Chikungunya (CHK) is an arboviral illness caused by CHIK virus and transmitted by the bite of *Aedes* *egypti* mosquito. The disease was first reported from Tanzania in 1952. The disease is so named from Makonde root verb kungulya meaning “that which bends up” which refers to the posture adopted by the affected person due to rheumatological manifestations of the disease.

After initial outbreak, the disease spread globally with increasing outbreaks in Africa, India and Southeast Asian countries. The first epidemic in India occurred at Calcutta in 1963. The massive outbreak which occurred in 2005 affected more than 1.4 million people spread over 13 states. The disease was reported mainly from the South Indian States, the worst hit being Andhra Pradesh while the northern states are spared.

The disease is characterized by a sudden onset of high grade fever, rash and arthralgias. The predominant symptom of Chikungunya infection is related to musculoskeletal symptom ranging from arthralgias to arthritis. The joint pain is worse in the morning exacerbated by movements rendering the affected person crippled. Ankles, wrists and small joints of the hand are most affected. Large joints like knee and shoulder may also be affected. Migratory polyarthritis with synovitis has been reported in 70% of the cases. The disease tends to affect the joints with preceding trauma or degeneration. It is usually a self limited illness like any other viral infections. A retrospective study has shown complete resolution in 87.9%, episodic stiffness and pain in 3.7%, persistent stiffness without pain in 2.9% while 5.9% cases had persistent painful restriction of joint symptoms. Enthesopathy and tendinitis was observed in 53% of cases. There are only anecdotal case reports of deforming arthritis secondary to Chikungunya infection.

The entity of post-chikungunya chronic arthritis is not well defined. Whether there is such a separate entity or a viral trigger producing Rheumatoid arthritis (RA) in a genetically susceptible individual is not known. Combe et al reported 21 cases of RA following Chikungunya infection. At present there are no defining criteria for post-chikungunya chronic arthritis. Most of the reported cases of post-chikungunya chronic arthritis have no pathological confirmation of persistent viral antigens in the synovium. Some of the differentiating features between RA and post-chikungunya chronic arthritis could be the nature of onset, evidence of similar illness in the family, age of onset, absence of serological evidence (rheumatoid factor, anti-CCPAb), radiological changes like erosions(marginal) and histopathological evidence.

Anti –CCP antibodies have higher specificity of around 97% in the diagnosis of RA. Even though there has been of late reports of false positive anti-CCPs in patients with tuberculosis, HCV infection and COPD, it still remains highly specific for RA, the presence of which is associated with erosive disease.

RA requires early management to prevent joint damage and deformities. The precipitation of RA following viral infection is well known. The aggressive treatment of RA during early stages with steroids, and DMARDs if not responsive then with biological therapy has proven to be beneficial in preventing erosions. Further genetic studies and animal models are required to define the entity called post-chikungunya chronic arthritis.

In the study done in Latur, by Mohini A Ganu and AS Ganu they have shown that chronic inflammatory, erosive and rarely deforming polyarthritis does occur after acute chikungunya infection in some (5.6%). It is seronegative and AntiCCP positive in majority. DMARDs like sulfasalazine and methotrexate are required and effective in treatment of PCCA.

References