Bilateral pseudothrombophlebitis

Sir: Katz et al defined the pseudothrombophlebitis syndrome as the presence of signs and symptoms of thrombophlebitis secondary to injury, disease, operation or other cause, demonstrated by arthrography. Subsequently, many other causes of pseudothrombophlebitis have been described, but Baker’s cyst remains the most common cause of the syndrome. We report a case in which a bilateral pseudothrombophlebitis was secondary to ruptured Baker’s cysts of both knees. To the best of our knowledge this clinical situation has not been previously reported.

A 59 year old man was admitted to hospital because of pain, swelling, and erythema of both calves. Over the preceding 10 years he had had recurrent attacks of transient migratory monoarthritis of the larger joints, which cleared up within a few days either spontaneously or with anti-inflammatory agents. Two weeks before the current admission he developed a synovial effusion of the left knee joint without evidence of previous local trauma. An arthrocentesis ruled out the presence of crystals or micro-organisms, and he was treated with anti-inflammatory drugs. One week later he developed a synovial effusion of the contralateral knee joint, with pain, tumefaction, and erythema of both calves.

On admission, blood pressure was 140/80 mmHg and temperature 37°C. There was difficulty in walking and both Homans’ sign and Löwenberg’s test were positive. The remainder of the physical examination was normal. The laboratory results showed a sedimentation rate of 121 mm/hr and an increase of other acute phase reactants. The complete blood count, muscle enzyme activity, rheumatoid factor, antinuclear antibody test, β2-xylene test, and the upper gastrointestinal series were either normal or negative. A deep vein thrombosis was ruled out by a phlebogram and Doppler ultrasound study. An ultrasound examination of the limbs showed the presence of fluid in the popliteal regions of both knees, extending along the fascial planes as far as the ankle. A culture of syovial fluid obtained by fine needle aspiration was negative. A bilateral nuclear magnetic resonance scan (figure) showed liquid collection extending down from the popliteal space to the lower third of both legs. These findings were considered compatible with a diagnosis of complicated popliteal cyst. An operation was performed, initially on the left knee, owing to the persistence of the symptoms after one month of conservative treatment with rest and anti-inflammatory agents. During the operation a large Baker’s cyst dissecting through the fascial planes of the gastrocnemius and soleus muscles of the calf was resected. Three months later the other knee was operated on.

Both intact Baker’s cysts and those complicated by rupture or dissection may manifest clinically as thrombophlebitis. The differential diagnosis may be at times impossible. Moreover, popliteal cysts may develop in patients without a history of joint involvement; therefore the absence of a previous history of joint involvement does not exclude the possibility of this diagnosis. A phlebogram will exclude thrombophlebitis, but the diagnosis of Baker’s cyst is best shown by arthrography, which is currently considered the most sensitive diagnostic method available. Computed tomographic scans and ultrasonography are other useful diagnostic examinations, but nuclear magnetic resonance scans have seldom been used. A Baker’s cyst might also coexist with a thrombophlebitis, which is probably secondary to the cyst itself (pseudo-pseudothrombophlebitis).

We were prompted to report this case as the existence of bilateral Baker’s cyst is uncommon and their simultaneous complication producing a clinical picture of bilateral pseudothrombophlebitis is extremely unusual. In our patient an arthrography was not deemed necessary before the operation because of the precise demonstration of complicated popliteal cyst by both ultrasonography and nuclear magnetic resonance examinations. We feel that nuclear magnetic resonance is an equally useful method for confirming the presence of a Baker’s cyst in patients with a clinical diagnosis of pseudothrombophlebitis.

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Cytomegalovirus pneumonia in a patient with rheumatoid arthritis treated with low dose methotrexate and prednisone

Sir: In a recent issue of the Annals Wallis et al emphasized the possibility of opportunistic infection in patients treated with low dose methotrexate. We report the case of a patient with rheumatoid arthritis receiving weekly low dose oral methotrexate in conventional dosage and prednisolone (10 mg daily) who presented with cytomegalovirus pneumonia.

Nuclear magnetic resonance scan of the limbs. Bilateral Baker’s cyst dissecting down through the fascial planes.
Cytomegalovirus pneumonia in a patient with rheumatoid arthritis treated with low dose methotrexate and prednisone.

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