CPPD combined with Fasciitis Ossificans in Young Male, The First Case Report in Korea

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CPPD crystal deposition disease is extremely rare in young male, furthermore, CPPD crystal deposition disease combined with fasciitis ossificans is the first case, as far as we know. We report a rare case of CPPD crystal deposition disease combined with fasciitis ossificans in young age of 27years old. He was admitted to a hospital with right hand multiple joint pain and swelling from 2015. He had recurrent and aggravated left foot and right knee joint pain and swelling from 6 months ago. On examination, there was swelling, painful restriction of movement in his right hand, left foot, and right knee joints. Simple x-ray of knee joints showed multiple calcifications scattered in lower thigh and lower leg (Fig.1). Ultrasonography of left knee showed that echogenic plaque was seen at deep investing fascia of left medial pretibial region of proximal lower leg (Fig. 2A). Multiple intaarticicular echogenic materials were floating in right intercapal joint with hypoechoic synovial thickening, suggesting crystal arthropathy with active synovitis (Fig. 2B). Lab finding showed hyperuricacid and hypomagnesium in serum, hypermagnesium in urine. Joint aspiration was done in right knee joint and weakly positive birefringent crystals were seen (Fig. 3). Excision and biopsy of left medial pretibial lesion showed heterotopic bone formation consistent with fasciitis ossificans in mature phase. It is necessary to check crystal arthropathy including CPPD crystal deposition disease if young person has arthralgia with multiple calcification.

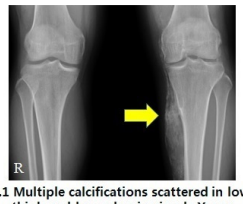

Fig.1 Multiple calcifications scattered in lower thigh and lower leg in simple X-ray

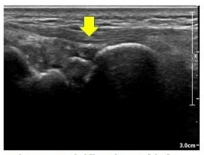

Fig. 2A Calcification of left knee fascia and intrameniscus

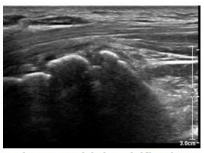

Fig. 2B Multiple calcification of right wrist

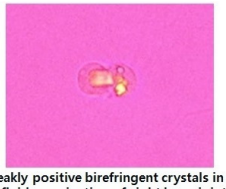

Fig.3 Weakly positive birefringent crystals in synovial fluid examination of right knee joint

Sarcoidosis presenting as multiple bursitis: a case report

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A 37-year-old man with no underlying disease visited the rheumatology clinic with swelling of multiple joints(bilateral - elbow, wrist, hip, knee, and ankle joints) and pain that started two months ago. The chest and involved joint X-rays showed no abnormal findings. The Musculoskeletal(MS) ultrasound(US) showed bursa enlargement with synovial villous formation in each involved joint.(Fig.1) Angiotensin converting enzyme level was ＞150 U/L (control, 9.0-47.0). Histopathologic examination of the synovial membrane of the ankle showed no evidence of granuloma. But clinically, sarcoidosis was suspected and 10 mg prednisolone(Pd) treatment was started. While maintaining the dose of Pd at 7.5 mg, pain and swelling occurred in the right hip region. MS US revealed a fusiform mass.(Fig.2) Hip magnetic resonance(MR) showed diffusely increased T2 signal intensity in the entire bilateral hip and proximal thigh muscles.(Fig.3) Histopathologic examination of proximal thigh lesion showed granuloma, consistent with sarcoidosis.(Fig.4) Once the Pd was increased to 20 mg, his symptoms improved. Sarcoidosis is a systemic inflammatory disease that can occur anywhere in the body. The most common organs of involvement are the lung and skin. Although MS sarcoidosis rarely occurs, it may directly involve the bones and manifest in various forms such as arthritis, bursitis, myositis, and osteitis cystoides multiplex. When the cause of bursitis is unclear, the possibility of a sarcoidosis should be considered.