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Case report

Bilateral Kienböck’s disease concomitant with gouty arthritis

Deepak Chouhan, Vivek Shankar, Mohammed Tahir Ansari

SUMMARY

A 38-year-old man presented with a 2-month history of pain and stiffness in the bilateral wrist. The pain in right wrist was disabling and severe enough to restrict the daily life activities. After the evaluation of clinical and radiological features, the patient was diagnosed with Kienböck’s disease Lichtman stage IIIB in the right wrist and stage IIIA in the left wrist. Routine laboratory investigations revealed a serum uric acid 9.27 mg/dL. Lunate excision and scaphocapitate fusion were done in the right wrist after discussing with the patient. The histopathological examinations of tophi in synovial tissue were negatively birefringent under polarised light microscopy. It confirmed the diagnoses of gout. Febuxostat was started postoperatively. The patient returned to work at the end of 5 months. There was no recurrence of symptoms and radiological signs of arthritis at the end of 1 year.

BACKGROUND

Osteonecrosis is a disorder that usually affects adults aged 20–40 years. The hip, knee or shoulder is the familiar site of involvement. Avascular necrosis of lunate bone (Kienböck’s disease) is a relatively rare disease and influenced by multiple factors. The exact cause of avascular necrosis of lunate bone is not known. Several local and systemic risk factors have been defined for this disease. Negative ulnar variance is a well-recognised local factor found to be implicated in the pathogenesis of Kienböck’s disease.1 The association of Kienböck’s disease also described with several inflammatory disorders, such as systemic lupus erythematosus,2 sickle cell anaemia,3 scleroderma,4 rheumatoid arthritis,5 dermatomyositis6 and gout.7-9

Kienböck’s disease is usually seen in a unilateral dominant wrist. The incidence of bilateral Kienböck’s disease reported in the previous series is very low (3%–7%).10 No risk factor has been defined for bilateral disease. Osteonecrosis of the femoral head in gout with predominantly bilateral involvement is well reported.11 Osteonecrosis of lunate bone is relatively rare in gout, and only three cases of Kienböck’s disease in combination with gouty arthritis have been described in the literature.7-9 All these described cases are unilateral. To the best of our knowledge, this is the first report of bilateral Kienböck’s disease concomitant with gouty arthritis.

CASE PRESENTATION

A 38-year-old man presented with complaints of pain and stiffness in the bilateral wrist for 2 months. The symptoms were more pronounced in the right wrist than the left wrist. The pain was insidious in onset, dull boring, which gradually increased in the last 2 months. The location of the pain was over the dorsum of both the wrists and the intensity of pain increased with the wrist movements. There was no diurnal variation in pain intensity. The patient used to take tablet paracetamol (1g) whenever he felt an increase in pain intensity. There was no medical history of corticosteroids intake, occupation causing repetitive microtrauma, collagen disorder or prior history of pain in the first metatarsophalangeal (MTP) joint. There was minimal swelling and tenderness over the dorsal aspect of the right wrist. There was mild tenderness over the dorsum of the left wrist, and the range of motion of the left wrist was normal. The range of motion of the right wrist was painful and restricted. The active motion was as extension: 0°–30°, flexion: 0°–20°, ulnar deviation: 0°–10° and radial deviation: 0°–10°. The preoperative Mayo wrist score was 35 points, and the pain was 1.5 according to the visual analogue scale. The grip strength was 23% in the right hand.

INVESTIGATIONS

The laboratory analysis showed a total leucocyte count 9.86 ×10^9/L, rheumatoid factor 51U/mL, erythrocyte sedimentation rate 30 mm/h, C reactive protein 4 mg/L and serum uric acid 9.27 mg/dL. Radiographs were suggestive of Lichtman stage IIIB in the right wrist and staged IIIA Kienböck’s disease in the left wrist (figure 1). On CT scan, the lunate bone of the right side was significantly collapsed, sclerosed with multiple fragmentations with flexion of the scaphoid and the lunate bone of left side was partially collapsed and sclerotic with tiny cyst-like changes with deformed shape (figure 2). MRI revealed fragmentation and collapse of the lunate bone with diffuse-altered marrow signal intensity seen as heterogeneous low signal intensity on T1W images and heterogeneously hyperintense signal intensity on short tau inversion recovery (STIR) images (T2 weighted) in the right lunate bone. Rests of the carpal bones, distal end of radius and ulna have patchy marrow oedema in the form of STIR hyperintensities and hypointense signal on T1 weighted (complimentary CT sections show patchy osteopenia). Mild edematous changes are noted in the soft tissues over the dorsal aspect of the wrist.
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Figure 1  Preoperative posterior–anterior radiographs of bilateral wrist showing the complete collapse of lunate with multiple fragmentations, stage IIIB in the right wrist (A) and stage IIIA Kienböck’s disease in the left wrist (B).

The MRI of the left wrist showed partially collapsed and completely T1 hypointense with slight fragmentation and bone marrow edema with areas of decreased signal intensity on T2-weighted images reflect sclerosis. Minimal soft tissue oedema was seen. The crystals were not visible in the MRI.

DIFFERENTIAL DIAGNOSIS

The differential diagnosis was limited at the time of the presentation. Ulnar carpal impaction syndrome was excluded as wrist pain centred over dorsum in the absence of positive ulnar variance. Contusion or osteochondral injury was less likely as there was no history of trauma. Osteoid osteoma was less likely as there was no worsening of pain during nighttime. The CT appearance of the hyperdense sclerotic lesion in the absence of endosteal resorption and cortical thinning rules out the possibility of enchondromas. Therefore, based on the clinical features in the presence of negative ulnar variance, characteristic MRI and CT findings, the initial diagnosis of Kienböck’s disease and synovitis was made. Reactive synovitis was considered in response to necrosed bone and carpal instability. The final diagnosis of gouty synovitis concomitant with Kienböck’s disease was made after histopathological examination. Although patient had synovitis in setting of hyperuricemia, we did not consider gouty synovitis preoperatively because of the rarity of its combination with Kienbock’s disease. The final diagnosis was only made after biopsy report.

TREATMENT

The patient was explained about the different surgical options, which included proximal row carpectomy, lunate excision, and scapho–trapezio–trapezoid fusion, lunate excision, and scaphocapitate fusion, radial osteotomy and wrist fusion. As radiological features were suggestive of carpal collapse with compromised central column articulations and radioscapophoid articulation remains spared. Therefore, Lunate excision and scaphocapitate fusion were planned to bypasses the diseased central column after the detailed discussion with the patient. Open synovectomy was performed through the ligament sparing dorsal approach. Numerous crystal-like deposits were found during surgery. The lunate bone was excised. The biopsy sample was taken from lunate bone and synovial tissue and sent for histopathological examination. The cartilage of the scaphocapitate articulation was removed. The bone graft was harvested from the dorsal aspect of the distal radius. The bone graft was packed into the scaphocapitate articulation, and scaphocapitate articulation was fixed with two 2.5mm compression screws (Arthrex). Wrist denervation was performed by neurectomy of the distal posterior interosseous nerve. Histopathological examination revealed multiple pale cosinophilic tophaceous deposits of various sizes within fibrocollagenous tissue that were negatively birefringent urate crystals under polarised light. Postoperatively, febuxostat 40mg was started two times a day. Pain and swelling were significantly decreased in the postoperative period. The patient refused surgery over the left wrist as his pain decreased over the left side.

OUTCOME AND FOLLOW-UP

The postoperative pain after 1 week was 1.5, according to the visual analogue scale. The time to return to work was 5 months. At the end of 1 year, there was no recurrence of pain or swelling and no radiological sign of degeneration (figure 4). The Mayo wrist score was 70 points. The grip strength in the operated wrist was 58%, tip pinch was 48%, tripod pinch was 45% and key pinch was 61%. The range of motion flexion/extension arc was 10°/65°.

DISCUSSION

Few cases of tophaceous involvement of wrist have been reported, and it can present as tendon ruptures, scapholunate dissociation, compressive median neuropathy and tenosynovitis. The proposed mechanism of avascular necrosis of lunate in gout may include crystal deposition in the cartilage and synovium
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Learning points

- Gout is a systemic disease and can also cause bilateral osteonecrosis of lunate.
- Serum uric acid levels should be done in patients of Kienböck’s disease.
- Suspicion of contralateral wrist involvement should be sought in cases of symptomatic unilateral disease.

Contributors

DC wrote the manuscript and provided clinical photographs. VS drafted and revised the manuscript. MTA performed the surgery. All authors have contributed significantly to the manuscript.

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ORCID ID

Mohammed Tahir Ansari http://orcid.org/0000-0002-4609-6891

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