Rheumatology Second Opinions™ Consultation

Date:

Patient:

Discussion:

56 years old Caucasian male from Cyprus is symptomatic since June 2021, with 2 months of discomfort in right third toe without any injury which has been getting worse. It was suspected to be Morton's neuroma and the MRI of right foot from 29/6/21 showed suspected Morton' neuroma in the 2nd/3rd and 3rd/4thintermetatarsal spaces, mild bursitis of second and third intermetatarsal bursae and inflammatory changes of the second and third MTP joints on the plantar aspects. He has been diagnosed as seronegative spondyloarthropathy and is on sulfasalazine. He is a current smoker with sedentary desk job and has a active lifestyle which includes hiking and long distance walking until recently. His past medical and family history is unremarkable. Even though, the history of later events has not been provided, it looks as if he has developed pain in neck, outer aspect of left hip and outer aspect of right hip. The MRI of right leg on 18/10/22 showed intermetatarsal bursitis between heads of 2nd/3rd and 4th/5th metatarsal spaces-?Morton's neuroma with tendinopathy of the flexor tendons of the 2nd and 5th toes. C-spine Xray- mild narrowing at C5-6, MRI of hips and pelvis from 10/5/23 showed tendinopathies involving Glutei Medius bilaterally suggestive of trochanteric bursitis and tendinopathy involving left ischial tuberosity. Assuming there is no trauma, these tendinopathies could be either idiopathic, degenerative or due to inflammatory conditions such as seronegative spondyloarthropathy

The labs showed normal CBC with differential except low lymph % at 17.4 (n=20-45), ESR-20, CRP- 14.6 on 12/4/23. HLA B27-negative. RF/CCP/ANA/ENA/ANCA-all negative. On 2/5/23- ESR increased to 26, CRP decreased to 1.842 and SPEP showed mild acute inflammation. The MRI of right foot from 29/6/21 showed suspected Morton' neuroma in the 2nd/3rd and 3rd/4thintermetatarsal spaces, mild bursitis of second and third intermetatarsal bursae and inflammatory changes of the second and third MTP joints on the plantar aspects.

Recommendations:

After review of all the data submitted, there appears to be a mild chronic inflammatory process. Seronegative spondyloarthropathy presenting with enthesitis or peripheral spondyloarthropathy remains in differential diagnosis though mild inflammation can also be seen in degenerative conditions. He is HLA B27 negative and I assume that his sacroiliac joints did not show any inflammation, erosions or ankylosis. He should be treated with long active NSAIDs such as Celebrex or meloxicam in addition to sulfasalazine. If sulfasalazine in a dose of 3gms/day is ineffective, a trial of low dose methotrexate up to 25mg/week SQ will be appropriate. Judicious use of steroid injections in tendon sheaths may be helpful in controlling tendinopathies. If there is no

response to either full dose of sulfasalazine or methotrexate, anti-TNF agents such as Adalimumab or anti IL-17 agent such as secukinumab can be tried.

Answers to patient`s questions:

1. Possible diagnoses: Seronegative Spondyloarthropathy presenting with enthesitis or peripheral spondyloarthropathy, Degenerative tendinopathies, Idiopathic tendinopathies, psoriatic arthritis without psoriasis

2. Use long acting NSAIDs such as Celebrex or meloxicam; increase SSZ to 3gms/d for 3 months-if no response, start weekly SQ MTX up to a max of 25mg/week for a total of 3-4 month; if MTX also fails-consider anti- TNF agents or anti IL-17 agents.

3. MRI of SI joints, Lumbar and Thoracic spine, periodic careful history taking and physical exam; monitor ESR/CRP

4. If possible, A biopsy of relevant area showing acute or chronic inflammation may be helpful

Additional:

A more thorough details of history and physical exam findings will be helpful in sorting out his illness. Thank you for using secondopinions.com

Electronically Signed by:

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