

A case of tibiofibular joint involvement in patient with ankylosing spondylitis

안양샘병원 내과

*김종욱, 고두현, 김태형, 오지민

Ankylosing spondylitis (AS) is a chronic, immune-mediated disease. It causes inflammation of the spinal joints that can lead to severe, chronic pain. AS can also cause inflammation in other areas of the body such as shoulders, hips, ribs, heels, and joints of the hands and feet. But there are few reports of tibiofibular joint (TFJ) involvement in patient with AS. Here, we report a single case of TFJ involvement in patient with AS. A 68-year-old man presented to our hospital with a chief complaint of low back pain for 1 year. Other symptoms were neck pain, shoulder pain, right knee pain and morning stiffness. On physical examination, modified Schober's test was negative and there was no definite swelling on knee, but FABERE test was positive. Laboratory tests were follows: ESR 29 mm/hr, CRP 35.3 mg/L, HLA-B27 positive. X-ray of pelvis revealed sclerotic change with bony erosion at both sacroiliac joints suggesting sacroiliitis. Increased uptake at right proximal tibia was observed on whole body bone scan (Figure 1). MRI performed to evaluate the sustained right knee pain, showed arthritis at proximal TFJ, with adjacent bone marrow edema and soft tissue swelling (Figure 2). Medical treatment with NSAIDs, sulfasalazine, acetaminophen was started. During a four-week medical treatment period, we were able to confirm that his symptoms are improving. Arthritis of TFJ is likely underdiagnosed because it is uncommon cause of lateral knee pain. Practitioners should consider TFJ involvement for patient with AS presenting lateral knee pain.

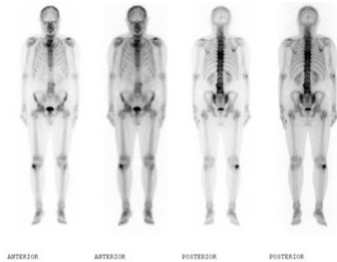


Figure 1 : Whole body bone scan showed increased uptake at right proximal tibia.

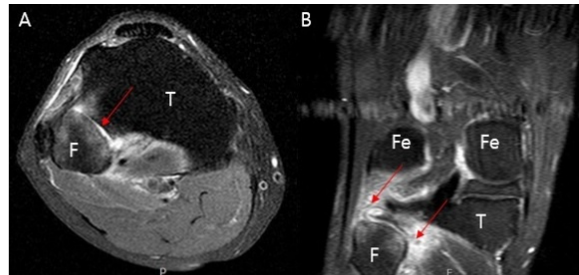


Figure 2 : Right knee MRI. Axial fat-saturated proton density MR image (Figure 2A) and coronal gadolinium-enhanced fat-saturated T1-weighted image (Figure 2B) showed arthritis at proximal tibiofibular joint, with adjacent bone marrow edema and soft tissue swelling (arrows). Fe indicates femur, T : tibia, F : fibula

A Case of Systemic Lupus Erythematosus with Fasciitis Presenting as Lower Back Pain

¹한양대학교 류마티스내과학교실, ²한양대학교 영상의학과교실

*최현주¹, 송승택¹, 송윤아², 이승훈², 배상철¹

Systemic lupus erythematosus (SLE) is an inflammatory autoimmune disease. It affects multiple organs, including the musculoskeletal system. Currently, cases of necrotizing fasciitis and eosinophilic fasciitis in SLE patients have been reported worldwide. However, in SLE, causes of fasciitis besides infection and eosinophilic fasciitis have not been reported yet. We report a case of the fasciitis that presented as a persistent lower back pain in a SLE patient. A 15-year-old girl with SLE presented with persistent lower back pain without a trauma history. As her symptoms did not respond to pain-killers, further evaluation was done. On lumbar spine magnetic resonance imaging (MRI), increased signal intensity on T2-weighted images and positive enhancement on contrast enhancement images were observed along the fascia of the lumbar muscles without any evidence of muscle involvement. Her symptoms improved with moderate-dose prednisolone therapy (0.5 mg/kg/day). Azathioprine was added as a steroid-sparing agent, and the prednisolone dose was carefully reduced, keeping her symptoms and laboratory data stable. When SLE patients experience persistent myalgia or lower back pain of unknown origin, further evaluation should be considered. Fasciitis, although rare, should be suspected in these patients. Laboratory tests, radiological examinations, and histological analysis could facilitate differential diagnosis

Table 1. Biochemical data

	At diagnosis of SLE (June, 2015)	At diagnosis of myofasciitis (August, 2015)	Follow-up after 2 months (October, 2015)	Reference range
WBC (/mm ³)	3.2	6.3	6.3	4,000-10,000
Hb (g/dL)	13.7	10.5	14.8	13-17
PLT (/mm ³)	124	194	267	150,000-450,000
AST (U/L)	72	13	13	0-40
ALT (U/L)	87	9	14	0-40
LDH (U/L)	295	217	199	100-280
CK (U/L)	69	14	28	26-280
Myoglobin (ng/mL)	40.6			13-71
CRP (mg/dL)	0.17	1.0	<0.3	0-0.3
ESR (mm/hr)	28	50	2	0-20
C3/C4 (U/mL)	42/10	50/10	54/8	-
Anti-dsDNA antibodies (IU/mL)	(+)	(+) > 600	(+) 121	-

ALT, alanine transaminase; AST, aspartate transaminase; C, complement; CK, creatine kinase; CRP, C-reactive protein; ESR, erythrocyte sedimentation rate; Hb, hemoglobin; IU, international units; LDH, lactate dehydrogenase; PLT, platelet; WBC, white blood cells