

Balanitis circinata

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A 24-year-old boy presented with arthritis of the right knee and both ankles since 2 weeks. On performing an examination, apart from arthritis of the affected joints, dactylitis of the left thumb was seen. On questioning, he admitted to having dysuria, and a genital examination revealed multiple erythematous shallow ulcers with serpiginous margins on the glans penis (Figure 1). He did not have a history of inflammatory back pain, heel pain, or pain at other enthesial sites. He never had pain or redness of the eyes, prolonged diarrhea, or rashes elsewhere. He did not have a family history of arthritis, uveitis, or psoriasis.

Circinate balanitis, which is seen in up to 40% of men with reactive arthritis (ReA), is often painless; hence, its presence is not voluntarily mentioned by patients, unless they are specifically asked about it. In almost half of the patients with ReA, the causative pathogen of preceding infection cannot be identified (1, 2). In such cases, the presence of circinate balanitis can serve to differentiate ReA from other infections associated acute arthritides, such as poststreptococcal ReA, rheumatic fever, or viral arthritis.

In patients with arthritis but with no history of preceding infection, undifferentiated spondyloarthritis (UspA) is an important differential. UspA is a chronic disease marked with asymmetric oligoarthritis and enthesitis. The presence of Circinate balanitis in such a setting indicates ReA rather than UspA, signifying a shorter disease duration and better prognosis. It is now believed that most cases of UspA are *forme fruste* of ReA itself in the absence of identified infectious triggers (3). As classic ReA with balanitis circinata has been described in the setting of Human Immunodeficiency virus (HIV) infection, it is important to test for the same in all these cases (4). Hence, the presence of circinate balanitis is not specific but is an important clue to the etiology of arthritis. The presence of long-standing psoriasiform lesions with destructive arthritis or prominent distal interphalangeal joint involvement suggests a diagnosis of psoriatic arthritis. On the other hand, a preceding history of infection in a healthy adult with a short history of arthritis is best labelled as of ReA.

Although circinate balanitis by itself usually does not require treatment, it can serve as a salient marker of underlying genitourinary infections, which warrant treatment to prevent relapses (3). Most often seen with genitourinary chlamydia induced reA, circinate balanitis can also occur with gastrointestinal infections. In refractory patients, topical salicylates usually suffice, though mild topical glucocorticoids and calcineurin inhibitors have also been successfully used (1).

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Figure 1. Picture of the uncircumcised penis showing multiple shallow ulcers with a white base and serpiginous edges on the glans; a few lesions have coalesced to give a polycyclic appearance

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