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Destructive arthropathy of the shoulder in a man

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Clinical case: male patient, 49 years old, with a history of spinal trauma (in the forest) 4 years before, describing a 3 year loss of the ability to feel hot, cold, pain, touch and vibrations in the whole right upper arm and a progressive swelling of the right shoulder. A MRI of the cervical spine was performed and a cyst within the spinal cord was described. It was interpreted as syringomyelia due to spinal cord injury.

On presentation he had a major swelling of the shoulder (fig 1) with important reduced range of motion, fever



Fig 1.

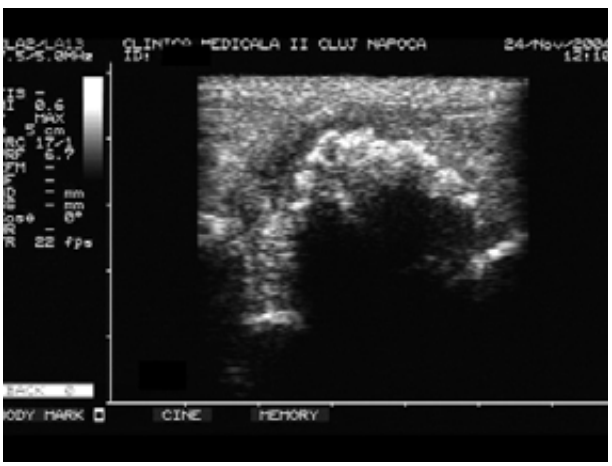


Fig 2.

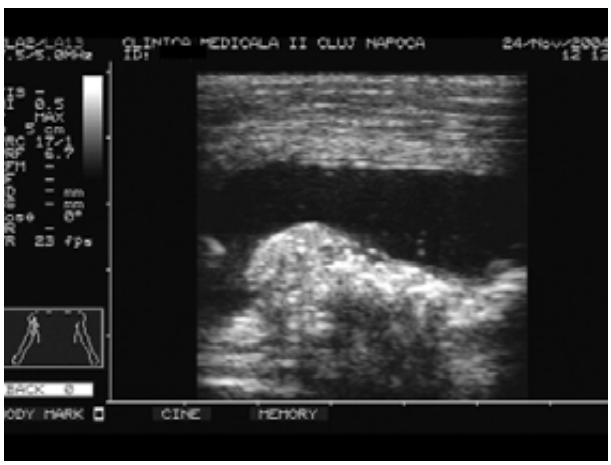


Fig 3.



Fig 4.

and high erythrocyte sedimentation rate. Radiography showed the aspect of a destructive arthropathy.

Ultrasonographic: fluid in the subdeltoid bursa and glenohumeral joint, important proliferation of the sinovia, multiple calcification of all the periarticular structures, rotator cuff tear, irregularities of the humeral head (fig 2, fig 3). Echoguided puncture of the bursa revealed sangiunolent fluid (fig 4). Electronic microscopy analysis of the fluid described the presence of the hydroxyapatite crystals. The biopsy of the proliferated sinovia showed unspecific synovitis.

Questions:

1. What is your diagnosis?
2. Do you find a connection between spinal injury and shoulder pathology?

The answers and the comments can be sent on email (medultrasonography@gmail.com)

Answers and comments in the next issue.

Answer Quiz vol 11 no. 3

Left lower quadrant tumoral mass in an elderly woman

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Summary of the clinical observation. An elderly patient with a tumoral mass located in the left lower quadrant was diagnosed with an obstructive colon tumor through means of abdominal ultrasound, abdominal CT and colonoscopy and required emergency surgery due to the abrupt occurrence of a bowel obstruction.

The intraoperatory diagnosis was as follows: obstructive sigmoid colon neoplasm, with invasion into the left ovary and into an intestinal loop. Splenic hilum lymphadenopathy. Bowel obstruction.

The surgery. a Hartmann resection, a splenectomy and a resection of the left ovary were performed.

Histopathology diagnosis. Well differentiated colonic adenocarcinoma (G1), with invasion in the Fallopian tube wall and negative circumferential resection margins. Worth mentioning: extended intratumoral necrotic areas, moderate peritumoral inflammatory lymphocytic infiltrate and desmoplastic reaction. Focal abscesses underlying the tumoral areas that also involve the serosal surface.

The post operatory outcome of this patient was favorable.

The answers to the questions specified in the last issue of the journal are as follows:

1. What is your ultrasound diagnosis?

The ultrasound diagnosis can be established without any difficulty, given the presence of the central aeric intratumoral image (bowel lumen).

2. How do you explain the discrepancy between the colonoscopy and ultrasound diagnosis and the CT diagnosis?

The discrepancy between the ultrasound and colonoscopy diagnosis, as compared to the CT diagnosis ("probably an inflammatory process that agglutinates and infiltrates some of the intestinal loops, thus narrowing their lumen") can be explained through the association of the desmoplastic-inflammatory peritumoral lesions (including the collection visualized by the ultrasound exam) that were misapprehended as the cause of the radiologic modifications.

3. Which aspect of the presented case is unusual and constitutes its singularity?

One unsual aspect of this case is the prolonged evolution from the moment of the tumor diagnosis (by means of barium enema). We also owe to mention the faulty clinical judgement that pointed to a gastric source for the iron-deficiency anemia, although the barium enema result was known, and the clinical manifestations – obvious.

Additionally, the fact that the patient did not present (throughout the clinical course) with any episodes of partial bowel obstruction was remarkable, given the impressive dimensions (10-11 cm) reached by the tumor at the moment of admission in Medical Clinic 1. Meanwhile the bowel obstruction occurred abruptly, one day prior to the scheduled date of the patient's transfer in the Surgical department, and this event precipitated the surgery.