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Hemarthrosis and Scurvy[☆]



Hemarthrosis por escorbuto

To the Editor,

Hemarthrosis refers to the presence of intraarticular blood and its usual presentation is acute monoarthritis, generally of the knee. The differential diagnosis of spontaneous hemarthrosis includes coagulation disorders, pigmented villonodular synovitis, vasculitis, rheumatoid arthritis and calcium pyrophosphate or hydroxyapatite crystal deposition diseases, among other causes.¹

On the other hand, scurvy is a disease provoked by deficiency of vitamin C or ascorbic acid, a water-soluble vitamin involved in collagen synthesis through the hydroxylation of lysine and proline in precollagen.² The diagnosis of scurvy is clinical and it is necessary to consider an extensive differential diagnosis with a number of diseases, especially vasculitides, as cutaneous purpura is one of its most characteristic clinical manifestations.³

We report the case of a 42-year-old man with a history of paranoid schizophrenia, who came to the emergency department with pain and progressive swelling of his left knee that had begun 2

weeks earlier. He had experienced no previous injury. Physical examination revealed gingivitis, purpuric cutaneous lesions and arthritis in his left knee.

He underwent arthrocentesis had yielded a blood-stained fluid (940,000 μ L red blood cells, 24,550 μ L nucleated cells—11% lymphocytes and 89% neutrophils—and 56 g/L proteins). A plain radiograph of the knee was normal and magnetic resonance imaging (MRI) revealed marked joint effusion and substantial intra-articular circumferential edematous infiltration, which was reported to be compatible with hemarthrosis, with no other pathologic findings (Fig. 1). On the other hand, a biopsy of the purpuric skin lesions showed extravasation of blood and siderophages, with no inflammatory infiltrate.

Antinuclear antibodies (ANA), antineutrophil cytoplasmic antibodies (ANCA), cultures of joint fluid, serological tests for hepatitis B or C virus and human immunodeficiency virus, as well as coagulation tests, routine analyses, and determination of acute-phase reactants were negative or normal. The medical history referred to a restrictive diet, in which the patient ate only milk and yogurt, as well as previous episodes of gingival bleeding.

The serum vitamin C levels were <0.10 mg/dL (normal values: 0.4–2 mg/dL).

After the diagnosis of scurvy, treatment was begun with vitamin C supplements and a supervised diet. The outcome was positive, with a rapid improvement of the skin lesions and resolution of the hemarthrosis.

At present, scurvy is a rare finding in developed countries,⁴ but rheumatologists should consider this possibility in the case of spontaneous hemarthrosis, especially if it is accompanied by other hemorrhagic manifestations or eating disorders, taking into account that the definitive diagnosis is usually confirmed *a posteriori*, as vitamin C levels are not routinely determined.

In short, scurvy is a very rare deficiency disease in western countries, although it can be observed in some psychiatric patients and alcoholics with eating disorders. With this case, we would like to remind professionals of this condition as the cause of rheumatic disease and, although not very frequent, it must be taken into account in the differential diagnosis of hemarthrosis. The key to the diagnosis is still in the physical examination and the medical history, although the usual ancillary tests are exclusively a help to rule out other processes.

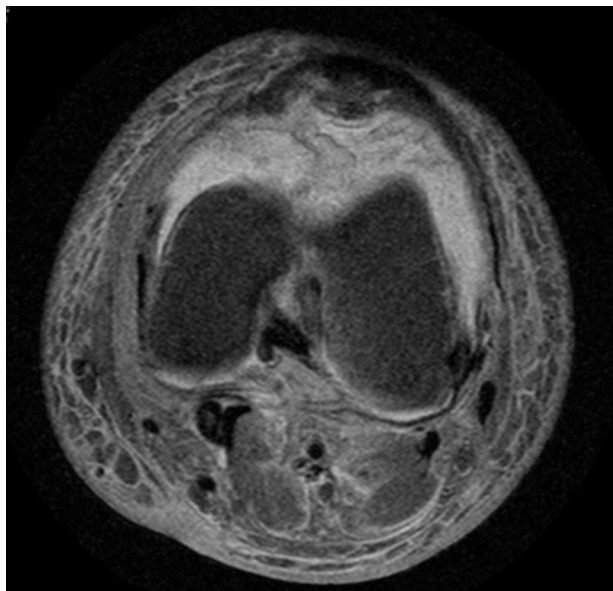


Fig. 1. Coronal T2-weighted magnetic resonance image of the left knee of the patient. A hyperintense signal can be observed in the anterior region in different phases compatible with hemarthrosis.

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Sarcoidosis-lymphoma Syndrome[☆]



Síndrome sarcoidosis-linfoma

To the Editor,

We found it very interesting to read the report on “Sarcoidosis-lymphoma Syndrome”, by Brandy-García et al., recently published in *Reumatología Clínica*,¹ in which the authors review the history of the first description and subsequent communications in Spain, and contribute to our knowledge of this condition. In their study, they point out the difficulty in distinguishing between the two diseases in the differential diagnosis, and particularly establish the complexity of the diagnosis of neurosarcoidosis, given the lack of specificity of the imaging studies, as well as the difficulty in accomplishing a pathological study.

The authors were able to summarize and analyze the most important and controversial aspects that the physicians responsible for these patients need to confront day after day; however, although we share their conclusions, we believe that some consideration should be given to the diagnostic tests. We wish to point out that when they mention normal lumbar puncture and cytometry in which a T lymphoid population was recognized, it is not clear which sample corresponded to the cytometric study.

Especially, in this case, it must be acknowledged that, given the absence of a histological study, it is evidently difficult to identify the definitive diagnosis on the basis only of the clinical signs and the imaging studies. However, the unavailability of a histological

diagnosis should not be a barrier that delays the diagnosis and treatment in these cases.

For this reason, we consider it relevant to point out the need for flow cytometry of the cerebrospinal fluid,^{2,3} whenever it is not contraindicated, in patients with a history of sarcoidosis and in whom the involvement of the central nervous system is suspected, to obtain confirmatory and more accurate data on the correct diagnosis.

We agree with the authors that there is a lack of scientific evidence on this subject. Therefore, we would like to thank them for publishing their notable contribution to help us to make progress in the diagnosis of this disorder.

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Rhupus and Autoimmune Hepatitis: A Rare Association[☆]



Rupus y hepatitis autoinmune: una asociación infrecuente

To the Editor,

Overlap syndromes are uncommon conditions in which the diagnostic criteria of more than one systemic autoimmune disease are met in a single patient.¹ In contrast to mixed connective tissue diseases (MCTD), in which certain clinical or serological

characteristics are identified, they do not fulfill the diagnostic criteria in order to be categorized as a defined disease.^{1,2}

“Rhupus” is an entity in which there is an overlap of systemic lupus erythematosus (SLE) and rheumatoid arthritis (RA), and the incidence involves less than 1% of the SLE population.^{1,2} Autoimmune hepatitis (AIH) is a chronic progressive liver disease. Its prevalence is relatively low, as it affects around 16.9 individuals in population of 100,000.³

We report the case of a 30-year-old woman, with a history of RA, who came to the hospital with acute pyelonephritis. Therapy was begun with antibiotics and symptomatic treatment, and the patient responded favorably. Four days later, she presented with pain in hypogastrium and right hypochondriac region, nausea, vomiting, paleness, pain and stiffness in the metacarpophalangeal joint (with synovitis) and bilateral coxofemoral joint, red eye syndrome, malar erythema and photosensitivity.

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