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Bilateral Erosive Sacroiliitis in Late Pregnancy Followed by Postpartum Peripheral Arthritis: Spondyloarthritis or Rheumatoid Arthritis?

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Abstract

Rheumatoid arthritis (RA) often improves during pregnancy, but the postpartum period may unmask previously unrecognized disease. Sacroiliac involvement is uncommon in RA and usually suggests spondyloarthritis. We report the case of a 25-year-old primigravida admitted at 37 weeks of gestation with acute, febrile, bilateral inflammatory buttock pain and markedly elevated inflammatory markers. Infection was considered unlikely, and magnetic resonance imaging (MRI) showed bilateral sacroiliitis with subchondral bone marrow edema, joint space narrowing, and erosions, initially suggesting axial spondyloarthritis. On postpartum day five, arthritis developed in the left wrist, the left second and third metacarpophalangeal joints, and the right thumb interphalangeal joint, with ultrasound-confirmed synovitis. Anti-citrullinated protein antibodies (ACPA) were positive at 143 U/mL, whereas rheumatoid factor was negative. The patient fulfilled both the 2010 American College of Rheumatology/European League Against Rheumatism classification criteria for RA and the Assessment of SpondyloArthritis International Society classification criteria for peripheral spondyloarthritis; spondyloarthritis, isolated or coexisting with RA, was considered at least as likely as RA. Intravenous methylprednisolone pulses, followed by low-dose oral prednisone and breastfeeding-compatible sulfasalazine, led to clinical and laboratory improvement, which was partial at three months. The erosions and the intensity of the inflammatory response suggested a cause beyond pregnancy-related sacroiliac changes. This case illustrates that atypical sacroiliitis during pregnancy may be the first manifestation of an inflammatory arthritis, with peripheral features emerging only after delivery, and that a positive ACPA result should not, by itself, outweigh a clinical picture typical of spondyloarthritis.

Categories: Radiology, Rheumatology
Keywords: anti-citrullinated protein antibodies, magnetic resonance imaging, postpartum period, pregnancy, rheumatoid arthritis, sacroiliitis, spondyloarthritis

Introduction

Rheumatoid arthritis (RA) is a chronic inflammatory arthritis that predominantly affects the small peripheral joints and for which anti-citrullinated protein antibodies (ACPA) are the most specific serological marker, whereas sacroiliitis is a hallmark feature of axial spondyloarthritis [1,2]. Sacroiliac involvement is rare in RA but probably underestimated [3].

During pregnancy, ligamentous laxity and mechanical stress on the pelvis can cause sacroiliac joint dysfunction and subchondral bone marrow edema of the sacroiliac joints on magnetic resonance imaging (MRI), which may be difficult to distinguish from inflammatory sacroiliitis [2,4]. According to the Assessment of SpondyloArthritis international Society (ASAS), active sacroiliitis on MRI is defined by the clear presence of subchondral bone marrow edema; structural lesions, such as erosions, may support its spondyloarthritic origin but are not required for the definition [5]. Erosions, however, are unusual in this setting and should prompt a search for an underlying inflammatory cause [4]. Pregnancy also modulates RA activity: disease activity improves in most patients during pregnancy, whereas the postpartum period carries a risk of flare and may unmask previously unrecognized disease [6,7]. Finally, pregnancy and the postpartum period are recognized risk periods for pyogenic sacroiliitis, and infection must be excluded first in any acute febrile presentation [8,9], bearing in mind, in our setting, brucellosis, tuberculosis, and disseminated gonococcal infection.

We report a case of bilateral erosive sacroiliitis occurring in the third trimester, followed on postpartum day five by peripheral arthritis with high-titer ACPA, raising the question of RA or spondyloarthritis. This case is unusual in that erosive sacroiliitis was the first manifestation of the disease during pregnancy, and it illustrates how pregnancy may delay the peripheral expression of an inflammatory arthritis until delivery. It also highlights the pitfalls of interpreting sacroiliac MRI in this setting. This report was prepared in accordance with the CAse REport (CARE) guidelines [10].

Case Presentation

A 25-year-old primigravida at 37 weeks of gestation with no relevant past medical history presented with acute-onset bilateral inflammatory buttock pain that had begun one week earlier. Her mother had an unspecified deforming inflammatory arthritis. The pregnancy had been uneventful, and there was no history suggestive of recent infection.

On admission, she was febrile at 38.5 °C, with a heart rate of 125 beats/min and a blood pressure of 110/70 mmHg. Buttock pain was rated 8/10 on a visual analog scale (VAS) [11] and caused marked functional impairment. Examination revealed positive sacroiliac provocation tests and a very painful left shoulder, with active and passive range of motion limited by pain, but no other peripheral arthritis and no signs of pyelonephritis. The obstetric status was stable.

Given the fever and acute onset, infectious sacroiliitis was initially suspected, while spondyloarthritis was also considered. Laboratory findings at admission are summarized in Table *1*. They showed leukocytosis with neutrophil predominance and markedly elevated inflammatory markers, whereas procalcitonin was negative, blood cultures were sterile, and renal function and liver enzymes were normal. Renal ultrasound was also normal. Empirical intravenous therapy with a third-generation cephalosporin (2 g/day) was started.

Parameter	Patient value	Reference range
Hemoglobin (g/dL)	11.3	12-16
Mean corpuscular volume (fL)	82.0	80-100
Mean corpuscular hemoglobin (pg)	26.5	27-32
White blood cells (×10³/µL)	12.89	4-10
Neutrophils (×10³/µL)	11.02	2-7.5
C-reactive protein (mg/L)	85	0-5
Erythrocyte sedimentation rate (mm/h)	111	<20
Procalcitonin (ng/mL)	0.04	<0.05
Creatinine (mg/L)	5.74	5-9
Alanine aminotransferase (U/L)	15	7-33
Aspartate aminotransferase (U/L)	26	10-35
Blood cultures	Sterile	Sterile

TABLE 1: Laboratory findings at admission (37 weeks of gestation)

Reference ranges are those of the hospital laboratory.

Pelvic radiography was deferred because of the pregnancy. MRI of the sacroiliac joints and lumbar spine, performed on day three, showed patchy subchondral signal abnormalities on both the iliac and sacral sides of both sacroiliac joints (low signal on T1-weighted images and high signal on T2-weighted and short tau inversion recovery (STIR) images), with joint space narrowing, irregular joint margins, and erosions, but no soft-tissue collection; the lumbar spine was normal (Figure *1*).

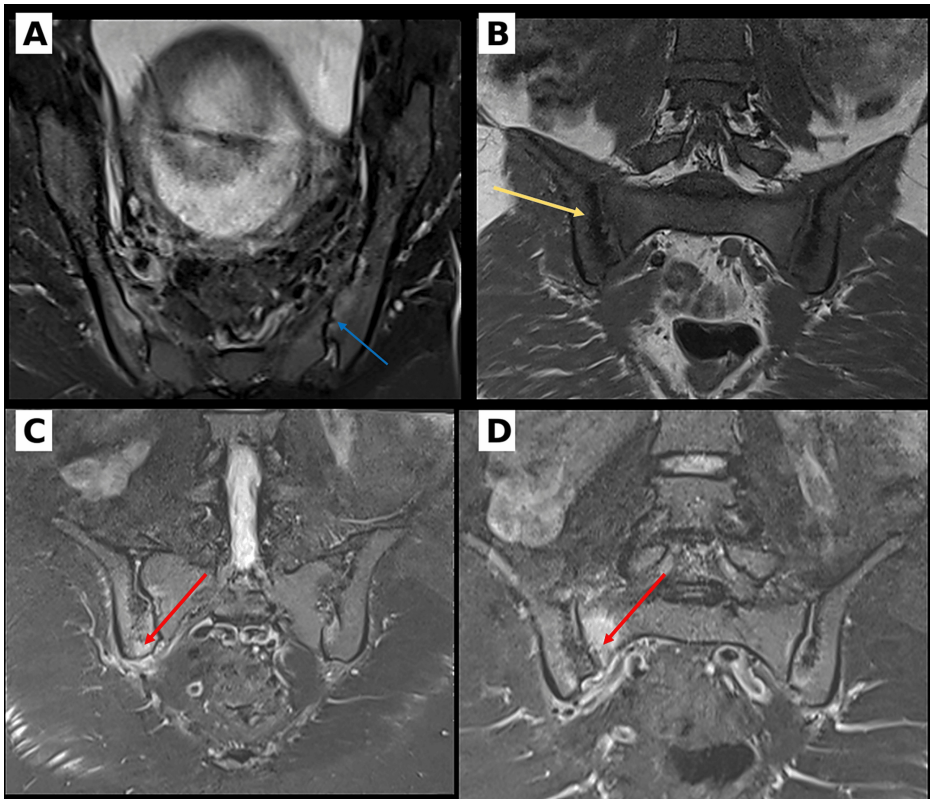


FIGURE 1: Sacroiliac joint MRI showing bilateral erosive sacroiliitis

MRI of the sacroiliac joints at 37 weeks of gestation. (A) T2-weighted image. (B) T1-weighted image. (C, D) Short tau inversion recovery (STIR) images. Bilateral subchondral signal abnormalities on both sides of both joints (low signal on T1-weighted and high signal on T2-weighted/STIR images), with joint space narrowing, irregular joint margins, and erosions, without soft-tissue collection.

Blue arrow: erosion of the left sacroiliac joint on the T2-weighted image. Yellow arrow: irregular margins and erosions of the right sacroiliac joint on the T1-weighted image. Red arrows: subchondral high signal on STIR images. MRI: magnetic resonance imaging

Axial and peripheral spondyloarthritis (involving the left shoulder) was then considered, and antibiotics were discontinued after three days. As non-steroidal anti-inflammatory drugs (NSAIDs) are contraindicated in the third trimester, therapeutic options were limited. Inflammatory markers remained elevated (C-reactive protein (CRP) 83.1 mg/L, then 96.4 mg/L). At 38 weeks, she delivered vaginally under epidural anesthesia, without maternal or neonatal complications.

On postpartum day five, sacroiliitis persisted clinically, and arthritis had developed in the left wrist, the left second and third metacarpophalangeal (MCP) joints, and the right thumb interphalangeal (IP) joint (Figure *2*). Ultrasound confirmed synovitis of these joints, as well as left glenohumeral synovitis with effusion in the tendon sheath of the long head of the biceps, which accounted for the initial shoulder pain. CRP rose to 271.8 mg/L and the erythrocyte sedimentation rate (ESR) to 120 mm/h; ACPA were positive at 143 U/mL, and rheumatoid factor (RF) was negative. No extra-articular features of spondyloarthritis were found: there was no psoriasis, no history or signs of uveitis, no gastrointestinal symptoms suggestive of inflammatory bowel disease, and no clinical enthesitis. The patient fulfilled the 2010 American College of Rheumatology/European League Against Rheumatism (ACR/EULAR) classification criteria for RA, with a score of 7/10: joint involvement 3 (four small joints and one large joint), serology 3 (ACPA 143 U/mL, more than three times the upper limit of normal of 20 U/mL), acute-phase reactants 1, and symptom duration 0 (less than six weeks) [12]. She also fulfilled the ASAS classification criteria for peripheral spondyloarthritis (peripheral arthritis with sacroiliitis on imaging) [13]. Spondyloarthritis, isolated or coexisting with RA, was therefore considered at least as likely as ACPA-positive RA.

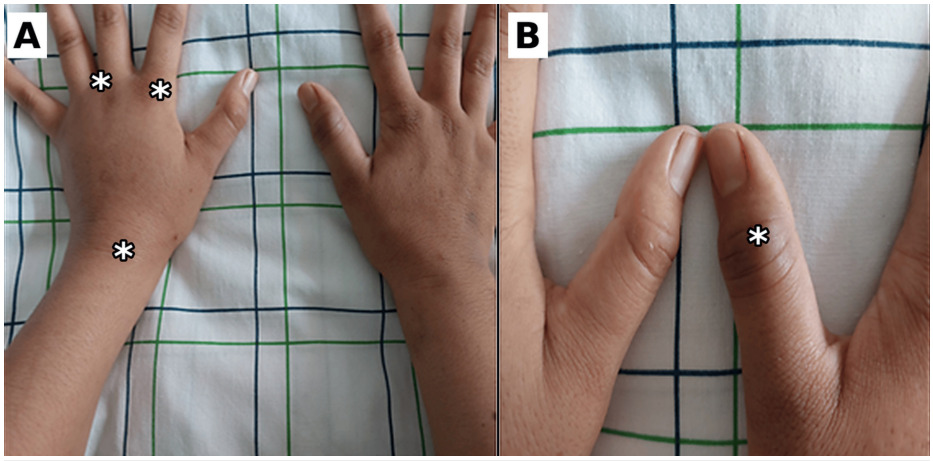


FIGURE 2: Peripheral arthritis on postpartum day five

(A) Arthritis of the left wrist and the left second and third metacarpophalangeal (MCP) joints. (B) Arthritis of the right thumb interphalangeal (IP) joint. Asterisks indicate the affected joints.

Intravenous methylprednisolone pulses (120 mg/day for three days) resulted in clinical and laboratory improvement (CRP: 6.73 mg/L). To allow breastfeeding, sulfasalazine (2 g/day) was combined with prednisone (7.5 mg/day). At three months, the improvement was partial: buttock pain was rated 5/10 on the VAS, with three tender and no swollen joints, a CRP level of 6 mg/L, and a disease activity score in 28 joints using CRP (DAS28-CRP) of 3.3 [14], indicating moderate disease activity; ESR was not measured. Breastfeeding was continued until this visit and then discontinued at the patient's request; methotrexate was then introduced, and corticosteroids were gradually tapered. The newborn, delivered at 38 weeks, was healthy. The timeline of events is summarized in Table 2. Written informed consent for publication of this case report, including the clinical details, MRI images, and photographs of the hands, was obtained from the patient.

Time point	Stage	Event
D−7	36 weeks	Onset of bilateral inflammatory buttock pain
D0	37 weeks	Admission: fever (38.5 °C), buttock pain (VAS 8/10), positive sacroiliac provocation tests, painful left shoulder; CRP 85 mg/L, negative procalcitonin; intravenous third-generation cephalosporin
D3	37 weeks	MRI: bilateral erosive sacroiliitis; axial and peripheral spondyloarthritis initially suspected; antibiotics discontinued
D7	38 weeks	Vaginal delivery under epidural anesthesia
D12	Postpartum day 5	Arthritis of the left wrist, left second and third MCP joints, and right thumb IP joint; left glenohumeral synovitis; CRP 271.8 mg/L; ACPA 143 U/mL; RF negative; 2010 ACR/EULAR criteria for RA (7/10) and ASAS criteria for peripheral spondyloarthritis fulfilled
D16	Postpartum	Methylprednisolone 120 mg/day for 3 days (CRP 6.73 mg/L), then prednisone 7.5 mg/day and sulfasalazine 2 g/day
M3	Follow-up	Partial improvement (VAS 5/10, DAS28-CRP 3.3, CRP 6 mg/L); corticosteroid tapering; methotrexate introduced after breastfeeding was discontinued

TABLE 2: Timeline of the clinical course and management

D: day; M: month; VAS: visual analog scale; CRP: C-reactive protein; MRI: magnetic resonance imaging; MCP: metacarpophalangeal; IP: interphalangeal; ACPA: anti-citrullinated protein antibodies; RF: rheumatoid factor; RA: rheumatoid arthritis; DAS28-CRP: Disease Activity Score in 28 joints using C-reactive protein; ; ASAS: Assessment of SpondyloArthritis international Society

Discussion

This case combines bilateral erosive sacroiliitis as the presenting feature during the third trimester of pregnancy with peripheral arthritis that emerged after delivery. The initial axial involvement pointed toward spondyloarthritis; the subsequent emergence of small-joint synovitis with high-titer ACPA raised the

possibility of RA, while the overall picture also fulfilled the classification criteria for peripheral spondyloarthritis.

Sacroiliitis not solely attributable to pregnancy

Fever and acute onset first required the exclusion of infectious sacroiliitis, as pregnancy and the postpartum period are recognized risk periods for this condition [8]. Bilateral involvement, the absence of a collection on MRI, negative procalcitonin, and sterile blood cultures made this diagnosis less likely, although a low procalcitonin level does not exclude deep musculoskeletal infection [15,16]. Other infectious causes relevant in our setting, such as brucellar or tuberculous sacroiliitis and, in a postpartum woman with wrist and hand arthritis, disseminated gonococcal infection, were not specifically tested for, which is a limitation of this report. However, the improvement achieved with high-dose corticosteroids, in the absence of antibiotics and with no relapse at three months, argues against an infectious cause.

Pregnancy itself may be associated with sacroiliac abnormalities on MRI. In a cohort of 103 primiparous women followed with serial MRI from gestational week 20 to 12 months postpartum, sacroiliac bone marrow edema was common, reaching 69% at three months postpartum, and 41% of the women fulfilled the ASAS definition of sacroiliitis at 12 months. However, edema predominated in the anterior and middle portions of the joint, and significant erosions were found in only 2.8% of the women [4].

In our patient, the bilateral erosions, joint space narrowing, and marked inflammatory response suggested a cause beyond pregnancy-related change; without follow-up imaging, however, persistence of structural lesions could not be confirmed. MRI, which avoids ionizing radiation, is well suited to assessing the sacroiliac joints during pregnancy and the postpartum period [2,4], but its findings should be interpreted alongside clinical, laboratory, and follow-up data.

A limitation of this report, however, is the absence of follow-up MRI after pregnancy, which would have allowed the evolution of the lesions to be assessed. In addition, the MRI was not formally scored according to the ASAS definitions.

RA with sacroiliitis or spondyloarthritis?

In RA, sacroiliac involvement is rare but probably underestimated. In a study of 100 patients with RA, Osman et al. reported inflammatory back pain in 52%, radiographic sacroiliitis in 22%, and active sacroiliitis on MRI in 13 of the 33 patients examined [3]. In patients with RA, however, lumbopelvic pain may also arise from degenerative or mechanical causes; in our patient, bilateral subchondral bone marrow edema, erosions, and marked systemic inflammation made this unlikely.

A literature review covering 1,950-2,020 identified only 81 cases of coexisting RA and ankylosing spondylitis, predominantly in men (71%), with HLA-B27 positivity in 90% [17]. Alenzi et al. described a situation similar to ours in an 18-year-old woman with strongly ACPA-positive RA and bilateral erosive sacroiliitis on MRI in the absence of HLA-B27; the authors concluded that both diseases coexisted and initiated a tumor necrosis factor (TNF) inhibitor [18].

In our patient, the high ACPA titer, more than seven times the upper limit of normal, and small-joint synovitis of the wrist and MCP joints are suggestive of RA; ACPA are found in only 2.6% of patients with other forms of spondyloarthritis and 10.6% of those with psoriatic arthritis [19]. Conversely, bilateral erosive sacroiliitis, a high CRP level, and asymmetric peripheral arthritis form a typical spondyloarthritis picture; the patient fulfilled the ASAS criteria for peripheral spondyloarthritis [13], and ACPA positivity alone does not rule out this diagnosis [19]. Moreover, the 2010 American College of Rheumatology/European Alliance of Associations for Rheumatology (ACR/EULAR) criteria apply only when synovitis is not better explained by another disease [12]. As in the case reported by Alenzi et al. [18], coexistence of both diseases is possible. In the absence of HLA-B27 typing and longer follow-up, however, spondyloarthritis, isolated or coexisting with RA, appears at least as likely as RA, and this case illustrates the overlap between these two entities.

Pregnancy and delayed clinical expression after delivery

Pregnancy modulates the immune response: in a meta-analysis of 10 studies, RA activity improved during pregnancy in 60% of patients, and 46.7% experienced a postpartum flare [6]. The postpartum period may also unmask previously unrecognized RA [7], possibly reflecting rapid immunological and hormonal changes.

In our patient, the glenohumeral synovitis present on admission suggests that the disease began during pregnancy; peripheral polyarthritis became fully apparent only after delivery, in parallel with the sharp rise in inflammatory markers.

After delivery, sulfasalazine and corticosteroids were chosen for their compatibility with breastfeeding, whereas methotrexate had to be avoided during lactation [20].

Conclusions

Atypical erosive sacroiliitis during pregnancy may precede the peripheral expression of an inflammatory arthritis. Our patient fulfilled the classification criteria for both RA and peripheral spondyloarthritis, and spondyloarthritis, isolated or coexisting with RA, is at least as likely as RA; a positive ACPA result should not, by itself, outweigh a clinical picture typical of spondyloarthritis. This case also highlights that sacroiliac abnormalities seen on MRI during pregnancy are not always explained by mechanical stress alone: erosions and marked systemic inflammation should prompt reconsideration of their cause. In young women with atypical sacroiliitis and peripheral arthritis, both spondyloarthritis and RA classification criteria should be considered, and HLA-B27 typing and follow-up are essential to establish the diagnosis. These conclusions are limited by the absence of HLA-B27 typing, a complete infectious workup, and follow-up MRI after pregnancy.

Additional Information

Author Contributions

All authors have reviewed the final version to be published and agreed to be accountable for all aspects of the work.

Concept and design: Imane Jahid, Manal El Morjani, Zineb Baba, Ahmed Mougui, Ahlam Belkhou

Acquisition, analysis, or interpretation of data: Imane Jahid, Manal El Morjani, Zineb Baba, Ahmed Mougui, Ahlam Belkhou

Drafting of the manuscript: Imane Jahid

Critical review of the manuscript for important intellectual content: Imane Jahid, Manal El Morjani, Zineb Baba, Ahmed Mougui, Ahlam Belkhou

Disclosures

Human subjects: Informed consent for treatment and open access publication was obtained or waived by all participants in this study. **AI use statement:** The authors used Claude AI (Anthropic PBC, San Francisco, CA), ChatGPT (OpenAI, San Francisco, CA) as follows: language polishing, translation, drafting summaries, structure or formatting, extensive copy editing or writing support, literature comparison in Abstract, Introduction, Case Presentation, Discussion, Conclusions, Table 1, References, Figure 2 (watermark removal only). The author collected all clinical data and wrote the original manuscript in French. Claude (Anthropic) was used to condense and edit the French draft, translate it into English, refine the language, and format the references. The author reviewed every suggested change, accepted or rejected each one, and verified all clinical data against the patient's records. All references cited from them were checked against the original publications. The author takes full responsibility for the content of the manuscript. The authors confirm that they have reviewed and verified all AI-assisted content and take full responsibility for the work. **Conflicts of interest:** In compliance with the ICMJE uniform disclosure form, all authors declare the following: **Payment/services info:** All authors have declared that no financial support was received from any organization for the submitted work. **Financial relationships:** All authors have declared that they have no financial relationships at present or within the previous three years with any organizations that might have an interest in the submitted work. **Other relationships:** All authors have declared that there are no other relationships or activities that could appear to have influenced the submitted work.

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