Conclusion: Slightly more than 50% of the sites selected for study contained tendon tissues useful for histologic examination. The same results were obtained for entheses in only one site. Overall, these sites appear suitable for study in patients with SpA.

del tendón y la vaina sinovial del tibial posterior, y en la inserción del peroneo corto en la cara externa de la cabeza del quinto metatarsiano.

Los tendones estuvieron constituidos por haces ondulados de células fusiformes con arreglo longitudinal separados por finos septos de tejido conectivo y tejido conectivo denso alrededor. En las entesis se identificó la unión del tendón, endotendón y epitendón al hueso a través de un fragmento de fibrocartílago no calcificado.

Conclusion: En un poco más de la mitad de los sitios seleccionados se pudieron obtener muestras de tendones para estudio histológico; el mismo resultado se obtuvo con respecto a las entesis de uno solo de los sitios estudiados. Estos sitios parecen ser ideales para el estudio de pacientes con SpA.


Introduction

Spondyloarthropathies (SpA) constitute a family of entities that share clinical and immunogenetic aspects. The most important clinical alterations result in inflammation and bone proliferation evident in joints (synovitis) and enthesitis (enthesitis) of the vertebral spine and coger extremities, and, in a minority of cases, in the affection of other tissues or organs. The SpA group includes ankylosing spondylitis (AS), reactive arthritis, psoriatic arthritis, arthropathies associated to Crohn’s disease or ulcerative colitis, and a growing group of undifferentiated forms. In the past few years, the morphologic study of SpA has been concentrated on the enthesis and neighboring structures such as bursae and synovial sheaths. 

The enthesopathy that characterizes SpA involves several processes: inflammation, proliferation and endocondral bone metaplasma, bone proliferation, and the formation of osteophytes and bony spurs. 

From a clinical standpoint, the acute phase of enthesitis is characterized by hypersensitivity and pain when pressure is applied to the affected sites, and frequently by increased volume, especially when bursae and synovial tendon sheaths are involved. In the chronic phase, enthesophytes, interosseous bridging and bone ankylosis can be found. 

Enthesopathy affects axial and periferal enthesitis. In the periferal sites, the enthesin most frequently affected are those on the lower extremities, specially on the calcaneous (plantar fascia enthesis and Achilles tendon), on the bones that form the tarsus, on the heads of the first and fifth metatarsals, on the anterior tibial tuberosity and on the greater trochanter. On the axial skeleton, the most frequently affected enthesis are the ones located on the ischium, the iliac crests and spines, the sacroiliac, interapophyseal and costosternal joints, and the vertebral bodies.

In Mexican patients with SpA, tarsal affection is an episode that frequently is accompanied by acute phase inflammation and, sometimes, by chronic phase ankylosis. 

The combination of inflammatory and structural tarsal alterations is known as ankylosing tarsitis. As a first stage in the study of the definition of tarsal affection in patients with SpA, it is important to identify the ideal site for biopsy sampling on the feet of cadavers with the purpose of implementing the procedure in patients with SpA.

Material and Methods

The study was done on tissues obtained from 6 human cadavers with an age less than 50, which died of different causes, none related with illness that could interfere with the present study. The sites selected and chosen by consensus were: a) superior extensor retinaculum tendon and sheath; b) inferior extensor retinaculum tendon and sheath; c) posterior tibialis tendon and sheath at the site of insertion to the internal side and periosteum of the first metatarsal; d) superior posterior tibialis tendon and sheath; e) peroneal brevis tendon and sheath on the site of insertion to the external side and periosteum of the fifth metatarsal; and f) superior portion of the peroneal longus and brevis tendon and sheath (Figure 1). Samples were obtained by both authors, AUV, a plastic surgeon, and RRG, rheumatologist.

Figure 1. Tibialis posterior enthesis. The image shows the tendon (T), non calcified fibrocartilage (FNC), calcified fibrocartilage (FC), a bone spur (ES), and bone (H) (×10).
Sample Preparation
Samples were carefully dried with the purpose of including at least 1 cm of tendon and synovial sheath and 0.2 mm of periosteum. Afterwards they were fixed in a 5-formaldehyde, 70% ethyl alcohol, and paraffin. Finally, 3 µ deep fragments were cut and stained with hematoxylin and eosin (HE) and with Masson’s trichromic.

Results
Thirty-one portions of tendons, 8 enthesis, and 5 periosteum were identified in biopsied tissues (Table). In none of the cases was synovial membrane identified. In more than half of any of the sites biopsied, tendon was identified—including endo and epitendon—but no tendon synovial membrane. In at least 50% of the samples taken in 2 of the biopsied sites, specifically on the posterior tibialis superior tendon and synovial sheath and on the insertion of the peroneal brevis to the external side of the fifth metatarsal head, enthesis was identified. The tendons were formed by undulated bands of fusiform cells with a longitudinal arrangement (tendon in itself) separated by fine septa of connective tissue (endotendon) (Figures 1 y 2). Some of the tendons were surrounded by dense connective tissue or epitendon (Figure 3). Findings on the enthesis included the site of union of tendon, epitendon, and endotendon to the bone through a fragment of non calcified fibrocartilage.

Discussion
The results of this study confirm the presence of tendon, endotendon and epitendon in approximately two-thirds of the simples taken, and enthesis in 2 of them. With respect

<table>
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<th>Table 1. Structures Identified in Each of the Studied Sites</th>
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<td>Site</td>
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<tr>
<td>Superior extensor retinaculum tendon and sheath</td>
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<tr>
<td>Inferior extensor retinaculum tendon and sheath</td>
</tr>
<tr>
<td>Tendon, synovial sheath, and insertion of the posterior tibialis on the head of the first metatarsal</td>
</tr>
<tr>
<td>Superior posterior tibialis tendon and sheath</td>
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<tr>
<td>Peroneal brevis tendon on its insertion to the external side and periosteum of the fifth metatarsal head</td>
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<tr>
<td>Superior part of the peroneus longus and brevis tendon and sheath</td>
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to tendons, this work shows the sites in which there is a larger probability of obtaining the best samples for histopathologic study. With respect to the enthesis only two sites were appropriate, specifically the insertions of the superior part of the posterior tibialis and the peroneal brevis. The application of the results of this study concerns the histopathologic study of foot affection in patients with SpA, with the goal of obtaining information that permits the establishment of theoretical bases for the pathogenesis of said process. In an indirect manner, the information obtained could explain some of the episodes that occur in the vertebral spine and sacroiliac joints of patients with SA. In detail, foot affection, especially in patients with juvenile SpA, produces pain and an increase in volume of the mid-foot as well as pain in the insertions of the Achilles’ tendon and the plantar fascia on the calcaneus. In the phase of most notable inflammation, some alterations can be found by magnetic resonance imaging which indicates the presence of inflammation in some of the affected zones, for example, zones of hypersensitivity on the abovementioned enthesis or through the width of the tarsal bones. In chronic phases it is possible to find structural alterations of a diverse nature that ultimately determine the degree of limitation of the patient. Such alterations are constituted by a progressive reduction of the joint space, bone proliferation on the entheses (enthesophytosis), bone bridging between the tarsal bones and, in more advanced cases, partial or total tarsal ankylosis. These types of alterations appear similar to the ones that are found on the vertebral spine in patients with AS and probably represent the same kind of mechanism and pathogenic alterations.

References