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Bilateral knee swelling differential diagnosis

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This is an article to access the distributed access under the Creative Commons Attribution license, which allows unlimited use, distribution and reproduction in any means, provided that the original author is credited and the source. Keywords Systemic Lupus erythematoso, synovitis, musculoskeletal TB, Osteonecrosis Case Report Systeonecrosis Lupus Erythematosus (SLE) Patients commonly have musculoskeletal complaints. We describe two SSI patients with persistent knee pain and swelling that were initially exchanged for inflammatory arthritis. Case 1 A 30-year-old black African female was diagnosed with me when she presented with a positive hemolytic anemia of coombs, lymphopenia, polyartrosis, oral ulcers and a sick skin eruption. Lei anti-function antigen of her (Ana) was positive, she had hypocomplementemia and she was negative. She was started on oral corticosteroids (initially dose initially high 60 mg / day and later weaned at 15 mg per day), sulphate chloroquine and azathioprine. Blood accounts and her wrist symptoms have improved. Four months after the diagnosis, she developed a monoarthrosis of the right knee. Despite the injections of intra-articular steroids, non-steroidal anti-inflammatoryers, knee symptoms persist. The simple x-rays of the knees and the chest were insignificant, but she had a high C-reactive protein (14 mg / l) and the very high ESR (88 mm / h). In the next four months, three joint aspirations were Gram and Ziehl-Neelsen spot and negative culture. A synovial biopsy presented for histology revealed granulomatous necrotization inflammation. The positive Ziehl-Neelon stain for acid-fast bacilli confirmed the diagnosis of tuberculosis infection myCobacterium osteoarticular (Figure 1). She had no history of the previous tuberculosis (TB), and there was no evidence of an extra lung disease elsewhere. The swelling of the knee and the symptoms of her have been resolved within 3 months from the beginning of anti-TB treatment, and this therapy was continued for 18 months. . Figure 1: Haemematoxylin and Eosin Custody stain 1 synovial biopsy showing a built-in granuloma with central necrosis (large arrow) surrounded by macrophages PALLISADING INPITALIOUS (small arrow). The Ziehl Neelsen stain revealed acid-fast bacilli. View Figure 1. Case 2 A 30-year female mixed racial ancesteration was diagnosed with SLE, with IV class nephritis with skin, arthritis and skin skin lesions. She was an Ana and Dsdna positive, HIV negative, and she had antiphospholipid antibodies. She was treated with solmedrol intravenously 500 mg a day for 3 days followed by oral corticosteroids at 60 mg per day 60 mg who were tapered at 15 mg a day over 4 months, sulphate chloroquer and mycophenolate Mofetil. Within 4 months, her SLIS was inactive but she complained about a painful right. At the exam, he had bilateral effusions of his knee, but no sinovite of any other joint. The knee has been sucked on two occasions, and the serous fluid has been shown to be an inflammatory fluid of type 2 (slightly swarm with a white cell count 2000-10000, the neutrophils of 20-70%), with cultures Bacterial and negative fungers. Negative. Steroids rude states, and the symptoms and swelling continued for the next four months. X-rays showed a medical fragmented epicondyle of the right knee (figure 1) and magnetic resonance of the right knee demonstrated an articular purpose, large bone infares with surrounding media edema and a seasonal femoral side, proximal and rotulus tibia in line with osteonecrosis (figure 2). The left knee had a small infarction of the proximal tibia. . Figure 2: X-ray bearing weight Both knees (case 2) with fragmented to the medial right epicondil (white arrow) and radiolucence in the distal of the tibia and proximal femur (black arrows). Watch figure 2. Figure 3: Imagine image without contrast (MRI) of the right knee with a pouring, and great bone infarity of medial and infringement infringers, as well as tibial metaphysis with surrounding edema. The left knee magnetic resonance has shown small inferts decrease. Watch figure 3. In an attempt to avoid arthroplasty, intravenous zolendronic acid has been administered, with dramatic clinical improvement. Within a month the swelling and pain had been solved. Unfortunately, the follow-up MRI eight months later showed a minimum improvement, and symptoms used, which requires a total arthroplasty right of the knee. Arthritis discussion is a common symptom in the les, and brings a differential diagnosis (Table 1). Inflammatory polyarthritis as part of SLE affects 70-95% of patients, it is often present at the time of diagnosis, and is a common component of lupus rockets [1]. All joints can be affected, with your hand and your knees is the most common. Imagement progress has shown that the clinical examination underestimates articular inflammation in patients with les, perhaps to explain the high frequency of arthralgia and pain between these patients. A recent ultrasound study of patients with les demonstrated to knee synovitis in 40%, pouring in 23 and synovial proliferation in 23% [2]. Magnetic resonance studies of patients with les with polyartralgia sinovite, tenosinovite show and bone edema with erosions, similar to changes observed in patients with rheumatoid arthritis [3]. Table 1: Differential diagnosis of arthritis in the patient les. Look at Table 1 SETTIC ARTRITE should be a consideration in patients with acute les or underwater tumofation joint, especially if associated with high inflammatory markers. A retrospective study of 29 patients with les with septic arthritis shown by the hip (59%) is the most frequently struck articulation, followed by the knee (34%) and ankle (21%) [4]. Most infections were due to Salmonella (59%) or other negative Gram bacteria (11%). Staphylococcus aureus (24%), or by Streptococcus pneumoniae (4%). Oligoarthritis verified in almost the half of the patients. Main risk factors for septic arthritis are the use of corticosteroids, immunosuppressive therapy, severe active SLE, and osteonecrosis. The differential diagnosis of a chronic monoarthritis includes osteo-joint TB infection, particularly in TB endemic countries. Large bearing joints weight, such as hip and knee and the spine are the most common sites [5]. Patients with SLE can be particularly at risk of this form of extra-pulmonary disease [6]. The diagnosis can be difficult and depends on synovial liquid culture or test Genexpert PCR, or synovial biopsy [7]. Risk factors for extra-pulmonary tuberculosis among LES patients include high-dosage corticosteroids, other immunosuppressive therapies, lymphopenia, nephritis and inflammatory arthritis [8-9]. Osteonecrosis (ON) is a common complication of the LES, which affects 2-30% of patients [10]. Even if the hip is the most common site, knee is well described. In a series of knee up Navaez describes gradual or sudden onset of pain, with tenderness and the presence of a pouring in 81% of patients [11]. More ON sites are often seen. In a series of 136 patients with knee on, 74% had at least one other big joint, commonly the other knee (82%) or hips (67%) [12]. The Eziology of ON in patients with Les is And the predisposing factors include glucocorticoid therapy, vasculitis, raynaud phenomenon, antiphospholipid antibodies and high disease activity [13,14]. Early disease can respond to fundamental decompression surgery or bifosphonate therapy, even if there are no major randomized control studies [15,16]. Advanced cases, like our patient, where the knee joint is destroyed requires an arthroplasty. In both cases described, it was a considerable diagnostic delay despite the follow-up in a specialized center. The expense and invasiveness of synovial biopsy and histology or magnetic resonance studies to advance diagnosis diagnosis. However, the awareness of differential diagnosis and the appropriate investigation of a strong persistent joint swelling is fundamental to make a diagnosis of TIMENEA in order to prevent joint destruction. Furthermore, these two cases also highlight the devastating side effects of long prolonged corticosteroids. This risk of corticosteroid-induced damage is increasingly recognized in SL patients and best practices is to use moderate doses for the shortest possible time [17]. In synthesis, a painful and swollen joint in a Swire patient should solicit the consideration of a different cause from inflammatory arthritis. In particular, persistent pain and swelling and involvement of a great articulation, are important clues to an "not dissolved" arthritis and should fear surveys for other causes, especially septic arthritis and osteonecrosis. She remembers: "You can only find what you are looking for, and just look for what you know." Ethics Statement The written informed consent was obtained from patients to publish this related case and accompanying images. Grossman references JM (2009) Lupus arthritis. Best Praction Res Clin Rheumatol 23: 495-506. OSONDON A, Igagnocco A, Alessandri C, Priori R, Conti F, et al. (2009) The ultrasonographic representation of the joint alterations of the knee in erythematosus systemic lupus. Clin Exp Rheumatol 27: 329-332. PRODUCT N, HACHULLA E, Flipo RM, Cortet B, Cotten A (2005) Mr Imaging Results in the hands in early rheumatoid arthritis: comparison with those of the systemic lupus erythematosus and primary syndrome of sjÅJA*gren. Radiology 236: 593-600. Huang JL, Hung JJ, Wu KC, Lee WI, Chan CK, et al. (2006) Septica arthritis in patients with systemic lupus Erythematosus: infections from salmonella and nonsalmonella respect. Semin Arthritis Rheum 36: 61-67. Pigrau-Serrallach C, RodrÁguez-Pardo D (2013) Joint bone and tuberculosis. EUR Spine J 22 Supplier 4: 556-566. Hodkinson B, Musnga E, Tikly M (2009) OsteoArticular tuberculosis in patients with systemic erythematosus lupus. QJM 102: 321-328. Pandey V, Chawla K, Acharya K, Rao S, Rao S (2009) The role of the polymerase chain reaction in the management of osteoarticular tuberculosis. Int orthop 33: 801-805. Sayarlioglu M, Innc M, Kamali S, Cefle A, Karaman or et al. (2004) Tuberculosis in Turkish patients with erythematosus systemic lupus: greater frequency of extrapulmonary location. Lupus 13: 274-278. Tam LS, Li EK, Wong SM, Szeto CC (2002) Risk factors and clinical features for tuberculosis among patients with systemic erythematosus lupus in Hong Kong. Scand J Rheumatol 31: 296-300. RP Gontero, Bedoya Me, Benavente and, Roverano SG, Parala SO2 (2015) Osteonecrosis in Systemic Lupus Eritematosus. Reumatol Clin 11: 151-155. NarvÁfÁez J, NarvÁfÁez Ja, Rodriguez-Moreno J, Roig-Escofet D (2000) Knee Osteonecrosis: differences between idiopathic and secondary types. Rheumatology (Oxford) 39: 982-989. Monta ma, Baumgarten kn, Rifai A, Bluemke from, Jones LC, et al. (2000) Atraumatic osteonecrosis of the knee. J SURGAMER JOINT BONE AM 82: 1279-1290. Sayarlioglu M, Yuzbasioglu N, Innc M, S, Cefle A, et al. (2012) Risk factors for avascular bone necrosis in patients with systemic lupus erythematosus. Rheumatol Int 32: 177-182. Fialho SC, BonfÁfÁi and, Vitule LF, D'Amico E, Caparbo V, et al. (2007) Activities of the disease as an important risk factor for osteonecrosis in the first systemic systemic lupus Lupus 16: 239-244. Hong YC, Luo RB, Lin T, Zhong HM, Shi JB (2014) Effectiveness of Alendronate to prevent the collapse of the femoral head in adult patients with nontraumatic osteonecrosis. Biomed Res Int 2014: 716538. Kalla AA, ID Learmonth. Klepp P (1986) Early treatment of avascular necrosis in systemic lupus Eritematosus. Ann Rheum Dis 45: 649-652. Thamer M, HernÁfÁın Ma, Zhang Y, Cotter D, Petri M (2009) Prednisone, lupus activity and permanent organ damage. J Rheumatol 36: 560-564. International Clinical Library | Science Resource Online LLC 3511 Silverside Road, Suite 105, Wilmington, DE 19810, USA Email: contact@clinmedlib.org Å, Å Å e unilateral knee swelling differential diagnosis. left knee swelling differential diagnosis. what does fluid behind the knee mean. what causes knee to swell with fluid

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