Blood tests demonstrated lymphocytopenia, raised troponin (peak 490 ng/L). On presentation, he was in cardiogenic shock with raised temperature. Myocarditis was identified at an early stage from imaging and blood tests, manifesting including hyperinflammation states and vasculitis. Including cardiac, ENT, neurological and gastrointestinal, as well as systemic.

Sincethat time our understanding of the variability of COVID-19 has become ingextra-pulmonary manifestations. Of this condition had been identified, experience was still limited regarding.

Investigations revealed high inflammatory markers; CRP 29 (0-10 mg/L) and large joints. She had a history of recurrent episcleritis and had been investigated for axial spondyloarthritis two years previously, but MRI imaging of the spine and sacroiliac joints did not show any inflammatory changes.

Examination in the rheumatology clinic confirmed right medial epicondylitis, bilateral shoulder tenderness, tenderness over the extensor tendons of the feet and painful cervical spine movement. Investigations revealed high inflammatory markers; CRP 29 (0-10 mg/L) and ESR 48 (0-15 mm/hr), a positive rheumatoid factor but negative anti CCP antibodies and a normal white cell count.

Acute seronegative spondyloarthritis was suspected but Chikungunya serology was requested at the suggestion of the patient,
because of the history of a mosquito bite. IgM and IgG antibodies were positive on immunofluorescence, confirming recent infection. She was initially given intramuscular depotmedrone and non-steroidal anti-inflammatory drugs (NSAIDs) with a short response but required oral prednisolone 20 mg daily to suppress the inflammation in her feet. An MRI confirmed an ankle effusion and peroneal tenosynovitis. After 6 months her symptoms improved, and she was able to stop prednisolone completely and she remains well 8 months after the initial infection.

**Case report - Discussion:** Chikungunya infection causes musculoskeletal symptoms in all affected patients, but the clinical presentation can be highly variable, ranging from mild joint pain to erosive arthritis. It can be divided into three phases: incubation phase, acute phase, and chronic phase. The incubation phase varies between one to twelve days after the mosquito bite.

The acute phase begins with high fever, headache, polyarthralgia/arthritis, lymphadenopathy, and anorexia. Joint involvement is often distal and symmetrical affecting the hands, wrists, shoulders, knees, ankles, and feet. A maculopapular rash is common. Dengue virus and Zika virus infections can present similarly.

Treatment for acute Chikungunya fever is supportive. Analgesic, anti-pyretic and NSAIDs are used for symptom relief. During the chronic phase, infected people develop symmetrical, migratory, oligoarticular or polyarticular arthritis with morning stiffness and joint oedema, which can last from months to years. Our patient had a previous history which was consistent with seronegative spondyloarthropathy, an acute presentation of inflammatory arthritis and results and imaging which supported this diagnosis. The correct diagnosis could easily have been missed if a travel history had not been taken and the patient’s suspicions ignored.

The best treatment for chronic Chikungunya arthritis is unclear. NSAIDs are often the first treatment but, as in this case systemic steroids are often necessary. Conventional synthetic DMARDs have also been reported efficacious. Biologic DMARDS have been used in resistant cases.

**Case report - Key learning points:** Chikungunya has emerged as a global disease affecting millions of people with significant musculoskeletal morbidity. Any patient has travelled to endemic areas including Africa and Asia, with fever and joint pain should be screened for Chikungunya virus as well as Dengue virus, and Zika virus. Diagnosis is either by RT PCR (positive 0-7 days of infection or Immunoglobulin M (detectable after 5 – 10 days of infection and persists for few months). Treatment is supportive in acute phase, may require low doses of steroids to aid resolution of symptoms. Conventional DMARDS have shown benefit in chronic phase with ongoing synovitis/tenosynovitis.

Patients may know more about rare, endemic diseases than their European doctors and their suspicions about potential diagnoses should always be considered.

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