Hypertrophic osteoarthropathy following aortic surgery

F Dellestable, P Pére, D Régent, A Gaucher

Clinical history
A 67 year old man presented with a one year history of increasing pain and swelling of his right lower limb. On examination he was apyrexial and there was diffuse inflammatory swelling and tenderness of his right lower limb with effusion of the knee. No clubbing was evident. Aspiration of the knee obtained a clear, mildly inflammatory synovial fluid. There were no crystals and cultures were negative. Initial laboratory investigations revealed: haemoglobin 10.8 g dl\(^{-1}\), erythrocyte sedimentation rate 76 mm/h, C reactive protein 21 mg litre\(^{-1}\); rheumatoid factor, antinuclear antibodies, VDRL negative; serum electrolytes, plasma calcium, alkaline phosphatase, liver function tests, and thyroid hormone concentrations normal. There was no relevant past medical history other than intermittent claudication which had been remedied by an aortobifemoral bypass with a Dacron graft five years previously.

Imaging findings and clinical course
Plain radiographs of the lower limbs were obtained. There was marked periosteal new bone formation along the diaphysis and metaphysis of the right femur, tibia, fibula and metatarsals, the left side being unaffected (figs 1–3).

\(^{99}\)Tc methylene diphosphonate bone scan showed increased linear pericortical activity in the entire right lower limb with associated increased radionuclide uptake in the adjacent soft tissue (fig 4). The rest of the skeleton was otherwise normal. Magnetic resonance imaging (MRI) of the right knee confirmed joint effusion, mild synovitis, and periostitis appearing as a regular line of low signal intensity separated from the underlying bony cortex by a narrow line of high signal intensity (fig 5). The patient refused further investigation and went home.

Differential diagnosis
The imaging features of unilateral localised periostitis in the lower limbs can be observed in a number of disorders including chronic osteomyelitis, syphilis, patent ductus arteriosus with reversal of blood flow,\(^1\) pulmonary metastatic disease from angioblastic meningioma,\(^2\) chronic venous stasis,\(^3\) Crohn’s disease,\(^4\) severe liver diseases (for example, primary biliary cirrhosis, Wilson’s disease, biliary atresia),\(^5\) thyroid acropachy,\(^6\) polyarteritis nodosa,\(^7\) diverticular abscess of the colon,\(^8\) and primary hypertrophic osteoarthropathy.\(^9\) These disorders were excluded on clinical, radiological, and biological grounds. Although in our patient left distal pulses were palpable and intermittent claudication was not present at initial presentation, an ischaemic left lower limb could not be totally ruled out. Indeed, this potential change in regional vascular distrib-
ution with relatively increased blood flow to the right lower extremity might have accounted for the preferential development of osseous changes in that limb. Thus the initial diagnosis was unilateral periostitis associated with differential arterial perfusion distal to an aortic graft.

Follow up and final diagnosis
Four months later the patient was readmitted for acute ischaemia of his left lower limb with chills and fever of several weeks duration. Blood cultures were positive for Streptococcus milleri. An extra-anatomical axillofemoral bypass was performed with excision of the aortobifemoral graft. A severe infection of the aortic prosthesis was found. Cultures of the resected graft grew Enterococcus and Corynebacterium xerosis. Despite lower extremity revascularisation and intensive antibiotic treatment, the patient died from cardiac and septic complications. No necropsy was performed. The final diagnosis was localised periostitis complicating aortic prosthesis infection.

Discussion
Periostitis is the hallmark of hypertrophic osteoarthropathy (HOA), a syndrome classically characterised by clubbing of the fingers and toes, periosteal new bone formation in the tubular bones, painful swelling of limbs, arthralgia, and arthritis. Signs of autonomic disorders, such as sweating, flushing, and blanching of the skin, also may be present. HOA may be divided into two categories: primary (hereditary or idiopathic) HOA, also called pachydermoperiostosis, and secondary HOA. Major causes of the secondary form include malignant or inflammatory conditions of the lungs, mediastinum, and pleura, congenital cyanotic heart disease, and inflammatory bowel diseases. Whether primary or secondary, the clinical and radiological findings of HOA are generally diffuse, bilateral, and symmetrical, involving both upper and lower extremities. Secondary HOA that is confined to the lower extremity in a unilateral or bilateral fashion is very rare and has been described in patients with a patent ductus arteriosus with reversal of flow, or an infected aortic graft.

Two main theories have been postulated to explain the pathogenesis of HOA. The first, the neurogenic theory, suggests that the autonomic nervous system might play a role in HOA in view of the prompt relief of symptoms and signs following surgical vagotomy. The second hypothesis, which is currently favoured, is humoral and proposes that the substance responsible for HOA might be a circulating factor normally present in the venous circulation and also normally inactivated or removed by the lungs. On the basis of this latter theory, a new hypothesis has recently been proposed, suggesting that both clubbing and periostitis could be produced by the release of platelet derived growth factor (PDGF) due to the peripheral fragmentation of megakaryocytes and platelet clumps which are normally trapped by the pulmonary capillary bed. This hypothesis also accounts for HOA complicating an infected aortic graft, as chronic infection may lead to the formation of platelet clumps with secondary release of PDGF in the arterial
breast tissue and subsequent bone proliferation along the shafts of long bones is the major radiological finding, appearing first in the distal diaphyseal regions. Initially, periosteal changes appear as a continuous thin line of new bone separated from the underlying bony cortex by a narrow radiolucent line. However, the morphology, extent, and distribution of the periostitis change during the course of the disease. Thus in mild and early cases, few bones are affected (most commonly the tibia and fibula) and the periosteal proliferation is limited to the diaphysis and appears as a single layer of new bone. Subsequently, more bones are involved, metaphysis and epiphysis may be affected, and periostitis becomes multilayered, fusing with the subjacent osseous tissue and leading to cortical thickening. In more advanced cases, ligamentous ossification may appear in the interosseous region between the tibia and fibula (fig 2).

Radionuclide bone imaging using $^{99m}$Tc methylene diphosphonate is a highly sensitive method of detecting abnormalities of HOA and is very useful in documenting the extent and exact distribution of periostitis. The scintigraphic abnormalities frequently appear before the roentgenographic findings and may be present before the development of symptoms. Bone scan shows a characteristic abnormal pattern confined in the affected limb with marked pericondylar cortical concentration of radionuclide tracer along the shafts of the long bones (fig 4A). Increased periarticular uptake of the radionuclide due to associated synovitis may also be observed. Blood pool early static images emphasise the increased vascular perfusion of affected areas. Diffuse accumulation of the radionuclide in the soft tissue corresponding to swelling of the affected extremity and changes in the regional blood flow is occasionally apparent on the delayed images (fig 4B).

Computed tomography is often preferred in the assessment of cortical osseous alterations. However, MRI allows direct visualisation of the periosteal proliferation, faithfully depicts its local relations with adjacent structures, and optimally assesses the bone marrow. On both T1 and T2 weighted images, the periosteal new bone formation appears as a characteristic line of low signal intensity which is initially separated from the subjacent cortex by a
narrow space of high signal intensity (fig 5). This high signal area is considered to represent fat, a finding that correlates well with what is seen pathologically in patients with HOA.24

MRI is superior to other imaging methods in the evaluation of joint effusion (low T1 and high T2 signal) and associated synovitis. In HOA, synovitis is usually mild, chronic, and non-inflammatory,1 appearing as an inhomogeneous mass of mixed hypo- and intermediate signal on T2 weighted images, whereas an inflammatory or infective synovitis would appear as a high signal intensity proliferation, hardly distinguishable from synovial fluid (fig 5B). Furthermore, in these patients with an infected aortic graft, MRI is very useful to exclude osteomyelitis and soft tissue infection, thus confirming that the periostitis is not only a response to adjacent infection.

**MANAGEMENT**

Almost all patients with aortic prosthesis infection will, without surgical intervention, succumb from massive gastrointestinal haemorrhage or sepsis. Therefore it is of the utmost importance to establish a definite diagnosis of vascular graft sepsis to reduce the incidence of aortoenteric fistula which is almost invariably the cause of death in this group of patients. Preoperative diagnosis of infected vascular grafts and aortoenteric fistulae may be difficult.25 The most useful investigations for accurate diagnosis of graft infection are gallium or labelled leucocyte scans,25 aortography when demonstrating an anastomotic aneurysm or intraprosthetic vegetations,26 and ultrasound and computed tomography of the aorta and graft, which may show a perigraft collection of fluid or gas indicating graft sepsis (fig 6). Enteroprosthetic fistula may be diagnosed by upper gastrointestinal endoscopy as it allows direct visualisation of the point of graft erosion into the bowel lumen.25 However, upper
Hypertrophic osteoarthropathy following aortic surgery