Case Presentations

Case 1

A 4 year old Caucasian female was admitted with history of painful soft tissue swelling and induration on her right upper back, posterior neck and torso following an all-terrain vehicle accident that occurred a few weeks before her admission. Patient also reported trouble sitting up and increasing stiffness with ambulation. She had been evaluated in orthopedic clinic a few months previously for scoliosis and suspected Klippel-Feil anomaly. Physical examination revealed extensive tender indurated swellings over upper back and neck. She was also noted to have bilateral hallux valgus (Figure 1). Laboratory data revealed normal electrolytes, blood cell counts, liver enzymes, alkaline phosphatase and LDH levels. CT of her shoulder revealed a bony projection extending off of the anterior and inferior surface of the clavicle, at the junction of medial two third and lateral one third of the clavicle. 

Case 2

A 17 year old Caucasian male presented to our endocrinology/bone clinic for evaluation of subcutaneous nodules. The lesions were first noted on his right index finger at two years of age. Over time similar lesions were noted on his right extremity. In the previous year he had noted more lesions in his right hand with extension into the forearm. He also had complaints of mild right wrist joint pain and stiffness with activity. He had undergone surgical removal of the lesions repeatedly (seven times). Family history was negative for ectopic ossifications, rickets, hormone deficiencies or other bone disorders. There was no history of consanguinity.

Physical examination showed a well appearing Tanner V adolescent, with no features of Albright Hereditary Osteodystrophy (AHO). Extremity examination was remarkable for 2-4 mm sized bony lesions palpable in the inter-digital space of right index and middle fingers and also extending along the radial aspect of the forearm. Similar lesions were noted on the dorsal aspect of the second digit of right foot and mid-plantar aspect of the same foot.

Laboratory evaluation for disorders of mineral metabolism was essentially within normal limits (Table 1). Plain X-rays showed sheet-like disorganized and scattered ossifications centered around the right foot and mid-plantar aspect of the same foot.

Table 1: Case 2 - Progressive Osseous Heteroplasia. Laboratory data.

| Labs                        | Results   |
|-----------------------------|-----------|
| Calcium                     | 9.8 mg/dL | (8.4-10.2) |
| Phosphorous                 | 3.8 mg/dL | (2.5-4.5)  |
| Intact Parathyroid Hormone  | 21 pg/ml  | (7-53)      |
| Alkaline Phosphatase        | 100 Units/L | (65-260)   |
| Albumin                     | 4.7 gl/dL | (3.4-5.0)  |
| Vitamin D 25-OH             | 34 ng/mL  | (10.0 - 55.0) |
| Vitamin D 1,25-(OH)₂        | 47 pg/mL  | (15-90)     |
| Urine Calcium/Creatinine ratio | 0.02       |

*Corresponding author: Anu Vishwanath, Section of Diabetes and Endocrinology, Department of Pediatrics, University of Oklahoma Health Sciences Center, USA, E-mail: anu-vishwanath@ouhsc.edu

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metabolically active soft tissue ossifications localized to right forearm, elbow and hand, posterior lateral border of the left scapula and the mid aspect of the left tibia (Figure 2). Guanine nucleotide binding protein alpha stimulating activity polypeptide (GNAS) gene sequencing identified a previously described mutation in the exon 7 of the GNAS gene, predicted to result in a frameshift and loss of function.

Discussion

Heterotropic ossification is a pathological condition where bone formation occurs in extra skeletal tissues (skin, soft tissues, muscle). The two known genetic forms of heterotropic ossification are FOP and POH.

FOP is a very rare disorder with a prevalence of about 1 in 2 million individuals [2]. It is a progressively debilitating condition characterized by extra skeletal bone formation. Most cases are due to sporadic mutations but autosomal dominant inheritance has been observed in a small number of families [1]. The most common mutation is a heterozygous single nucleotide substitution c.617G>A in ACVR1 (located on chromosome 2q33-24) which encodes activin receptor type 1 (ACVR1) also known as activin like kinase 2 (ALK2), a bone morphogenetic protein (BMP) type 1 receptor. This mutation leads to a R206H substitution in the glycine–serine region of the cytoplasmic domain of ACVR1, which is highly conserved [1,3,4]. This gain-of-function mutation leads to dysregulated enhanced BMP signaling, responsible for the new bone formation in connective tissue, as occurring in this condition.

Patients with FOP have congenital malformations of the great toes such as hallux valgus, malformed first metatarsal or monophalangism. Painful episodes of soft tissue swellings typically occur in the first decade of life, often before age five, precipitated by soft tissue injury, intramuscular injections, viral infection, muscular stretching, falls or fatigue. These flare-ups can initiate ossification and heterotropic bone formation in skeletal muscles, tendons, ligaments, fascia, and aponeuroses leading to restricted mobility, progressive deformity of spine and eventually to respiratory decline. Progressive episodes of HO occur in specific anatomic patterns, and are typically seen first in the dorsal, axial, cranial, and proximal regions of the body and later in the ventral, appendicular, caudal, and distal regions [1,5].

A four day course of high-dose corticosteroids (prednisone 2 mg/kg/day, administered as a single daily dose) is recommended starting within the first 24 hours of a flare up that affects major joints, the jaw, or the submandibular area. A second course of corticosteroids may be necessary. For symptomatic relief, NSAIDs or cox-2 inhibitors (in conjunction with a leukotriene inhibitor) may be used. Bisphosphonates and muscle relaxants are other treatment options.

Emphasis should be on palliative or preventive measures such as prevention of injuries and infections, appropriate immunizations while avoiding intramuscular injections, appropriate occupational therapy for kyphosis, scoliosis and limb swelling to facilitate activities of daily living, preventive oral care, monitoring of cardiorespiratory function and audiology screening. Family and patients need to be counseled about the progressive nature of the disease and the measures to minimize the flare-ups [2,6].

POH is caused by a mutation in the GNAS locus. Loss or gain-of-function mutations in G proteins have been identified in several endocrine disorders. The GNAS locus is a transcriptionally complex imprinted locus located on chromosome 20q13.11 [7]. Heterozygous inactivating mutations of GNAS have been identified as the cause in most cases of POH, and the mutation in exon 7 identified in our patient has been described as a ‘hotspot’ [8]. Intrafamilial inheritance analysis of POH indicates that the mutation tends to be paternal in origin [9]. Family pedigree analyses document the wide clinical and phenotypic variability among affected individuals carrying the same gene mutation, and some patients with POH exhibit features of AHO [9,10].

Clinical presentation of POH is characterized by progressive cutaneous ossification occurring in childhood and progressive involvement of the subcutaneous and deep connective tissue, with no features of AHO or parathyroid hormone (PTH) resistance as seen in Pseudohypoparathyroidism type 1a or 1c (PHP1a/1c). There is a subset of patients with progressive HO who present with multiple features of AHO or with both AHO and PTH resistance (POH/PHP1a/1c) [8]. Given that POH overlaps with features of AHO (Pseudopseudohypoparathyroidism), and also PHP1a/1c, it is suggested that all these conditions are part of a similar pathophysiological group of disorders of extra skeletal ossification caused by inactivating mutation of GNAS, with POH at one end of the phenotypic spectrum [8]. GNAS mutations seen in POH have previously been identified in patients with PHP1a, thus raising the question of parental origin of the mutation [8,10].

The basic pathophysiology behind the extra-skeletal ossification in POH is still to be elucidated. Factors contributing to the complexity of pathophysiology include the ubiquitous nature of GNAS expression and several downstream signaling pathways mediated through GNAS products, as well as genomic imprinting occurring at this locus. Alpha subunit of the stimulatory G-protein (Gsα) mediated mechanisms are thought to be involved in osteoblast and chondrocyte differentiation [11]. Further research and studies in this area may provide better options for treatment of this rare but debilitating disease.

Therapeutic options for POH at this time are limited owing to the complexity of the gene mutation and dearth of knowledge about the pathophysiology involved. Surgical removal is an option for well-circumscribed lesions interfering with mobility, but the risk of recurrence has been noted to be higher in diffuse lesions. Again, emphasis and education on preventive measures is of utmost importance to avoid unnecessary therapies and procedures leading to further progression of the disease and complications. Affected members and families benefit from customized occupational therapy to assist with activities of daily living, psychological support, genetic counseling and access to support groups [12].

Both patients described here had seen multiple care providers before the diagnoses were made. The patient with FOP had undergone extensive physical therapy to improve shoulder joint mobility before the diagnosis was made. Similarly the patient with POH had undergone multiple surgeries to remove the ‘calcifications’ without a definitive
diagnosis which may have led to recurrence or increased severity of the lesions.

In conclusion, both FOP and POH have a progressively debilitating course, causing families tremendous amount of anxiety. Having a clinical suspicion leads to early diagnosis with appropriate referrals, preventing unnecessary interventions and providing families with necessary support.

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