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MONOARTHRITIS: PROBABLE OUTCOMES

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Background: Numerous joint disorders initially produce swelling in a single joint and new onset monoarthritis will probably further lead to the involvement of other joint groups and development of extraarticular manifestations. It is essential to take a proper diagnostic approach for organizing appropriate treatment and lowering possibility of disease progression.

Objectives: The aim of this study was to investigate joint distribution, determine rheumatological diseases of patients with acute monoarthritis and reveal the development of further systemic manifestations.

Methods: 100 patients (age 18-75 years) with clinically apparent monoarthritis of less than 6 weeks duration were included in the study. Criteria of exclusion were infection, trauma and crystal induced arthritis. Joint distribution, presence of systemic manifestations and development of chronic inflammatory rheumatic disease were evaluated. Presence of arthritis was proved with help of ultrasound examination. Complete blood count, ESR, CRP, RF, anti-CCP; HLAB27; MEFV mutations and X-ray of swollen joint were performed for all patients. Temperature was also measured.

Results: Mean age of patients with acute monoarthritis was 46±13 years. Female predominance was noted (61%). 71% of patients had elevated ESR, 69% CRP. In 24% of cases homozygous or heterozygous mutations of MEFV gene were revealed. 21% of patients had positive RF and 18% anti-CCP. 11% patients carried HLA-B27 antigen. 28% of examined patients had subfebrile fever. Hepatosplenomegaly was determined in 16%, uveitis in 5%, psoriatic plaque in 4%, interstitial pneumonia in 2% of cases

At the baseline 82 patients were diagnosed with rheumatological disease. Baseline data is shown in the Table 1 below.

Table 1. Baseline data

Diagnosis	Number of patients
FMF	23
Osteoarthritis (reactive synovitis)	16
Rheumatoid arthritis	15
Reactive arthritis	10
Ankylosing spondylitis	6
Psoriatic arthritis	4
SLE	3
Schönlein-Henoch purpura	2
Sarcoidosis	2
Behcet diseases	1

Conclusion: In this study monoarthritis in majority of cases underlies FMF. Though FMF is not considered as a frequent cause of acute monoarthritis, more attention should be paid on this pathology in focus of monoarthritis, especially in specific for FMF region. Further follow up of acute monoarthritis progression is needed.

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“RICE AND SARDINES”: AN UNUSUAL CAUSE OF RASH AND JOINT SWELLING

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Background: Systemic vasculitis presents with numerous widespread manifestations. Various diseases can masquerade as systemic vasculitis (1). It is crucial to carefully evaluate patients with unusual presentations to look for vasculitis mimics. Scurvy, a disease caused by severe and prolonged vitamin C deficiency, still occurs in industrialized countries (2). Ascorbic acid is involved in various biologic processes including the synthesis of mature collagen. Lack of ascorbic acid especially affects blood vessel integrity leading to haemorrhagic manifestations characteristic of scurvy (3).

Objectives: Case report highlighting that scurvy is still prevalent in the west and may present with features resembling vasculitis.

Methods: Information was obtained from the patient's medical records.

Results: A 61 year old Caucasian female presented with a 3 weeks' history of bilateral lower limb pain, rash and swelling. She was referred to acute medicine to exclude deep vein thrombosis suspected by her general practitioner. She was previously fit and well apart from diagnosis of coeliac disease and various food intolerances. She believed her symptoms started following a recent course of Metronidazole for suspected dental infection which manifested with gum bleeding. She was found to have purpuric spots and ecchymosis bilaterally in her legs, from the toes to the groin. The left knee was swollen with evidence of hematoma around the joint. She denied fever, weight loss, night sweats, arthralgia, myalgia, rash, Raynaud's, alopecia, mouth or genital ulcers, ear-nose-throat manifestations. She denied chest pain, difficulty in breathing or symptoms of peripheral neuropathy. There was no history of asthma, inflammatory bowel disease or uveitis. She reported occasional alcohol intake, she did not smoke cigarettes nor use recreational drugs. Examination otherwise revealed no other major abnormalities with normal vital signs. Initial differential diagnosis included platelet or coagulation disorders or vasculitis. Initial blood tests revealed normal full blood count, coagulation screen, ESR, CRP, liver and renal biochemistry. Urine dip was positive for blood but not for protein. Knee aspiration was attempted but no fluid could be aspirated. Knee x-ray was unremarkable. ANA, ANCA and anti-GBM antibody tests were negative. On further review and enquiry into her symptoms and lifestyle she admitted having a diet exclusively of "rice and sardines" for nearly 2 years. This information along with clinical features led to the suspicion of Vitamin C deficiency that was subsequently confirmed. Ascorbic acid levels were <2.8 micromol/l (normal range 26.1-84.6 micromol/l). Replenishment of vitamin C was followed by a rapid and sustained recovery. Detailed investigation for additional macro and micronutrient deficiencies were undertaken with referral to a dietician and to gastroenterology.

Conclusion: This case illustrates scurvy can present in previously "well" individuals and should be considered as a possible differential diagnosis of vasculitic lesions in the appropriate clinical context. Detailed dietary history is invaluable.

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SPINAL HYDATID CYST DISEASE: WHAT FEATURES IN SURGICAL DEPARTMENTS?

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Background: Cystic echinococcosis (CE) is a zoonosis caused by the larvae of *Echinococcus granulosus*. Cysts can develop in any part of the body, although the liver and lungs are most frequently involved. Bone echinococcosis is one of the rarest forms of the disease, accounting for 0.5 to 4.0% of all echinococcosis. Spinal cysts are disabling causing destruction similar to malignant bone lesions, with high risk of neurological deficit.

Objectives: To increase awareness of this disease, the clinical data of eight patients with spinal CE were analyzed retrospectively.

Methods: Clinical data of eight patients with spinal CE were analyzed retrospectively, collected over ten years on the department of orthopedics in the Military hospital of Tunis.

Results: The mean age of the patients was 49 years. The median disease duration was five years. All patients presented with back pain and paresthesia without neurological deficit. Radicular pain was reported by two patients. The diagnosis of spinal CE was made after the diagnosis of visceral CE in two patients. Former X rays showed nonspecific abnormalities and patients were treated initially by symptomatic treatments based on paracetamol and non-steroidal antiinflammatory drugs without any improvement. All of the patients needed Magnetic resonance imaging (MRI) to explore chronic back pain with paresthesia, revealing spinal CE. The typical MRI appearance is a multilocular cyst. Six patients had cervical and thoracic spinal cysts, one patient had a lumbar spinal cyst and one patient had cervical, thoracic and lumbar cysts. Further examinations with Computed tomography scans (CTscans) were needed before surgery for better examination bone destruction. All patients underwent surgery.