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POLYARTHRITIS SIMILAR TO RHEUMATOID ARTHRITIS AS AN INITIAL PRESENTATION OF ANTISYNTHETASE SYNDROME: A CASE REPORT

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BACKGROUND

Antisynthetase syndrome (ASS) is a rare chronic immune-mediated rheumatological disease, characterized by the classic triad: myositis, interstitial pneumopathy and arthritis. Only half of the patients will have these typical manifestations and, more rarely, at the time of diagnosis. Its heterogeneity depends on which antibody will be produced against a specific tRNA synthetase. Anti-Jo-1 is found in 30% of patients. Symmetrical polyarthritis is an atypical initial presentation, often confused with rheumatoid arthritis until other typical symptoms of ASS appear.

CASE REPORT

Female, 62 years old. In May 2020, the patient showed symmetrical and additive polyarthritis of proximal interphalangeal, metacarpophalangeal, wrists (Fig. 1), knees and ankles, with morning stiffness greater than 2 hours. Prednisone 10 mg/day was prescribed, and diagnostic tests were requested. After 2 weeks, she returned with persistent arthritis and appearance of erythema and edema on the face, V sign, change in periorbital color (suggestive of heliotrope) and muscle weakness in the pelvic and scapular girdle (grade 4). Subcutaneous methotrexate 15 mg/week was prescribed. In August 2020, she remained with cutaneous signs, myositis and polyarthritis and evolved with skin and hands thickening. Chest radiography showed micronodular infiltrate and thoracic tomography showed ground glass in 30% of the parenchyma (Fig. 2). Radiography of hands and feet had slight epiphyseal porosis without erosion. Laboratory data: ANA 1: 160, anti-Jo-1 > 200 UI/mL (up to 25 UI/mL), anti-SSA/Ro 96.6U (up to 20 U), aldolase 18.4 U/L (up to 7.6 U/L), CPK 300 U/L (up to 211 U/L), negative rheumatoid factor and anti-CCP. The positivity of an antisynthetase antibody, arthritis, interstitial lung disease, myositis and mechanic's hands can be classified as ASS (by Solomon and Connor's criteria). Azathioprine 2 mg/kg/day was started, and the dose of prednisone was adjusted to 1 mg/kg/day. The patient was reevaluated after one month, showing considerable improvement in the articular, myopathic and cutaneous manifestations.

Figure 1. Proximal interphalangeal and metacarpophalangeal arthritis.

Figure 2. Thoracic tomography with ground glass in 30% of the parenchyma (green arrows).

CONCLUSION

Antisynthetase syndrome arises in individuals predisposed and exposed to a trigger. Myositis is usually absent or subclinical, and anti-SSA/Ro is usually positive associated with an antisynthetase antibody. Cutaneous involvement may resemble findings of dermatomyositis. This report reinforces the importance of clinical monitoring in face of a patient with chronic, additive, seronegative polyarthritis of small and large joints, with prolonged morning stiffness, suggestive of rheumatoid arthritis. The appearance of myositis, erythroderma, interstitial lung disease and the positivity for anti-Jo-1 led to the diagnosis of ASS.