EDITORIAL

A “very rare case of bilateral Kienbock’s disease” or a “common case of rheumatoid arthritis”?  
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Weeks ago we visited a 32-year-old lady with complaint of bilateral wrist pain for 3 years. She started to mention her problem with showing her right wrist as the initial complaint. A few months later the other wrist also has been involved in the process of disease. The patient has been suffered from nocturnal pain and marked morning stiffness and accentuation of pain. She had several visits to general orthopedists and hand surgeons in two different cities. After the first visit, she underwent MRI of both wrists and diagnosis of “a very rare case of bilateral Kienbock’s disease” was made by almost all of visiting physicians. She was scheduled for surgical intervention. None of previous doctors asked her about the details of her present illness, past history and family history. Her mother was a case of oligoarticular disease with inflammatory nature for years with inadvertent diagnosis of osteoarthritis who recently diagnosed as mild seropositive rheumatoid arthritis (RA) with favorable response to mild RA remedies. Her mother recommended her to consult with her rheumatologist. She had been declined surgical intervention due to unknown outcome and waxing and waning symptoms. On her last medical seek, she was visited by a general internist in Tehran. After a mini review on her history and physical examination, he hypothesized that she may have some kind of rheumatic disorder. So some laboratory tests were requested. Interestingly very high titers of anti-cyclic citrullinated peptide (anti-CCP> 1000 units/ml) and medium titer of C-reactive protein was reported. Antinuclear antibodies and other relevant laboratory tests were all negative. Patient was referred to a rheumatologist for further evaluation and treatment. 

On her physical examination she revealed soft tissue swelling along with ulnar side of both wrists with limited range of motion on flexion and extension at both wrists. 

Other joints were unremarkable. No mucosal lesions or any other positive findings were noted in her systemic evaluation. 

Her wrist MRI showed bilateral lytic bone lesions in both carpal bones with the biggest one affecting lunate bones (fig 1). Some hypo-intense lesions around the distal end of radius bone were also observed compatible with inflammatory synovitis. MRI report indicated lesions with radiologic impression of Kienbock’s disease or inflammatory disease. 

Diagnosis of oligoarticular RA was made and systemic treatment with short course oral prednisone, sulfasalazine 500 mg/ day and methotrexate 10 mg/week was instituted. She had complete recovery from pain, swelling and morning stiffness after three weeks of combination therapy. 

Several important points in similar situations are notable: 

1. Careful history taking is almost abandoned in routine practice among all medical disciplines in underdeveloped countries. 
2. Understanding borders and overlapping between medical and surgical issues are not fully understood even among academic staff at least in developing countries. 
3. Meaningful collaboration between medical and surgical providers is not established in most centers. 
4. “Common” diagnoses in one discipline may be considered as “rare variant” of another disease in other disciplines.
5. Hidden spectrum of most rheumatologic, immunologic and genetic disorders are easily overlooked.
6. Rheumatologists are frequently charged for over-diagnosis of RA.

Due to poor knowledge and underestimation of the great spectrum of rheumatic diseases, most of patients get labeling as local pathologies or psychiatric problems. So many unnecessary surgical operations are imposed to the innocent victims.

Noteworthy, the first rheumatologists were clever orthopedists who were looking to bone and joints as professional internists and this was the historic point that rheumatology was separated from orthopedics more than 60 years ago. From that time, medical and surgical aspects of bone and joints were partially clarified. Rapid development of our knowledge about medical conditions involving the bones and joints resulted in a huge body of science in field of rheumatology so far. Laboratory research on molecular and immunologic events in human body had a major role in these discoveries.

Similar story was reported for misdiagnosis of other specific joint diseases such as hemochromatosis and gout. Hemochromatosis is much rarer than RA but gout could be as frequent as RA in most countries. Avascular necrosis of carpal bones may occur in several rheumatic disorders especially in systemic lupus erythematosus. It may be in part due to nature of disease or more importantly secondary to systemic glucocorticoid therapy. Kienbock’s disease secondary to RA is reported by some authors however in our case, misdiagnosis of de novo RA is the case.

We recommend early referral of unknown and problematic conditions to highest level of experts in each field. This could be true for rheumatologist in case of trauma and of course for the orthopedists in case of non-traumatic bone and joint conditions.

REFERENCES