Diagnosing Crohn's Disease in Patients with Arthritis

The arthritis associated with Crohn's disease occurs in up to 26% of those diagnosed with the gut disorder. The inflammatory peripheral arthritis classically involves the knees and ankles, affects fewer than five joints, often coincides with flares of Crohn's disease, but lasts less than 10 weeks before spontaneous improvement. A less common polyarticular arthritis similar to rheumatoid arthritis has also been described, persists long-term and remains independent of the bowel's disease activity. Finally, Crohn's patients may also develop an inflammatory spinal and sacroiliac arthritis that is indistinguishable from ankylosing spondylitis.

The connection between arthritis and Crohn's disease is often made by the appearance of joint symptoms at or after the onset of bowel symptoms. The arthritis often begins in the first years of Crohn's disease and especially in children, up to 70% of joint flares coincide with exacerbations of intestinal disease. However, the diagnosis of Crohn's disease is sometimes made years after the onset of arthritis, especially in patients with a lack of abdominal symptoms and negative testing for fecal occult blood. In some cases, the treatment of arthritis with nonsteroidal anti-inflammatory drugs, sulfasalazine, or methotrexate may by itself cause gastrointestinal side effects that delay the consideration of the diagnosis of Crohn's.

The accompanying paper takes the unusual approach of searching for Crohn's disease in arthritis patients, rather than for arthritis in Crohn's patients. Excluding only those arthritis patients with irritable bowel or hemorrhoids, the authors performed ileocolonoscopy with biopsy on 29 with chronic abdominal pain, diarrhea, dysentery, or perianal abscess or fistula. Only two biopsies were normal, and 14 cases of Crohn's disease were newly diagnosed. Weight loss proved to be the only significant predictor of Crohn's disease, while fever, perianal fistula, abdominal pain, history of dysentery, and uveitis were also more common in those with Crohn's. Although the series of patients is small, the rate of discovering colitis was high, with simple items from the history and physical exam providing important clues about the presence of Crohn's.

Fortunately, there is considerable overlap in medications effective for inflammatory arthritis and Crohn's disease. Methotrexate and sulfasalazine were remarkably effective in the current study and required only occasional augmentation by corticosteroids. In those patients with an insufficient response of either the intestinal or joint disease, the use of the TNFα antagonists infliximab or adalimumab provides real hope for control of inflammation. However, heightened awareness of the connection between arthritis and Crohn's disease is the first step towards initiating effective therapy.

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References