, Fournie et al, and the Vasey and Espinoza criteria.

She was put on Sulphasalazine 1g twice daily, Azathiopine 50mg twice daily, Diclofenac 50mg per os thrice daily and later on Methotrexate 2.5mg once daily.

Three weeks later the scaly eruptions and itching had disappeared, but the joint and nail affection persisted. Methotrexate was stopped two weeks later when the patient developed stomatitis.

The joint malformations and ankylosis would require physiotherapy and/or musculoskeletal surgery.

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Our centre has registered 4 cases within the period of January 2005 to September 2005, one of which is discussed here. The youngest was a male aged 24 years and the oldest was a 36-year-old female. All were from the North-West Province, but two from the same (Bororo) tribe. Clear-cut diagnoses were not made in the first 3 but, all had psoriatic lesions and arthritis.

Discussion:

Psoriatic arthritis and other rheumatologic conditions are difficult to harness in low resource settings because their diagnosis and management are sometimes beyond the scope of practice of general medicine and the necessary diagnostic paraclinical tests may not be available or affordable. Documentation and access to documentation may be factors that limit knowledge on the subject in our setting. Our patient was not aware of the nature or severity of her disease and her major worry was the incapacitation associated with the disease.

In some cases atypical presentations of disease are attributed to the supernatural and traditional treatment is sought first. The photos we present portray the extensive musculoskeletal damage that had set in and which may have been prevented in the presence of timely and adequate management. Management was further stalled by the difficulty in procuring Methotrexate in the injectable form. The other drugs used (Azathioprine and Sulphasalazine) were obtained as a donation from a charitable organisation in England; drawing our attention to the fact that long-term management would be impossible once our stock ran out. These drugs are difficult to find even in the big cities and are quite expensive.

Despite the diagnosis and institution of therapy exhaustive paraclinical investigation was impossible due to financial constraints (X-ray and ultrasound). Tests for HLA and ANA, CT scan and MRI were unavailable and their results may not have improved the outcome of treatment. The need for musculoskeletal surgery and physiotherapy was ascertained on a clinical basis.

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The fact that we have had two cases from the same tribe may go in line with the hereditary nature of the disease. ⁽¹⁾ This tribe is known to practice a lot of inbreeding. Further research would be necessary to elucidate the issue.

Her symptoms started much earlier than the usual age and may explain the severity of her condition. ⁽²⁾

Also the improvement of symptoms associated with pregnancy is consistent with literature. ⁽³⁾

We believe that the availability of rheumatology and dermatology clinics in low resource settings can help the overall outlook of the pathology. Such clinics already exist for other diseases like HIV/AIDS, diabetes, Sickle cell anaemia, and high blood pressure. Rheumatology and dermatology clinics exist only in the cities of Yaoundé and Douala.

It will be necessary to evaluate the prevalence, geographic and ethnic distribution of the disease with the aim of implementing adapted educational programs and intervention strategies. If the prevalence of such pathologies is on the rise due to the HIV epidemic, ⁽⁴⁾ we in sub Saharan Africa must be ready to face the problem. We should also strive at developing adapted clinical diagnostic tools in the absence of key biological elements. Equally, more trained personnel would be necessary. In the absence of permanent consultants, the punctual intervention of volunteers would make a difference, as has been the case in other domains of human development.

Photo 1: Shows the scaling erythematous plaques over the trunk and abdomen.

Photo 2: Shows asymmetrical joint affection, dactylitis, sausage joints, and nail affection, with arthritis mutilans on the left hand and fixed flexion deformity.

Photo 3: Shows bilateral knee ankylosis.

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Photo 1

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Photo 2

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Photo 3

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