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Pelvic Osteoid Osteoma Simulating Sacroiliitis[☆]



Osteoma osteoide pélvico simulando sacroileitis

To the Editor,

The course of sacroiliitis is characterized by inflammatory pain in the lumbosacral and gluteal region. When the condition is bilateral, it is most commonly caused by spondyloarthritis. Sometimes only 1 side is affected and, in this case, it is necessary to rule out other less common causes, such as infections or tumors, among others.

We report the case of a 49-year-old man who presented with a 1-year history of pain in right buttock. He had previously been examined in orthopedics and rehabilitation, and brought with him a technetium bone scintigraphy that showed diffuse hyperactivity in right sacroiliac joint compatible with sacroiliitis.

The patient complained of pain in right buttock that waked him up during the night and was relieved by nonsteroidal anti-inflammatory drugs (NSAID). He had no history of traumatic injury, fever or arthritis, and reported nothing during work-up that suggested spondyloarthritis or recent infections. The physical examination was completely normal, with negative results in sacroiliac pain provocation tests (flexion, abduction, external rotation [FABER], distraction, compression and Laguerre tests), and the joint showed no peripheral or axial functional limitations. The neurological examination revealed no evidence of disease. The results of the laboratory tests, including the acute phase reactant levels, were normal. With respect to imaging studies, as there were no evident bone changes on plain radiography of the pelvis, the patient underwent magnetic resonance imaging (MRI) of the sacroiliac joints. There was a hypointense area on T1-weighted sequences (Fig. 1) and a hyperintense area in short tau inversion recovery (STIR) images (Fig. 2) on the border of the iliac side of the right sacroiliac joint, with an isointense central zone on T1-weighted sequences (Fig. 1), which was hypointense on the STIR sequences (Fig. 2). These findings pointed toward a definitive diagnosis of osteoid osteoma, which was confirmed by computed tomography (CT). The patient was treated immediately by means of CT-guided radiofrequency ablation and his symptoms disappeared.

Osteoid osteoma is a benign bone tumor that occurs in the femur or tibia in 50%–60% of the cases; between 7% and 10% are located in the spine.¹ Pelvic osteoid osteoma, like that of our patient, is less common. It occurs more frequently in males between the ages of 10 and 30 years. A typical symptom is nocturnal pain, which is

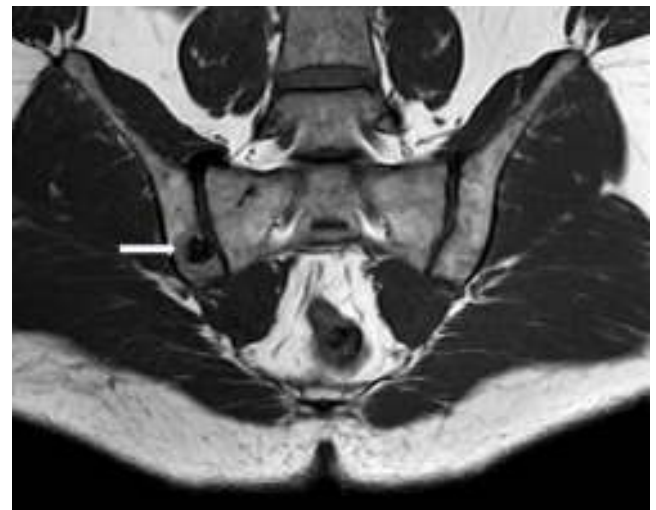


Fig. 1. Semicoronal plane of sacroiliac joint in a T1-weighted image, showing a hypointense area on the border of the iliac side of the right sacroiliac joint, with an isointense central zone.

relieved by NSAID.² The pattern of nighttime pain associated with this type of tumor can lead to its being mistaken, as in the case we report, for certain inflammatory rheumatic diseases, especially when located at certain sites, a circumstance that can result in a delay in the diagnosis. Although the osteoid osteoma is not often included in the differential diagnosis of sacroiliac pain, we should take it into account when the pain is relieved by NSAID, and in

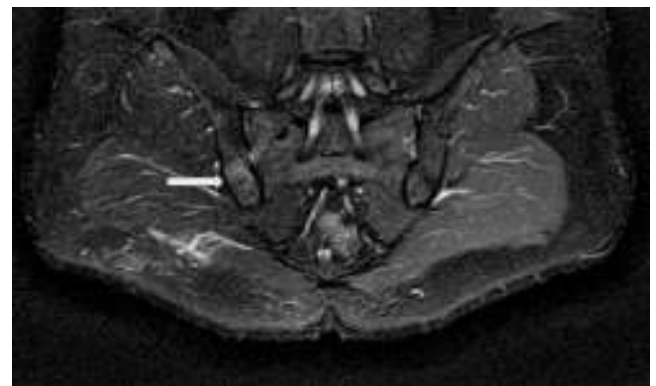


Fig. 2. Semicoronal plane of sacroiliac joint in a STIR sequence, showing a hyperintense area on the border of the iliac side of the right sacroiliac joint, with a hypointense central zone.

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the case of young patients in whom the pain does not respond to conventional treatment.³

Plain radiography does not always show the typical image with the nidus. Thus, it may be necessary to resort to other techniques such as MRI and/or CT (as MRI may not be very helpful, CT is the technique of choice in this type of tumor), since bone scintigraphy has a high sensitivity, but a low specificity.² Computed tomography-guided radiofrequency ablation is the preferred therapeutic approach, as it is less invasive than other techniques and the outcome is good.¹

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Ankle Arthritis and Nail Clubbing as a Form of Presentation of *Listeria monocytogenes* Endocarditis[☆]



Artritis de tobillo y acropaquias como forma de presentación de un caso de endocarditis por *Listeria monocytogenes*

To the Editor,

Endocarditis is an uncommon but serious complication of infection by *Listeria monocytogenes* (*L. monocytogenes*). This Gram-positive facultative anaerobic intracellular bacterium often contaminates foods like fresh milk and raw fish or meat. It produces infections in certain population groups (the very elderly and newborn infants, immunocompromised patients and pregnant women¹). Infections by *Listeria* have different clinical presentations. Endocarditis is typical in immunocompromised adults and is associated with a high mortality rate.²

We present the case of a 36-year-old woman who presented with arthritis of her left ankle. Her history included a pregnancy that had ended in delivery 5 months earlier. Since then,

she had had a recurrent fever syndrome, with polyarthralgia and distal swelling of her fingers and left ankle. Physical examination revealed arthritis in left ankle, acropachy affecting the fingers of both hands, a diastolic murmur in the aortic area and crackling rales in both lung bases. Laboratory tests showed anemia of chronic disease (hemoglobin: 9.8 g/dL), elevated acute phase reactants (erythrocyte sedimentation rate: 120 mm/h and C-reactive protein: 107.34 mg/L), and negative autoantibody tests (rheumatoid factor, antinuclear antibodies and anti-cyclic citrullinated peptide antibodies). Musculoskeletal ultrasound confirmed the arthritis in left ankle (power Doppler signal). An echocardiogram revealed the presence of vegetation on the partially calcified, bicuspid aortic valve, partial prolapse of this valve, and severe aortic regurgitation, with no evidence of heart failure (Fig. 1). The blood cultures performed resulted in the isolation of *L. monocytogenes*.

The diagnosis was infective endocarditis with severe aortic regurgitation, and a 5-week regimen of treatment with ampicillin and gentamicin was initiated. After 3 weeks of antibiotic therapy, the aortic valve was replaced by a mechanical prosthetic valve, and the postoperative course was uneventful. At the present time, the patient is asymptomatic.

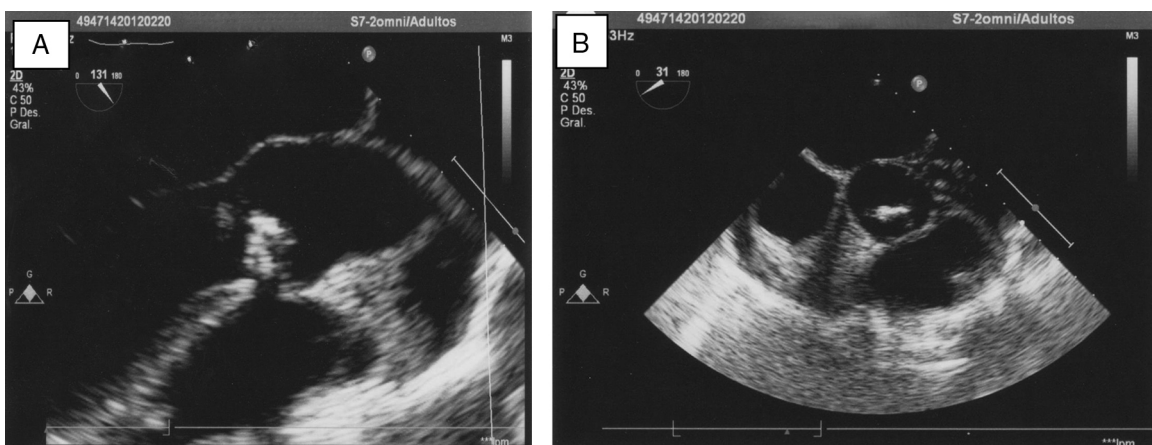


Fig. 1. (A and B) Transthoracic echocardiography. The image shows the vegetation on the partially calcified bicuspid aortic valve, which appears with a partial prolapse and severe regurgitation. There is no evidence of heart failure.

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