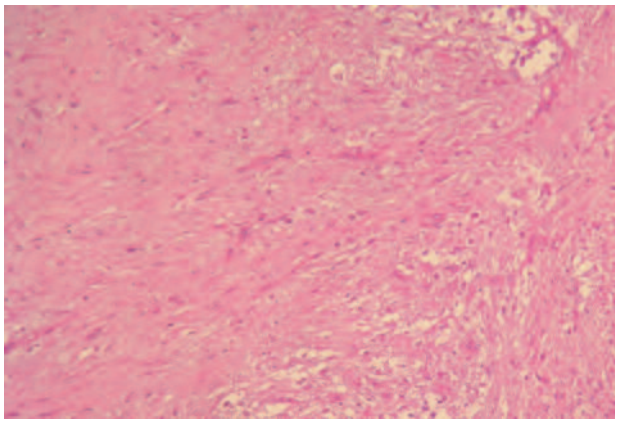
Figure 4: The tumor is made of histiocytes, foam cells and multinucleated giant cells scattered throughout a fibrous hypocellular stromal background (Hematoxylin Eosin x 400)



Conclusion

We reported here in a histopathologically-proven TGCT of the tendon sheath arising from the PCL. To the best of our knowledge, this is the fifth case described in the literature. Localized forms of TGCT exceptionally involve the larger joints and are very rarely intra-articular. The intra-articular form occurs almost exclusively in the knee. As in our patient, masses are generally well circumscribed with a dense capsule and no joint effusion. Although non specific, MRI is the best noninvasive diagnostic technique. Local excision by arthroscopy or open surgery is the treatment of choice. In our case, we preferred to practice an open surgery given the nonspecific tumor appearance on MRI.

References

1. Sheppard DG, Kim EE, Yasko AW, Ayala A. Giant-cell tumor of the tendon sheath arising from the posterior cruciate ligament of the knee: a Case report and review of the litera¬ture. Clin Imaging 1998; 22:428-430.
2. Kim RS, Lee JY, Lee KY. Localized pigmented villonodular synovitis attached to the posterior cruciate ligament of the knee. Arthroscopy 2003; 19: e32-e35.
3. Aksoy B, Ertürer E, Toker S, Seçkin F, Sener B. Tenosynovial giant cell tumour of the posterior cruciate ligament and its arthroscopic treatment. Singapore Med J 2009; 50:e204-e205.
4. Camillieri G, Di Sanzo V, Ferretti M, Calderaro C, Calvisi V. Intra-articular tenosynovial giant cell tumor arising from the posterior cruciate ligament. Orthopedics 2012; 35:e1116-8.

Renal colic as initial presentation for herpes - zoster infection in an adult female

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Acute renal colic (ARC) is usually referred to an urologist, and the principal concerns are to treat pain and determine the underlying aetiology. Although the diagnosis of ARC is clinical, a long list of non-urinary pathological conditions may mimic it. Herpes zoster (HZ) results from reactivation of latent varicella zoster virus in sensory dorsal root or cranial nerve ganglia. HZ usually begins with a prodrome, such as pain, itching or tingling in the area that becomes affected. This may precede the characteristic rash by days or even weeks (1). Bogomolov et al (2) found that about one out of 8 patients with HZ (over a series of 170 patients) had been erroneously diagnosed before the appearance of herpetic eruption as having other diseases (erysipelas, renal colic, acute pancreatitis, acute abdomen..). This point to the difficulties encountered in making the diagnosis at the initial disease period. Moreover, this infection might also occur without skin lesions (zoster sine herpete) so that serological assays for the early detection of virus DNA can be useful (3).

HZ usually manifests as a painful vesicular rash along a dermatomal distribution that may be accompanied by pain that is localized to the area (1). Pain associated with HZ should be treated early and if a patient responds poorly, he should be referred rapidly to pain specialist.

Herein we present a case of HZ miming renal colic at early presentation. We didn't find that the early treatment, which included Antiinflammatory medications, affected the presentation of symptoms or alter the immune response to the virus.

Case

A 66-year-old patient, with no particular medical history, presented for isolated right acute renal colic. She reported no gastrointestinal problems or bowel or bladder dysfunction. There

was no history of trauma and she denied any systemic upset. On examination she appeared well, apyrexial and her abdomen was soft and non-tender. Renal and abdominal ultrasounds didn't reveal any abnormalities. Laboratory data showed a normal white blood cell count. The erythrocyte sedimentation rate and C-reactive protein were normal. Urinalysis was negative. We concluded to atypical low back pain. Antiinflammatory medications provided some relief. Two days later she was admitted for right lumbar typical zoster exanthema. The rash appeared in the right upper lumbar region and involved the right T11-L1 dermatome. She had a patchy, vesicular appearance in different stages of progress. The rash was mildly pruritic and painful. Oral acyclovir in addition to analgesics leads to rapid decrease of pain and exanthema.

Her symptoms slowly improved. She remained afebrile and neurological examination remained normal. Her rash resolved over 9 days, consistent with the typical course for HZ infection. At clinic review two months after her initial presentation there was complete resolution of both the vesicular rash and pain.

Conclusion

Herpes zoster should be included in the differential diagnosis of renal colic especially in patients with normal physical and imaging findings.

References

1) Gupta LK, Khare AK, Mittal A, Kuldeep CM. Herpes zoster in infance. Indian Dermatol Online J. 2013;4:252-4.
2) Bogomolov BP, Bakhur EG. Diagnostic difficulties in herpes zoster. Ter Arkh. 1984;56:138-40.
3) Koch P, Diedrich O, Pennekamp PH, Schmitz A. Rare differential diagnosis of a radicular spine syndrome: herpes zoster radiculitis. Z Orthop Ihre Grenzgeb. 2006;144:583-6.

Simultaneous bilateral tibial stress fractures in a handball player

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A stress fracture is defined as a fracture of a bone caused by repeated mechanical stress which over time exceeds the bone's intrinsic ability to repair itself. The site of occurrence is most commonly the weight-bearing lower limb (1, 2). Stress fractures have become an increasing cause of morbidity because of the increasing participation of the population in sporting activities (3). In this report, we describe an unusual case of simultaneous bilateral stress fractures of the tibial shafts in a young handball player, exposed to a sudden increase in joint loading due to his part-time occupation.

Case report

A twenty-year-old national handball player presented a bilateral leg pain evolving for two months. The onset of symptoms was gradual and occurred after a sharp increase in the rate of training.

Clinical examination revealed a young man walking normally, without pain. However, there was marked tenderness over the anterior and posteromedial aspects of both tibial shafts. There were no local inflammatory signs. Initial radiographs and CT scan of both legs were normal. A full blood count, plasma viscosity, CRP and renal biochemistry were all normal.

Despite a period of rest and given the persistence of symptoms, a new radiological assessement was requested including Tc-99m scintigraphy showing two mid-diaphyseal tibial foci of intense uptake suggestive of stress fractures. The new radiographs of legs face and profile showed a patchy multi-appearance of the anterior cortex of the right tibia in its middle part and a fracture of the anterior cortex of the left tibia in its middle part (Fig 1, 2).

The patient was then operated.. He had a bilateral tibial nailing after intramedullary reaming and without Buckle (Fig 3). The postoperative course was uneventful. Full support has been enabled in immediate postoperative. The resumption of training was done at 3 weeks post-operative.

Figure 1 : Radiograph of the right tibia showing multi-appearance of the anterior cortex

Figure 2 : Radiograph of the left tibia showing a fracture of the anterior cortex in the middle part of the tibia

The player returned to action at 2 months post-operative. Plain radiographs performed 6 months later were normal.