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Case Report

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An Unusual Case: TheImportance of WristArthritis in Post-Polio Sequelae

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Introduction

Joint pain and accompanyings welling is the most common complaint in clinical practice. In this cases, the important thing is to determine the underlyingetiology and to give appropriatet reatment. The most common cause of most joint disease observed in the form of acutemono arthritis is gout and calcium pyrophosphate crystal storage disease. The prevalence of gout disease peaks among the ages of 40 to 50. The causes of increased prevalenceare advanced age, the use of diuretics for obesity and hypertension, trauma and excessive alcohol consumption.1Gout is 5 times more common in males. The gout attack occurs most often in the first metatarso falangialsingle joint in the ankle.

Case report

A 45-year-old male patient had developed polio sequelae in both lower extremities due to previous poliomyelitis. He was able to do daily tasks and activitie susingonly the wheel chairby his both upper extremities (Figure: 1). He was admitted to our family medicine outpatient clinic with swelling and severe pain in his right hand wrist forthelast 3-4 weeks. He was taking analgesics for the last month. He did not have a history of chronic illness or drug use such as diuretics.

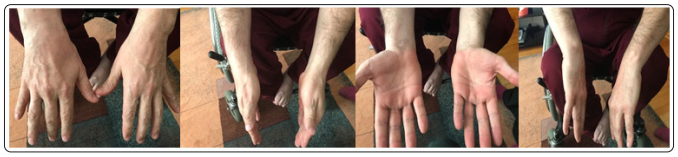

Figure1 : Post-Polio (polyomyelitis) sequela with right wrist swelling

Clinical examinationr evealed a slight redness, flexion and extension limitation in the right wrist. A two-way wrist radiograph was taken against the possibility of a fracture or trauma.

There was a slightly ticlesion in the epiphysis of the metacarpophalangeal bone (Figure 2).

The body temperature was 36.5 C. C-reactive protein (CRP) concentration was 23 mg / L (normal range<5 mg / L) and serum creatinine level was 0.58 mg / dL (base linevalue: 1.25 mg / dL) Serum uricacidlevel was8.1 mg / dL (normal range 3.5-7.2 mg / dL). No other abnormal findings were detected.

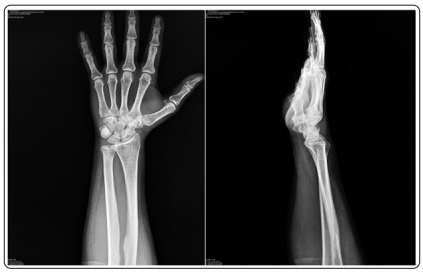

Figure 2: Lyticlesion in metacarpophalangeal distal epiphysis

The patient was diagnosed with goutand was given oral all opurinolandanalgesic for seven days. Oral 0.5 mg colchium was given daily. After 15 days, the pain, swelling and movement limitation were completely dissolved. Serum uricacidlevel (2.6 mg / dL) decreased with CRP. No goutattack was reported during the last sixmonths.

In the literature, isolated wrist gout arthritis is a rarecondition. It is seen in 0.8% of earlygout cases. Gout arthritis can be seen in the wrist in 19to 30% of untreated goutcases (2). Acute goutattack is duetourate crystals that precipitate acute inflammation in the joint.The digestion of food scontaining excess purine, trauma, starvation, surgery, excessive alcohol in take and medications affect this concentration.Gut arthritis is usuallyseen as monoarticular. It is seen in the first metatarsophalangeal joint in the lower extremity at 50-60% (3). In our case, the metacarpophalangeal joint was retained on the right wrist, but noetiological risk factors were known to precipitate intra-articular acute inflammation except the post-polysequelae. However, uricacid and CRP levels were high in blood.

In our case, excessive force on the right wrist due to the post-polio sequelae triggered intra-articular inflammation by creating a mechanical trauma. Since he could not usehis lower extremities, the pain in his right wrist was thought because of mechanical muscle strain and sonoeffective diagnosis and treatment was applied for the last 7-8 years. In the case of an unusualcondition similar to our case, a preliminary diagnosis of gout mono arthritis should be considered. Our case is important in terms of creating an awareness about this situation.

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