Idiopathic palmer fasciitis (Case report)

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Abstract: 56 years old female complained of left-hand pain and swelling for 1 month. on examination there were tenderness and swelling over the palm and the planter area with tenderness over 2nd and 3rd flexor tendon of the left hand with swelling over the 2nd and 3rd MCP joints of the left hand with swelling of the 3rd digit, dark Color pigmentation over the planter fascia. idiopathicpalmerfasciitis is an uncommon disorder characterized by progressive flexion contractures of both hands, inflammatory fasciitis, fibrosis. although many cases were reported association of malignancy with similar conditions, our patient had not showed any evidence of malignancy over 30 months follow up. hersymptoms were improved and resolved after moderate dose of steroids with tapering dose over 3months. we are reporting 56 years old Saudi women with idiopathic palmer fasciitis successfully treated with administration of corticosteroid with no evidence of malignancies.
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Introduction

Idiopathic palmer fasciitis is uncommon disorder characterized by progressive flexion contractures of hands, inflammatory fasciitis, fibrosis, and a generalized inflammatory arthritis. Although most of the cases was published in the literature associated with various types of malignancies but our patient have been not associated with any malignancy over 30 month follow up period. her symptoms improved by course of steroids and no relapses of her symptoms and repeated work up for malignancy show no evidence of malignancy over follow up period.

Case Report

56 years old female not known to have any chronic illness was referred to Rheumatology clinic for hand pain for 1 month.

Patient was then seen in the clinic and she mentioned that she started to have hand pain which was started suddenly and was taken NSAIDs for the pain as it was sever enough and did not allow her to do her duties as school manager. The patient denies any history of joints pain, stiffness, rashes, oral or nasal ulcers, Raynodsphenomena, fever, jaw claudication, headache or visual changes. Wight loss, fatigability, weakness, thrombosis or previous obstetrical complication or any other history suggestive of rheumatic disease, also no history of alcohol and elicited drug use. Her past medical history was unremarkable, with no prior history of malignancy. She did not take any medication and no family history of similar condition.

On examination

There were tenderness and swelling over the palm of the over planter area with tenderness over 2nd and 3rd flexor tendon of the left hand with swelling over the 2nd and 3rd MCP joints of the left hand with swelling of the 3rd digit, dark Color pigmentation over the planter fascia area as shown in (figure 1-a, 1-b)

She had no sclerodactyly, nail pitting, Raynaud's phenomenon or telangiectasias, and no proximal muscle weakness was evident. Other joints were unremarkable, chest, abdomen and cardiovascular exam were normal No evidence of lymphadenopathy or lower limb swelling.

Ultrasound were done and shows thickening of palmer fascia with no evidence of tenosynovitis or erosion at the bones `

Labs

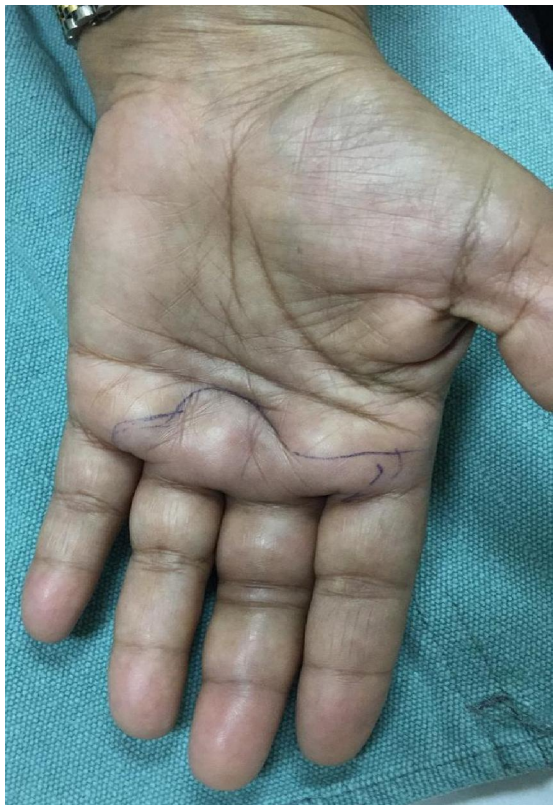
Pertinent lab results included a negative rheumatoid factor (RF), negative cyclic citrullinated peptide (CCP) antibodies and a negative result for antinuclear antibodies (ANA). A myositis antibody panel was also negative. Serum creatine kinase level was 36 u/L (normal range 24–173). The erythrocyte sedimentation rate (ESR) was 52 mm/hr (normal range 0–40). The C-reactive protein (CRP) was 11.1 mg/L (normal range 0.0–4.9). The complete blood count, electrolytes and hepatic function panel were normal. A chest X-ray was normal, and X-rays of both hands were normal. Bilateral knee X-rays were normal.

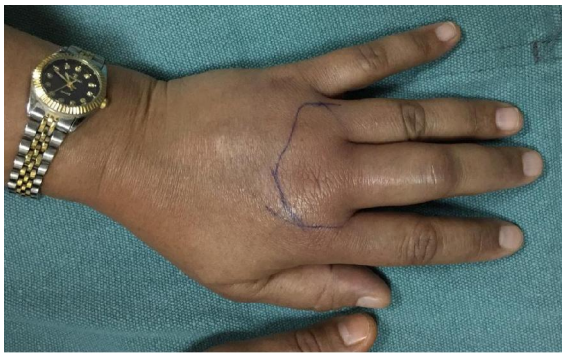
Hospital course

She underwent Mamogrm, CT CAP, Pelvic ultrasound, upper and lower GI scope.

And dexa scan, all were normal. Patient was discharged from hospital with impression of idiopathic palmer fasciitis and she received short oral corticosteroid course (20 mg oral predisnole) and then she was followed in the clinic after one month with

marked improvement in her symptoms and steroid were tapperd dawn until stopped 6 months after seen again and her symptoms were resolved and the finding on previous exam were disappeared, and labs including ESR and CRP were normalized. and then the patient continues follow up to the clinic for 30 months without any recur to his symptoms and malignancy work up was repeated and came back all were negative.





Patient was advised for admission for extensive malignancy work up.

Discussion

Idiopathic palmer fasciitis is rare disease in which the patient develops rapidly progressive contractures of both hands and arthritis of the wrists and larger joints. The exact mechanism of the disease still poorly understood, one theory was may include the activation of certain factors with profibrotic activities, transforming growth factor β or connective tissue growth factor (7).

There was a lot of believe that this condition is paraneoplastic and its associated with malignancies as shown in the table but in our case report there was no clear source of malignancy although patient had extensive work up for it. it has been reported as these rheumatological presentation could precced the malignancy onset by 1-24 month.

We regard the present case as idiopathic because we have been followed her up more than 30 months after her first symptom without any evidence of internal malignancy. The patient was improved with corticosteroid, while most palmar fasciitis and polyarthritis syndrome (PFPAS) patients associated with malignancy did not responsive to steroid treatment.

The differential diagnosis includes other conditions associated with contractures of the hands. The musculoskeletal manifestations of PFPAS are similar to RSD but is characterized by its considerably more aggressive nature and diffuse articular involvements. Most cases of RSD have a preceding noxious event and symptoms of vasomotor disturbances. Bone scanning of the patient with RSD usually shows an asymmetry between affected and non-affected limbs. Our patient, however, did not show those clinical features.

Eosinophilic fasciitis is characterized by painful and erythematous swelling of the extremities. Eosinophilia in the peripheral blood were absent, is prominent at the acute stage. and no evidence of peduo- orange appearance of skin or groove sign, is prominent at the acute stage.

In summary

We present 56 years old Saudi female who present with idiopathic palmer fasciitis and has been extensively worked up for malignancy twice in 30-month duration and she had complete resolution of her initial symptoms with short course of oral corticosteroid.

All rheumatological work up were negative.

We recommend that patient need to continue follow up in future in case she had relapse of her symptoms or she developed malignancy.

Table -1 summarizes the published cases of PFPAS associated with malignancies.

Author (Ref.)	Year	Age (yr)/Sex	Associated malignancy	Effect of treatment on manifes
Medsger et al. (1)	1982	65/F	Ovary	No improvement
		50/F	Ovary	No improvement
		62/F	Ovary	Improved with chemotherapy & CS
		58/F	Ovary	No improvement
Baron (2)	1982	65/F	Bladder, Lung, Colon	Improved with CS
Baer et al. (8)	1983	62/F	Pancreas	No improvement
Shiel et al. (9)	1985	86/F	Lung	No improvement
		75/F	Ovary	Improved with CS
Pfinsgraff et al. (3)	1986	66/F	CML	Improved with CS
		59/F	Pancreas	Improved with Penicillamine
		66/F	Squamous cell carcinoma	No improvement
		71/F	Adenocarcinoma	No improvement
		54/M	Hodgkin	Improved with chemotherapy
Valverde-Carcia et al. (10)	1987	55/F	Breast	Improved with chemotherapy & CS
Caron et al. (11)	1989	74/F	Thyroid plasmacytoma	No improvement
Willemse et al. (12)	1991	54/F	Coelomic epithelial	Improved with CS
Van den Bergh et al. (13)	1991	59/M	Prostate	No improvement
Strobel et al. (14)	1992	59/F	Ovary	Not mentioned
Leslie (15)	1992	55/F	Uterine cervix	No improvement
Laszlo et al. (5)	1995	75/F	Idiopathic	Improved with CS
Viniker et al. (16)	1996	25/F	Ovary	No improvement
Dhote et al. (17)	1997	66/F	Breast	Improved with chemotherapy
Saxman et al. (18)	1997	54/F	Breast	Not mentioned
Wright et al. (19)	1997	57/F	Ovary	Not mentioned
Grados et al. (20)	1998	59/F	Renal pelvis	No improvement
		92/F	Uterine	No improvement
Eekhoff et al. (21)	1998	71/M	Large cell carcinoma	Not mentioned
Matteson (22)	1998	69/F	Ovary	No improvement
Enomoto et al. (4)	2000	44/M	Stomach	Improved with operation
Kase et al. (23)	2000	54/F	SCC of cervix	Improved with chemotherapy
Roman et al. (24)	2001	45/M	Hepatocellular carcinoma	Improved with CS
Docquier et al. (25)	2002	74/F	Uterine adenocarcinoma	No improvement
Virik et al. (26)	2002	69/M	Gastroesophageal carcinoma	Improved with CS
Rammeh et al. (27)	2003	37/M	Multiple myeloma	Not mentioned
Martorell et al. (28)	2004	62/F	Ovary	Improved with chemotherapy
		70/F	Ovary	No improvement
		73/F	Ovary	No improvement
		51/F	Ovary	No improvement
Denschlag et al. (29)	2004	73/F	Fallopian tube	Improved with chemotherapy
Giannakopoulos (30)	2005	67/F	Pancreas	Improved with chemotherapy
Present case	2005	31/F	Idiopathic	Improved with CS

CS, Corticosteroid; CML, chronic myelogenous leukemia; SCC, squamous cell cancer.

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