TABLE 76-2 DIFFERENTIATING FEATURES OF COMMON ARTHRITIDES

DISEASE	DEMOGRAPHICS	JOINTS INVOLVED	SPECIAL FEATURES	LABORATORY FINDINGS
Gout	Men, postmenopausal women	Monoarticular or oligoarticular	Podagra, rapid onset of attack, polyarticular gout, tophi	SF: Crystals, high WBC count, >80% PMNs
Septic arthritis	Any age	Usually large joints	Fever, chills	SF: High WBC count, >90% PMNs, culture
Osteoarthritis	Increases with age	Weight-bearing, hands		Noninflammatory SF
Rheumatoid arthritis	Any age, predominantly women ages 20-50 yr	Symmetrical, small joints disease	Rheumatoid nodules, extra-articular	SF: High WBC count, >70% PMNs
Reactive arthritis (Reiter's syndrome)	Young males	Oligoarticular, asymmetrical	Urethritis, conjunctivitis, skin and mucous membranes	SF: Moderate WBC count, >50% PMNs
Spondyloarthropathy	Young to middle-aged men	Axial skeleton, pelvis (sacroiliac joints)	Uveitis, aortic insufficiency, enthesopathy	
Systemic lupus erythematosus	Women in childbearing years	Hands, knees	Nonerosive joint disease, autoantibodies, mostly mononuclear; multiorgan disease	SF: Low to moderate WBC count, almost 100% have antinuclear antibodies

PMNs, Neutrophils; SF, synovial fluid; WBC, white blood cell.

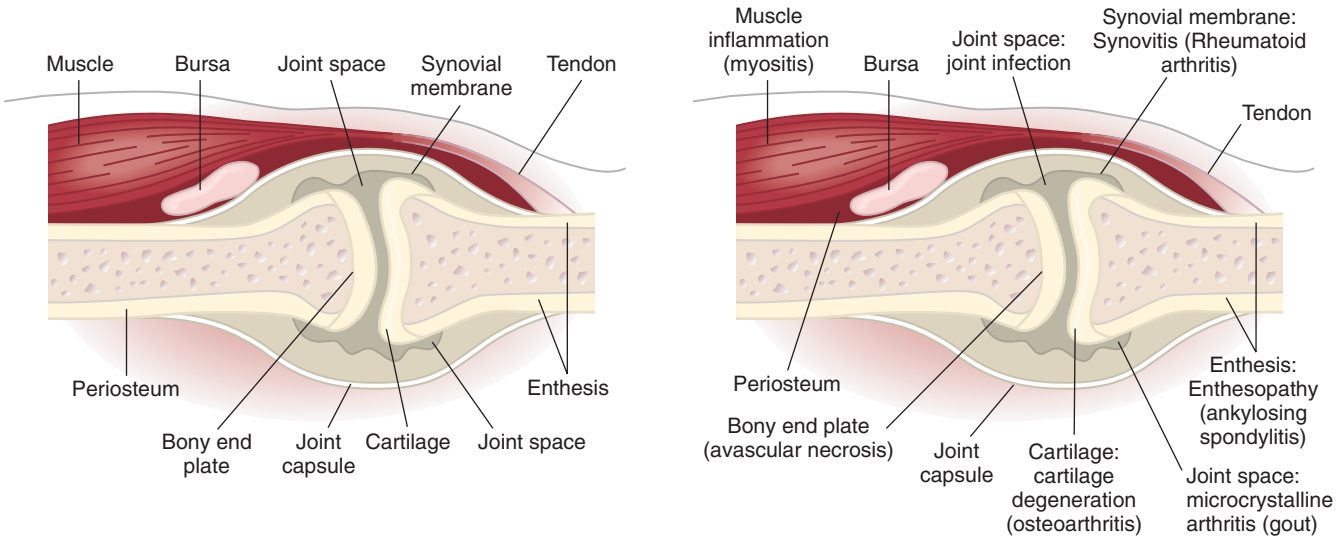

FIGURE 76-1 Anatomic structures of the musculoskeletal system *(left)*. Locations of musculoskeletal disease processes *(right)*. (From Gordon DA: Approach to the patient with musculoskeletal disease. In Bennett JC, Plum F, editors: Cecil textbook of medicine, ed 20, Philadelphia, 1996, WB Saunders, p 1440.)

is often a sign of hip disease and may be reproduced on examination of the hip. Palpable synovitis (i.e., thickening of the synovial membrane) is helpful in diagnosing inflammatory arthritides such as rheumatoid arthritis.

Different diseases have distinctive patterns of joint involvement, which provide critical diagnostic information. For example, prominent disease of distal interphalangeal joints is seen in psoriasis and inflammatory osteoarthritis. Wrist and metacarpophalangeal involvement are almost universal in rheumatoid arthritis but rare in osteoarthritis. Examination of the axial skeleton may reveal diminished lumbar flexion, decreased rotational motion of the spine, and decreased chest expansion, features of ankylosing spondylitis and other spondyloarthropathies. Patients may report symptoms in only a single joint, but finding additional affected joints on physical examination can change the entire evaluation.

Because rheumatic diseases may involve any organ system, a full physical examination should be performed for all patients. Alopecia and funduscopic changes (in SLE), uveitis (in spondyloarthropathy and juvenile arthritis), conjunctivitis (in reactive arthritis), sicca symptoms (in Sjögren syndrome), oral and other mucous membrane ulcers (in reactive arthritis, SLE, and Behçet syndrome), lymphadenopathy (in SLE and Sjögren syndrome), and cutaneous lesions (in psoriasis, dermatomyositis, scleroderma, SLE, and vasculitides) should be considered. Recurrent otorhinolaryngologic complaints, such as sinusitis, should raise suspicion for granulomatosis with polyangiitis (i.e., Wegener's granulomatosis). Lesions of psoriasis in the scalp, umbilicus, and anal crease; thickening of the skin on the fingers in scleroderma; and mucous membrane ulcers are often overlooked.

The lung examination may find evidence of interstitial fibrosis (in scleroderma, SLE, rheumatoid arthritis, and myositis), and a cardiac evaluation may reveal aortic insufficiency (in SLE and spondyloarthropathy), pulmonary hypertension (in systemic sclerosis), or evidence of cardiomyopathy (in systemic sclerosis, myositis, and amyloidosis). Pleural and pericardial rubs may be detected in SLE, rheumatoid arthritis, and scleroderma. Hepatosplenomegaly (in SLE and rheumatoid arthritis) and abdominal distention (in scleroderma) are also valuable clinical clues.