

Answers and additional information for Clinical Quiz in the previous page

Q 1.

- Sclerotic area deep to subchondral bone of medial femoral condyle.
- Osteochondritis Dissecans (OCD)
- Berndt and Harty :
Stage I. normal radiograph
Stage II. partially detached osteochondral fragment.
Stage III complete non-displaced fracture remaining within the bony crater.
Stage IV: detached osteochondral fragment as a loose body. This is in stage IV as confirmed by MRI.
- Stop strenuous activities, NSAIDs, arthroscopic re-attachment / cartilage cell cover.

OCD is a condition where a variable amount of joint cartilage with its underlying bone loses its blood supply. It can involve cartilage surface of any joint. Knee and the talus are most commonly affected.

Etiology of OCD is unknown. Recurrent injuries and growth disturbances have been implicated.

Symptoms include pain, stiffness and even locking.

There is no cure. Management depends on the location, size and stage of the lesion. Arthroscopic debridement, re-attachment, cartilage cell transfer etc. are being tried.

Q2.

- Trigger finger. In the earlier stages, the finger may 'snap' like trigger to achieve extension but in long term the finger may remain flexed.
- The flexor tendon becomes swollen and unable to glide within the flexor sheath.
- Any pathology that results in swelling of the tendon, the synovial cover or tightening of the flexor sheath can cause triggering. Diabetes, rheumatoid arthritis, pregnancy and malignancy are among some of these causes.
- The thumb, index and middle fingers are most commonly affected.
- A trial of NSAIDs, with or without steroid infiltration may relieve most of the cases. But slitting open the affected flexor sheath may be necessary in some cases.

Q3.

- Right sided Erb's palsy.
- Large baby and obstructed labour with shoulder dystocia.
- Chances of full / near full recovery is more than 90%.
- Mother is likely to be a diabetic.
- Relative indication of surgery is when a complete Erb's palsy fails to start to recover in 4 months as indicated by non- recovery of biceps and brachialis muscles.

Q4.

- Multiple calcified loose bodies of various sizes in the knee joint including the supra-condylar fossa with degenerative changes in the joint.
- Synovial chondromatosis.
- Arthrotomy, removal of loose bodies and joint debridement. The condition may recur and the associated joint degeneration may require total joint replacement.

SCM is a rare synovial abnormality. The synovial cells undergo metaplasia forming numerous minute pearl like cartilaginous

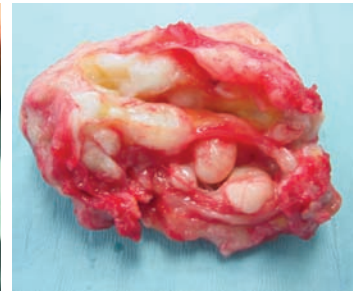
excrescences. They grow in size and may shed into the joint cavity where they continue to grow as cartilage gets its nutrition from the synovial fluid. In time they get calcified and can be seen radiologically as loose bodies.

There is synovial hyperplasia with large amount of synovial fluid. Some of the loose bodies can be palpable and mobile.

More common in middle aged females than in males.



Removal of loose body from the knee.



Osteochondral loose body with surrounding synovial tissue.

Q5.

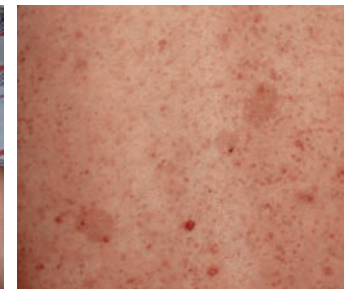
- Gout / gouty arthritis
- High uric acid (>420 mmol/l), high serum creatinine (>130mmol/l) and urea (>6.4 mmol/l).
- Bi-refringent needle shape crystals
- Gouty tophi over subcutaneous bony areas e.g., 1st metatarsalphalangeal joint, shin and elbow. Also over ear lobules.
- Treatment starts with colchicine every two hours until acute pain settles followed by hypo-uricemic drugs and NSAIDs.

Q6.

- Lobulated swelling over proximal forearm and pigmented skin lesions over the body
- Skin nodules and pigmented skin lesions
- Neurofibromatosis with sarcomatous change over the forearm
- Scoliosis, pseudoarthrosis and local gigantism.



Neurofibroma over medial aspect of right lower leg.



Multiple café-au-lait spots over the back.