WHAT IS IT?
● Sexually acquired reactive arthritis (SARA) is an inflammation of the synovial membranes, tendons and fasciae, triggered by genital infection.

CAUSES
● The precise mechanisms are not clearly understood, but SARA appears to involve an immune response. A number of microorganisms have been implicated: Chlamydia trachomatis, Neisseria gonorrhoeae, Ureaplasma urealyticum and Shigella sonnei.
● It is 10 times more frequent in men than in women, although it may be under-recognised in women.

SIGNS AND SYMPTOMS
History includes possible previous or family history of spondyloarthritis or iritis; sexual intercourse, usually with a new partner, within three months prior to onset. Symptoms include:
● Genital infection;
● Pain, with or without swelling and stiffness, at one or more joints; especially knees and feet;
● Tenosynovitis;
● Dactylitis;
● Pain and redness of the eye – usually due to conjunctivitis; other conditions such as posterior uveitis should be investigated;
● Low back pain and stiffness;
● Malaise, fatigue and fever;
● Psoriasis.

COMPLICATIONS
● Heart lesions – usually asymptomatic although tachycardia and rarely pericarditis and aortic valve disease may occur.
● Renal pathology, such as proteinuria, microhaematuria and aseptic pyuria – usually asymptomatic.
● Rarely, thrombophlebitis of the lower limbs, subcutaneous nodules, nervous system involvement.
● Erosive joint damage, especially in the small joints of the feet, with 12 per cent exhibiting foot deformities, although severe deformity is rare.
● Fever and weight loss.
● Inadequately treated or recurrent uveitis may result in cataracts and blindness.

DIAGNOSIS
Diagnosis involves three components:
● Recognition of the typical clinical features of spondyloarthropathy;
● Demonstration of evidence of genitourinary infection;
● Investigation of specificity and activity of arthritis.

TREATMENT
Treatment is directed at presenting symptoms, by relevant specialists.
● Antimicrobial therapy for occurrence of genital infections.
● Rest with the restriction of physical activity, especially weight-bearing activity where leg joints are involved.
● Physiotherapy in order to prevent muscle wasting.
● Gold pads to alleviate joint pain and oedema.
● Administration of intra-articular corticosteroid injections, for single troublesome joints.
● Administration of systemic corticosteroids for severe arthritis.
● Sulphasalazine, methotrexate and/or azathioprine where disabling symptoms persist for three or more months, or where there is evidence of erosive joint damage.
● Gold salts and D-penicillamine are occasionally used when persistent polyarthritis is present.
● Topical salicylate, corticosteroids and/or calcipotriol, for mild-to-moderate skin lesions.
● Methotrexate and/or retinoids, for severe skin lesions.
● Referral to an ophthalmologist for eye lesions.
● Low-dose tricyclic drugs at night, if post-inflammatory pain and fatigue are severe.

PROGNOSIS
● In most cases SARA is self-limiting with the first episode lasting four to six months. About 50 per cent of patients have recurrent episodes.
● Symptoms persist for more than one year in 17 per cent of patients.
● Persistent disability occurs in 15 per cent of patients, mainly due to erosive damage

REFERENCES

WEBSITES