Imagens em Reumatologia

056 - A RARE CUTANEOUS TWIST IN RHEUMATOID ARTHRITIS: PALISADED NEUTROPHILIC DERMATOSIS UNVEILED

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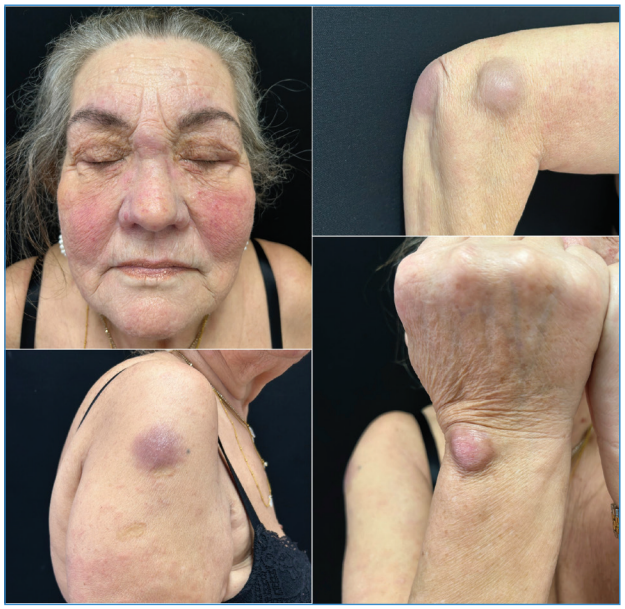
A 71-year-old woman was referred to the Rheumatology clinic with a 4-month history of polyarthritis affecting the wrists and small joints of the hands and feet. Laboratory tests revealed positive rheumatoid factor (34.8 IU/mL) and anti-CCP antibodies (82 U/mL), supporting rheumatoid arthritis (RA). Four months prior to the onset of joint symptoms, she developed violaceous cutaneous nodules on the dorsal right wrist, lateral elbow and shoulder, and glabellar region (Figure 1). A skin biopsy revealed a dense inflammatory infiltrate involving both superficial and deep dermis, extending into the subcutis, composed of lymphocytes, histiocytes, plasma cells, neutrophils, and eosinophils. Extensive necrosis surrounded by histiocytes with focal palisading was observed, consistent with palisaded neutrophilic and granulomatous dermatitis (PNGD).

PNGD is a rare inflammatory dermatosis associated with systemic autoimmune diseases, particularly RA, and may present as violaceous nodules or plaques over extensor surfaces.



056 - Figure 1. Violaceous cutaneous nodules

072 - BEYOND THE HALO IN GIANT CELL ARTERITIS – AXILLARY ARTERY COMPLICATIONS OF SUBCLINICAL ARTERITIS

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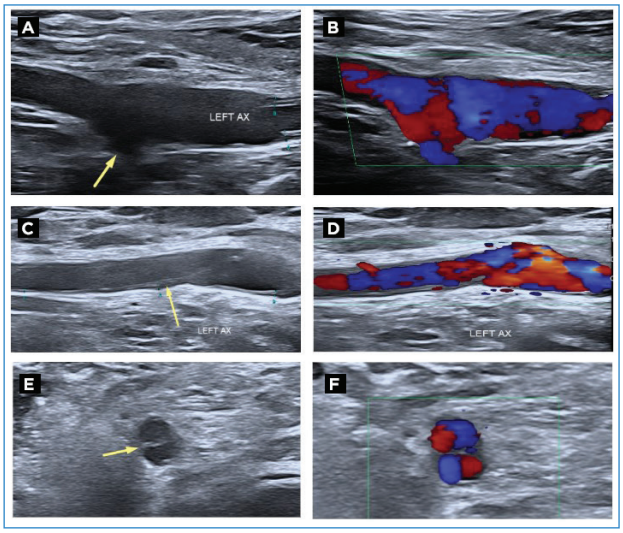
Aortic complications in giant cell arteritis (GCA) with large vessel involvement are well established. Herein, we report two cases of female patients, 63 and 79 years old, diagnosed with GCA with axillary artery complications. Both patients presented with large vessel involvement and were clinically asymptomatic at the time of diagnosis of the axillary artery complication. In the first case, follow-up axillary artery ultrasound (AAUS) showed a chronic halo and aneurysmal dilatation of the left axillary artery (Images A and B), while on treatment with prednisolone (10mg qd) and SC secukinumab (300mg qw4). In the second case, treated with prednisolone (5mg qd) and SC tocilizumab



072 - Figure 1. **A,B:** Aneurysmal dilatation of the left axillary artery. **C,D:** Dissection of the left axillary artery, longitudinal view. **E,F:** Dissection of the left axillary artery, transverse view.

(162mg qw), follow-up AAUS revealed a double lumen in the left axillary artery, compatible with arterial dissection (Images C–F).

080 - FOTOSSENSIBILIDADE NA ARTRITE REUMATOIDE: COINCIDÊNCIA OU CONSEQUÊNCIA?

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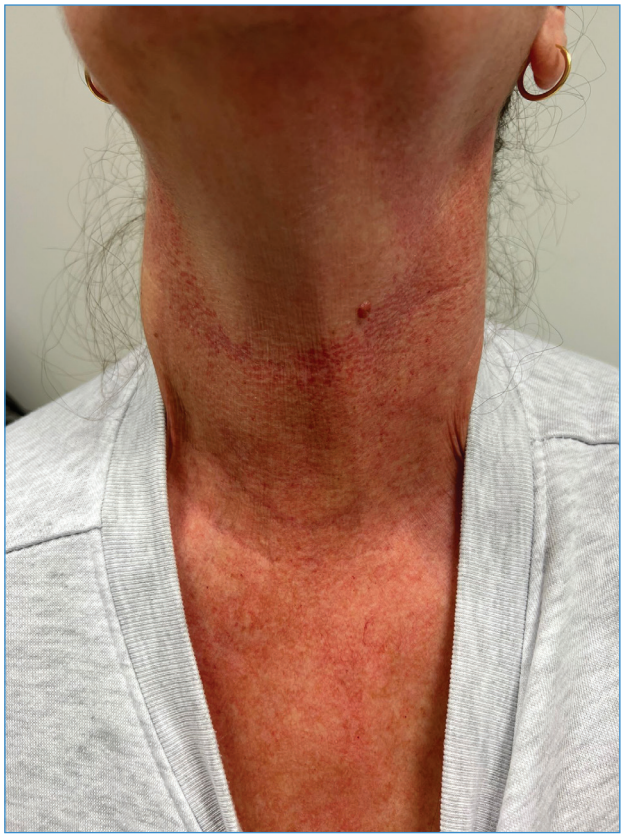
Doente do sexo feminino, 60 anos, seguida em Reumatologia por artrite reumatoide. Dois meses após o início de tratamento com adalimumab subcutâneo 40 mg de 15/15 dias, apresentou lesões cutâneas compatíveis com poiquilodermia de Civatte: padrão reticulado, hiperpigmentação, telangiectasias e discreta atrofia cutânea nas regiões cervical, anterior do tórax e dorso superior, com preservação da área submentoniana. Sem outros fatores despoletantes identificados. Iniciou terapêutica com laser e bilastina 20 mg 2x/dia, com melhoria do prurido, mas sem regressão das lesões após a suspensão do fármaco. O tratamento com adalimumab foi reintroduzido e, neste momento, a doente encontra-se em remissão clínica.



080 – Figura 1. Dermatite de Civatte

083 - THE TREE-LIKE SYNOVIUM: MRI APPEARANCE OF LIPOMA ARBORESCENS

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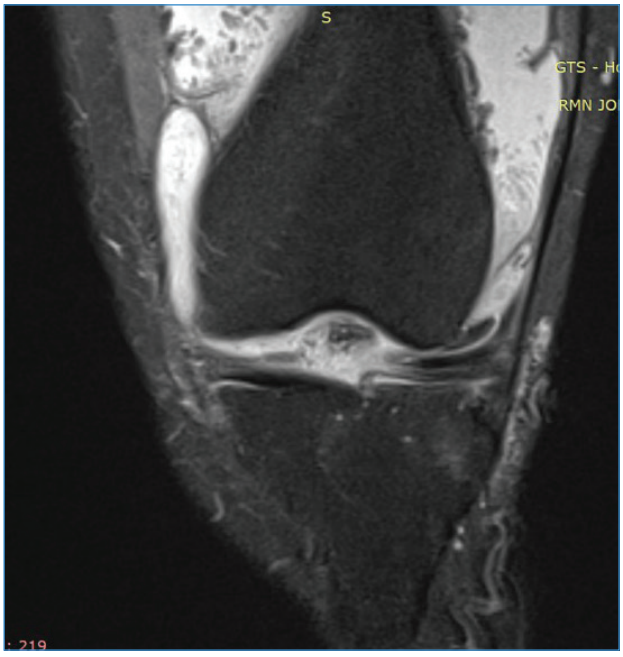
Lipoma arborescens (LA) is a benign synovial tumour characterized by the proliferation of mature adipocytes within the synovial cells. It is most frequently observed in the knee, between the fourth and fifth decades of life. Magnetic resonance imaging (MRI) is considered the imaging modality to evaluate this condition, with synovial biopsy reserved in cases of diagnostic uncertainty.

We present an MRI image of LA in the right knee of a 62-year-old female with undifferentiated arthritis and polyosteoarthritis. The patient had previously undergone synovectomy of the contralateral knee due to recurrent massive hydrarthrosis, with histology confirming the diagnosis of LA. The current MRI of the right knee demonstrates tricompartmental osteoarthritis, joint effusion, and marked synovial thickening with a villous/arborescent morphology and fat signal intensity, located in the suprapatellar (sub-quadriceps) recess and extending into the patellar recesses, consistent with LA.



083 – Figure 1. MRI Appearance of Lipoma Arborescens in the Knee Joint

097 - OSTEITIS AND PUSTULOSIS: TWO SIDES OF THE SAME STORY

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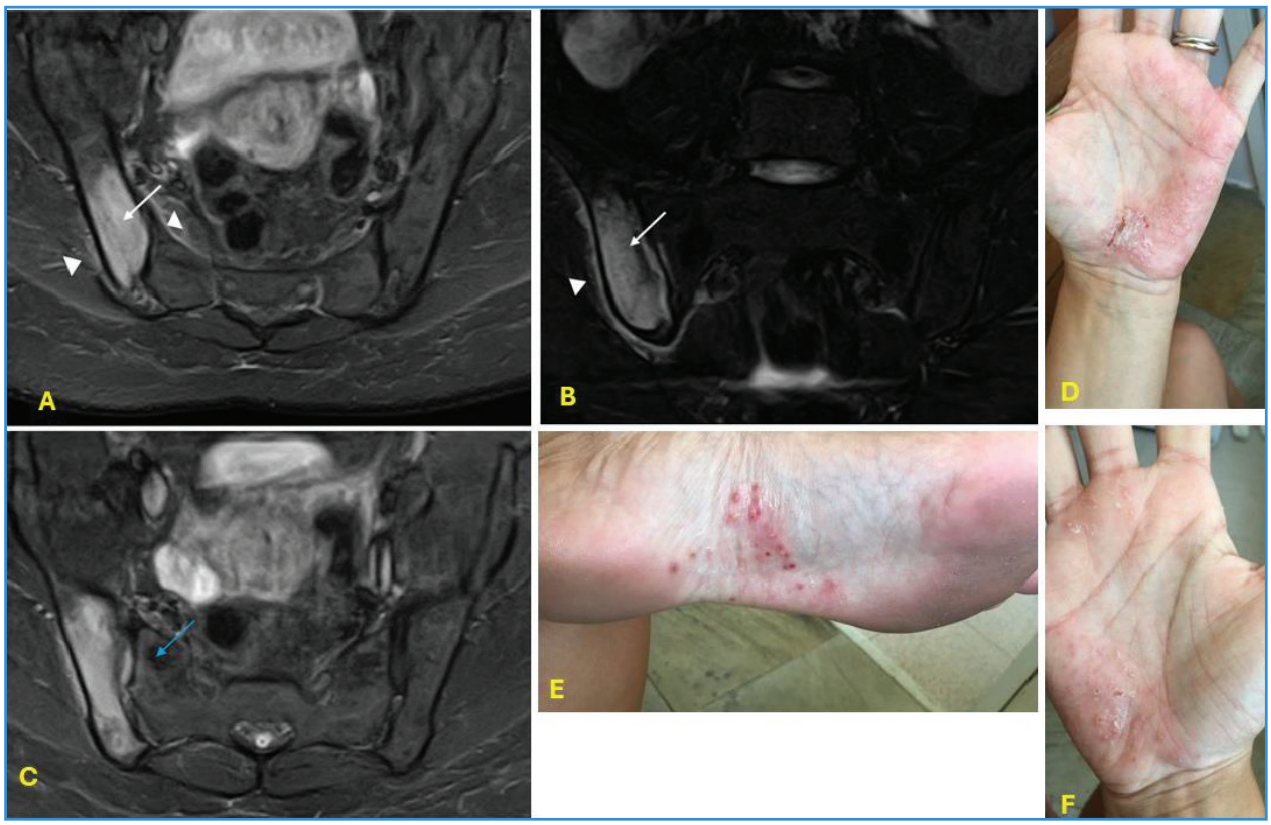
A 36-year-old woman presented to the Rheumatology outpatient clinic with a 9-year history of inflammatory back pain associated with pustular psoriasis. She had a previous diagnosis of psoriatic arthritis (PsA), which was unresponsive to anti-inflammatory drugs (NSAIDs), methotrexate (MTX), and adalimumab (ADA, primary failure), but had a good response to secukinumab, which was later discontinued due to pregnancy.

The patient remained asymptomatic for five years without any medication. However, five years after discontinuation of secukinumab, right lumbosacral pain with morning stiffness lasting more than one hour and severe functional limitation affecting all daily living activities ensued, unresponsive to both ibuprofen 600 mg thrice daily and celecoxib 200 mg twice daily. On physical examination, she had erythematous papular lesions on her palms and torso (Figure 1- Panels D, E, F), pain over multiple costochondral joints, and positive FABER and Volkmann maneuvers, with marked tenderness over the right sacroiliac region. Blood work-up was unremarkable, with no elevated C-reactive protein or erythrocyte sedimentation rate. Magnetic resonance imaging (MRI) showed prominent bone marrow edema in the body of the right iliac bone and adjacent muscles, with minimal involvement of the ipsilateral sacrum (Figure 1 – Panels A, B, C) and no evidence of synovitis. The case was discussed with the Radiology team, which stated that the findings were consistent with osteitis, reinforcing that there was no evidence of active or previous sacroiliitis (erosions or adipose metaplasia). According to the patient's medical records, previous X-rays had evidence of sternoclavicular osteitis.

Given the presence of pustulosis, asymmetric and exuberant osteitis of the right iliac bone, and a histo-



097 – Figure 1. Panels A, B, C: Axial STIR and coronal T2 FSAT MRI show increased signal intensity in the body of the iliac bone (white arrow) and adjacent muscles (piriformis and gluteus medius) (arrowheads), with minimal changes in the sacrum (blue arrow) with no involvement of the sacroiliac joint space. **Panels D, E, F:** Skin pustulosis.

ry of sternoclavicular osteitis, the diagnosis of SAPHO syndrome (Synovitis, Acne, Pustulosis, Hyperostosis, and Osteitis) was considered. Although PsA cannot be definitely ruled out, exclusive axial involvement, chondrocostal joint involvement, and osteitis without concomitant synovitis/sacroiliitis are rare. Additionally, although pustular psoriasis has been described in PsA patients, it is not the psoriasis subtype most commonly associated with PsA. Normal inflammatory markers are frequent in PsA, but their presence alongside atypical features, poor response to NSAIDs, MTX, and ADA, and a subsequent long-term asymptomatic period led to diagnostic reconsideration. Differential diagnosis also included pustulotic arthro-osteitis because of palmoplantar pustulosis and a history of sternoclavicular involvement. However, pustulosis was not exclusively palmoplantar, ruling out this exceedingly rare diagnosis. Most patients with SAPHO present with an incomplete form, exhibiting only a subset of the features. Additionally, although it is a chronic disease, the clinical course is frequently marked by acute/subacute exacerbations followed by asymptomatic phases. Given the patient's prior favorable response and the evidence (from case reports) that anti-IL-17 therapy could be beneficial, secukinumab 300 mg every 4 weeks was reintroduced, leading to significant improvement within two months, with complete resolution of the pain and marked improvement of the skin lesions. This case adds to previous literature reporting the potential benefit of secukinumab for patients with SAPHO syndrome.

103 - POST-TRAUMATIC SPONDYLOARTHRITIS-LIKE ANKYLOSIS AND NEUROGENIC HETEROTOPIC OSSIFICATION IN A YOUNG TETRAPLEGIC MAN

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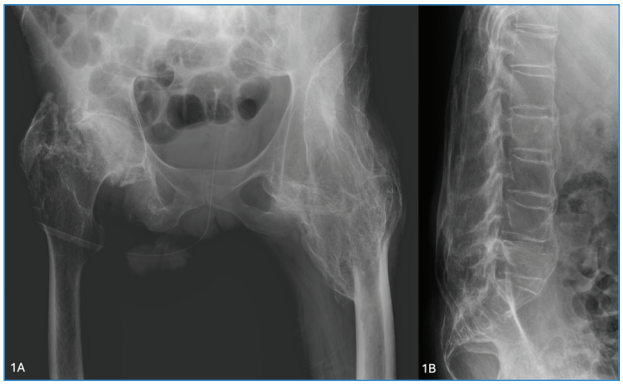
A 33-year-old man with spastic tetraplegia due to cervical spinal cord injury at C4 level, following a 5-meter fall at the age of 19, was referred to our Rheumatology Department for progressive axial and peripheral joint stiffness. Axial symptoms began one year post-trauma.



103 – Figure 1. A–1B: Pelvic and lumbosacral radiographs showing sacroiliac ankylosis, hip ossification, and syndesmophytes.

Examination revealed widespread joint ankylosis and marked stiffness of pelvic and shoulder girdles. Radiographs showed neurogenic heterotopic ossification of the hips (grade II on the right, grade IV on the left, according to Brooker classification) and sacroiliac joint ankylosis (Figure 1A), as well as extensive syndesmophyte formation in the lumbosacral spine (Figure 1B). No prior history of inflammatory back pain, uveitis, psoriasis or chronic diarrhoea, and HLA-B27 was negative.

These striking radiographic findings suggest a rare post-traumatic spondyloarthritis-like phenotype, possibly secondary to prolonged immobilization. Early recognition is essential to guide rehabilitation and prevent functional decline.

109 - MAXILLARY LYTIC LESION: A RARE PRESENTATION OF SARCOIDOSIS

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Introduction: Sarcoidosis is a systemic granulomatous disease of unknown etiology, typically affecting the lungs and intrathoracic lymph nodes. Osseous involvement is rare, occurring in approximately 3–13% of cases, and craniofacial localization is particularly uncommon. The clinical presentation is often nonspecific, mimicking neoplastic or infectious conditions, delaying diagnosis and management.
Case Report: We report the case of a 60-year-old woman with a history of metabolic syndrome and obstructive sleep apnea, who presented with intermittent left nasogenian pain over the preceding year. Episodes

lasted several days and were partially relieved with NSAIDs and cold compresses. Examination showed no cutaneous lesions or facial dysmorphia. She had tenderness over the left genian and vestibular regions without swelling or drainage. Oral inspection revealed edentulism and a whitish hyperplastic lesion on the anterior alveolar ridge mucosa of the second quadrant, suspicious for malignancy

Laboratory workup showed elevated serum angiotensin-converting enzyme at 80 U/L (reference <52), low vitamin D (14 ng/mL), mild hypocalcemia (8.2 mg/dL), and mildly elevated inflammatory markers (C-reactive protein 0.59 mg/dL; erythrocyte sedimentation rate 29 mm/h). Serologies for HIV, HBV, HCV, and interferon-gamma release assay were all negative.

Maxillofacial CT identified a 20×19×15 mm lytic lesion in the medial left maxillary alveolar ridge with soft tissue extension, sinus wall erosion, nasal cavity involvement, marked alveolar bone loss and incisive foramen destruction, highly suspicious for malignancy. Initial cytology suggested acute inflammation. Incisional biopsy revealed non-caseating epithelioid granulomas with Langhans- and foreign body-type multinucleated giant cells, CD68-positive, with no neoplasia or organisms, confirming osseous sarcoidosis.

On further inquiry, the patient denied fever, weight loss, respiratory or cardiovascular symptoms, neurological complaints, or muscle weakness. She reported no inflammatory joint pain, dactylitis, or skin lesions such as erythema nodosum or pseudofolliculitis. She did recall 2 episodes of painful, photophobic, vision-blurring redness in the left eye, suggestive of anterior uveitis, although ophthalmologic examination revealed no signs of ocular sarcoidosis.

To assess systemic involvement, an 18F-FDG PET/CT revealed increased uptake in the known maxillary lesion (SUVmax 4.8) and in right paratracheal and paraesophageal mediastinal lymph nodes (SUVmax 10.6), consistent with active granulomatous disease. No additional osseous or extrapulmonary lesions were identified. A chest CT showed centrilobular micronodules with upper lobe predominance and small mediastinal lymph nodes, without hilar enlargement or fibrotic changes.

Sarcoidosis with confirmed osseous and probable pulmonary involvement was diagnosed, and methotrexate 10 mg/week was initiated. The patient remains under follow-up.

Discussion/Conclusion: Osseous sarcoidosis is rare and may mimic malignancy or infection, particularly in atypical locations such as the maxilla. Histologic confirmation is required, as imaging can be misleading.2 This case highlights the need to consider sarcoidosis in the differential diagnosis of destructive craniofacial lesions, even without classic systemic features. PET/CT supports evaluation of disease extent and activity. Early recognition and a multidisciplinary approach are key to accurate diagnosis and appropriate management, avoiding unnecessary invasive procedures.

116 - DACTYLITIS-LIKE HAND SWELLING WITHOUT INFLAMMATION: AN OCCUPATIONAL MIMIC

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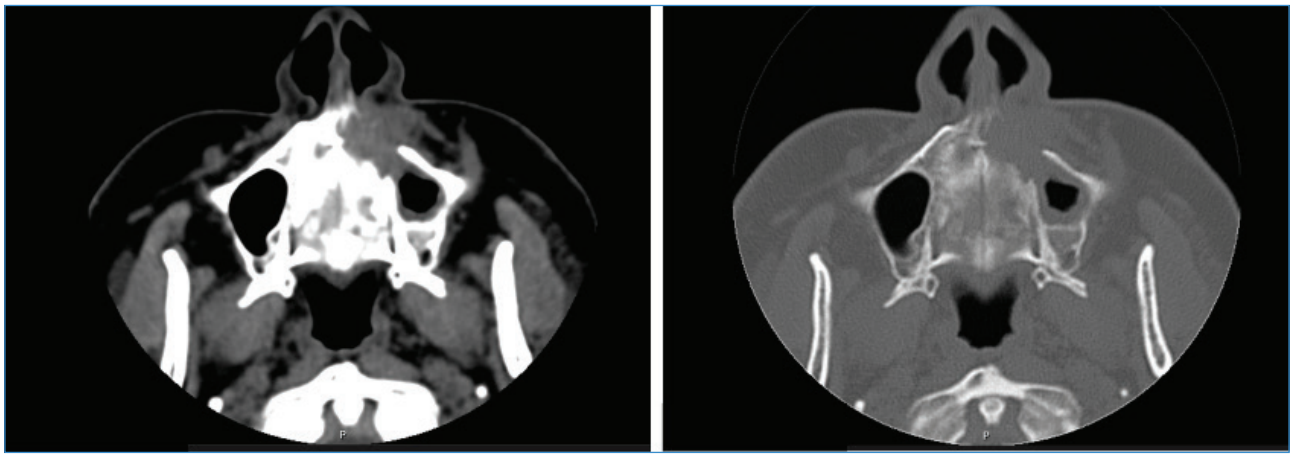
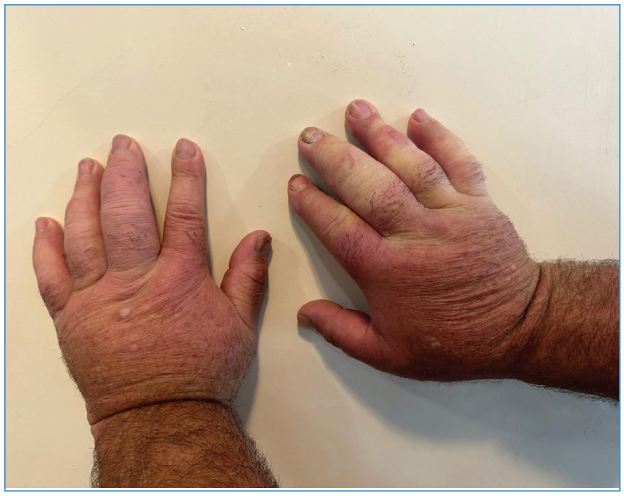
A 56-year-old man was referred to our Rheumatology clinic due to global swelling of the hands. He was a professional sea urchin harvester. He denied joint pain, uveitis, or gastrointestinal symptoms. There was no



109 – Figure 1. Maxillofacial CT (axial plane; A: soft tissue window; B: bone window): Expansive lesion originating from the left maxilla.



116 – Figure 1. Edematous hands of the patient, a sea urchin harvester.

personal or family history of psoriasis, and no associated systemic symptoms.

On physical examination, there was bilateral pitting edema of the dorsum of the hands, especially on the left hand and fingers with a dactylitis-like appearance. Nonsuppurative nodules with a hyperkeratotic surface were noted on the dorsum (Figure 1). There was no joint tenderness, or limitation.

Magnetic resonance imaging and ultrasound of the left hand revealed marked subcutaneous tissue edema, without joint, tendon or bone involvement.

No rheumatologic disease was identified. Findings were consistent with occupational chronic traumatic scleroedema. Awareness of such non-inflammatory mimics is crucial to avoid misdiagnosis and unnecessary immunosuppressive therapy.

122 - BEYOND THE BIG TOE: AN ATYPICAL GOUTY TOPHUS IN THE KNEE

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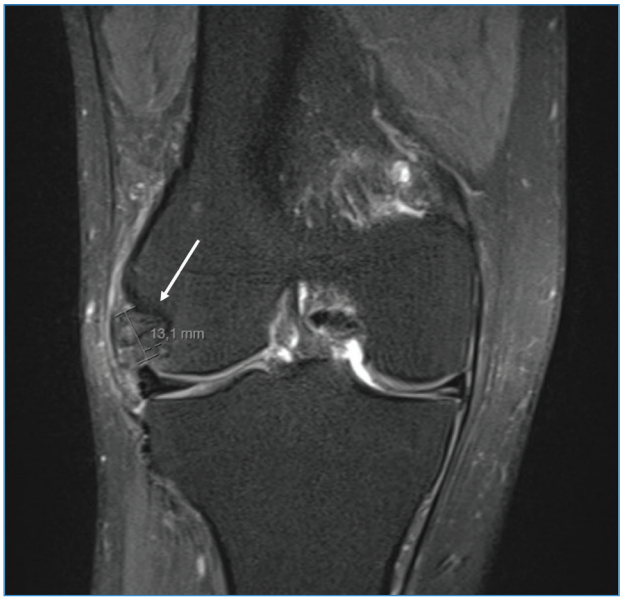
Case Presentation: A 63-year-old man reported 12-month lateral right-knee pain with mixed mechanical/inflammatory features (VAS 6/10). Exam revealed full extension without flexion contracture, minimal effusion, and lateral joint-line tenderness. Plain radiograph was normal; ultrasound suggested a lateral meniscal tear. Due to poor response to steroid injection and physiotherapy, MRI was performed, showing a bulky,



122 – Figure 1.Fat-suppressed T2-weighted MRI image showing distal popliteus tendon enlargement and heterogeneity with hyperintense signal consistent with intratendinous monosodium urate crystal deposition (tophus). Adjacent juxtacortical femoral erosions are visible, with no significant surrounding bone marrow edema or signs of active tendinopathy, suggesting chronic tophaceous involvement without acute inflammatory changes.

heterogeneous distal popliteus tendon with adjacent femoral erosions, suggestive of intratendinous monosodium urate tophus (Fig.1). The patient recalled untreated prior podagra; uric acid was 8 mg/dL. Allopurinol was initiated.

Discussion: Tophaceous gout involving the popliteus tendon is rare. Unusual locations may delay diagnosis, especially when early imaging suggests mechanical pathology. MRI is critical in refractory cases to uncover occult crystal deposits. Early treatment can prevent irreversible joint and tendon damage.

191 - CARROT FRACTURE: FRATURA CERVICAL EM DOENTE COM ESPONDILITE ANQUILOSANTE

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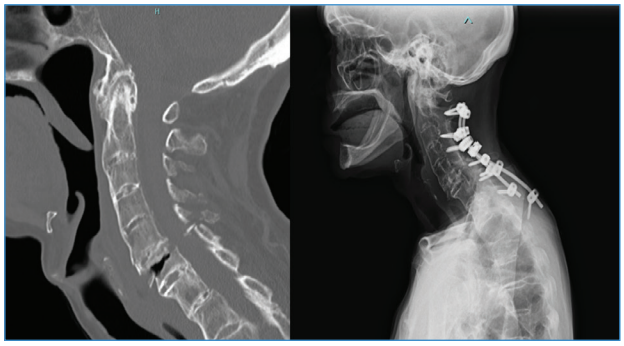
Mulher de 83 anos, autónoma, com antecedentes de espondilite anquilosante, osteoporose fraturária, sob zoledronato anual e síndrome parkinsónico de diagnóstico recente. Recorreu ao serviço de urgência por cervicobraquialgia direita agravada após queda da



191 – Figura 1. Esquerda: TC da Coluna Cervical inicial a demonstrar a "carrot fracture". Direita: radiografia em incidência lateral, extralonga, da Coluna Vertebral, após intervenção cirúrgica.

própria altura. Ao exame objetivo sem alteração da força muscular e da sensibilidade. Radiografia com fratura cervical, a carecer de caracterização por TC. Esta revelou fratura transversa do corpo vertebral de C6 com extensão ao arco posterior e luxação anterior de C6, condicionando apagamento do espaço subaracnoideu perimedular. Esta fratura corresponde a "carrot fracture" ou "chalk-stick fracture" que é um tipo de fratura da coluna vertebral observada tipicamente em doentes com espondilite anquilosante podendo ocorrer após traumas minor. A doente foi submetida a cirurgia com fixação laminar de C2, parafusos em barra óssea sobre C3-C4-C5, laminectomia sobre o fulcro da fratura e parafusos laminares C7-D1-D2-D3.

204 - BILATERAL KNEE SYNOVIAL CHONDROMATOSIS - AN ATYPICAL CASE

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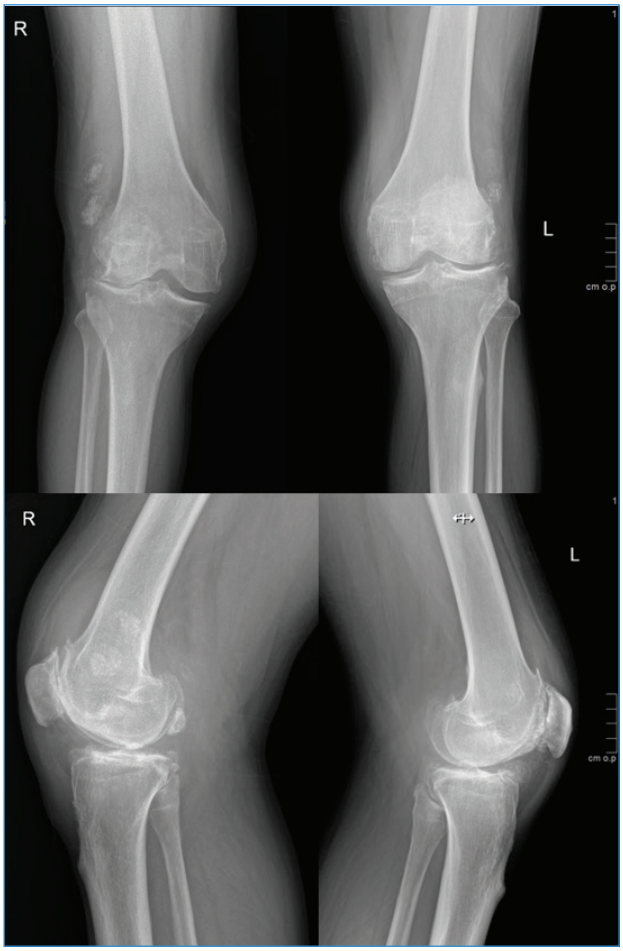

204 – Figure 1. Knee radiographs with several intra and extra-articular calcifications and advanced bilateral osteoarthritis

Case Report: A 46-year old man was admitted for fever and right knee pain and swelling for the past two days. At physical examination, he had bilateral knee deformity which had been present since childhood. Knee radiographs (Fig. 1) showed multiple round intra and extra-articular calcifications and advanced bilateral osteoarthritis.

Due to clinical suspicion of septic arthritis, he underwent surgical arthroscopic lavage and debridement. During the procedure, multiple chondral lesions were observed, covering most of the articular surfaces and several intra-articular free bodies. The pathology analysis of these fragments was compatible with synovial chondromatosis (SC).

Discussion: In SC is a benign and usually monoarticular disease, most often affecting the knee (~70%) and hip (<20%), in which cartilaginous foci form in the midst of the synovial developing into articular free bodies. Treatment is typically surgical and while some cases resolve spontaneously, most untreated cases evolve to secondary osteoarthritis.

217 - MANIFESTAÇÕES CUTÂNEAS CLÁSSICAS DA DERMATOMIOSITE

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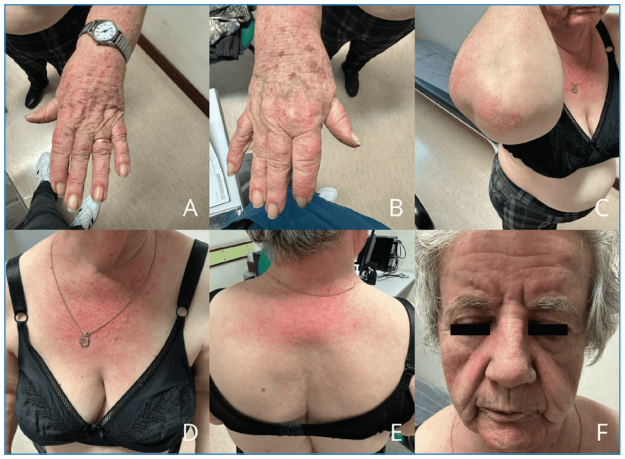
Doente do sexo feminino, 77 anos, com erupção cutânea eritematosa da face (fronte, região malar e periorbitária), tronco (face anterior do trono e região posterior do dorso), cotovelo direito, antebraços e dorso das mãos (figu-



217 – Figura 1. A e B - Pápulas de Gottron; C – Sinal de Gottron nas superf. extens.; D – Sinal do decote; E – Sinal do Xaile; F – Heliotropo

ras), com 2 meses de evolução, que agravavam com exposição solar. Do estudo analítico realizado, destacava-se positividade para o anticorpo Anti-TIF1 gama. Realizou biópsia cutânea, que evidenciou dermatite liqueinóide, compatível com dermatomiosite. Face à apresentação clínica e achados do estudo complementar, foi possível assumir o diagnóstico de dermatomiosite.

225 - QUISTO GANGLIÓNICO DA GORDURA DE HOFFA – UMA LOCALIZAÇÃO RARA

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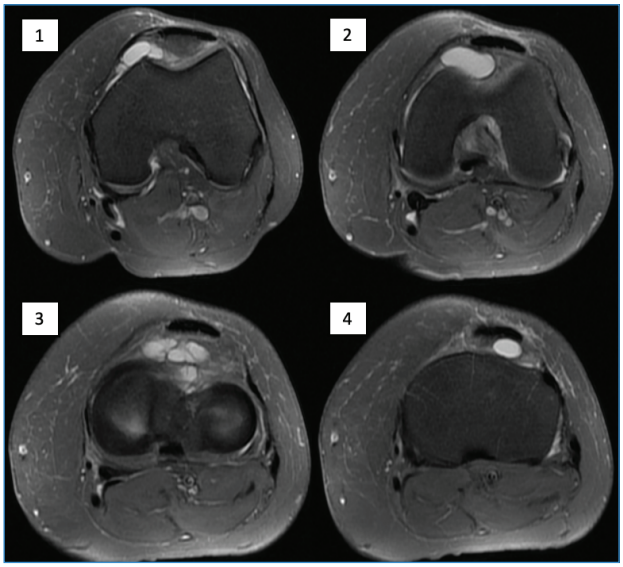
Os quistos gangliónicos são lesões mixóides de causa desconhecida, preenchidas por material gelatinoso. Ao contrário dos quistos sinovias, não comunicam com a articulação e carecem de membrana sinovial. A nível do joelho ocorrem mais frequentemente a nível de inserções tendinosas, sendo rara a sua apresentação na gordura de Hoffa.

Mulher de 65 anos apresenta-se com tumefação de tecidos moles a nível da face anterior do joelho esquerdo com ligeiro desconforto local. A ecografia articular revelou a presença de lesão lobulada na bolsa de gordura de Hoffa, de limites bem definidos, de conteúdo anecóico, com ausência de proliferação sinovial no seu interior. Foi solicitada RMN do joelho que confirmou o diagnóstico de quisto gangliónico multiloculado da gordura de Hoffa, com 45x26mm de maiores eixos.

Este caso ilustra como perante uma lesão quística rara, a ecografia e a RMN se assumem como ferramentas fundamentais para sua correta caracterização anatómica e diagnóstico diferencial.



225 – Figura 1. Lesão multiloculada, hiperintensa em T1, bem delimitada e localizada na gordura de Hoffa, compatível com quisto gangliónico

234 - ONYCHODYSTROPHY AND ACROOSTEOLYSIS AS THE INITIAL PRESENTATION OF SYSTEMIC SCLEROSIS IN AN ELDERLY WOMAN

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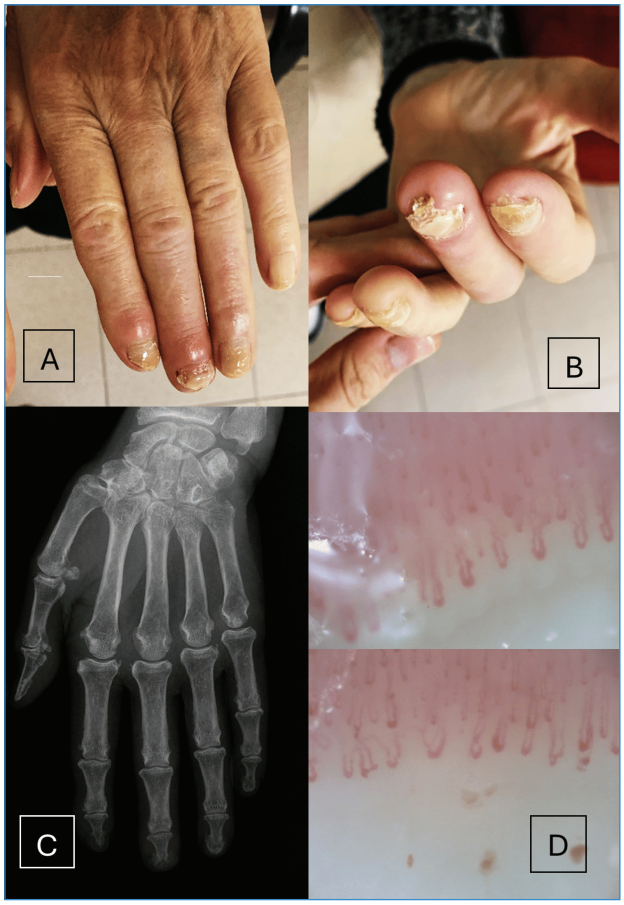
An 85-year-old woman with a 7-year history of polymyalgia rheumatica in clinical remission presented with onychodystrophy of the 2nd, 3rd and 4th digits of the left hand, unresponsive to topical and antifungal treatments.

She reported a 4-month history of triphasic Raynaud's phenomenon and a resolved digital pulp ulcer on the 3rd digit of the left hand. Physical examination revealed nail dystrophy, periungual hyperaemia, malar telangiectasias, pitting scars, and mild skin thickening (mRSS 2). Laboratory tests showed ANA 1:1280 (AC-3 pattern) with positive anti-centromere B antibodies, and a systemic sclerosis (SSc) blot positive for anti-centromere A (++) and anti-centromere B (+). Nailfold capillaroscopy was consistent with a "scleroderma-like" pattern and hand X-rays showed acroosteolysis of the 2nd and 3rd digits. A diagnosis of limited cutaneous SSc with anti-centromere antibodies was established.

This case highlights onychodystrophy as a rare initial manifestation of SSc.



234 – Figure 1. A and B) Onychodystrophy and pitting scars; C) hand X-ray showing acroosteolysis; D) nailfold capillaroscopy

241 - THIRD TIME'S THE CHARM: A CHALLENGING DIAGNOSIS OF TUBERCULOUS TROCHANTERIC BURSITIS

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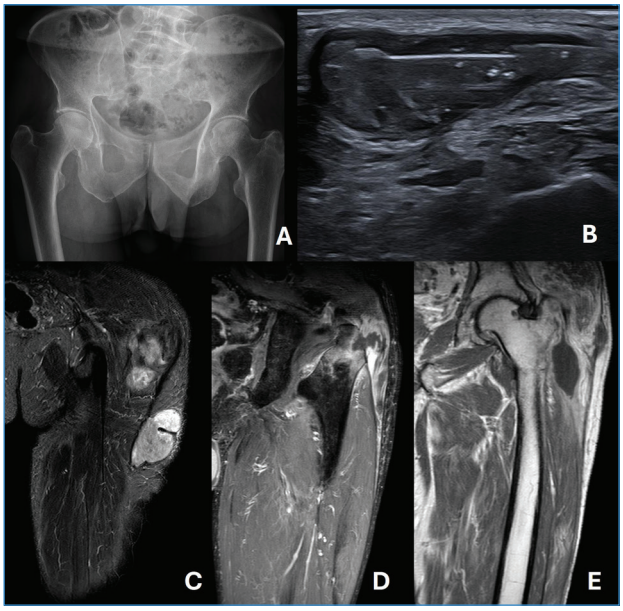
A 74-year-old man presented with mechanical left hip pain, previously treated with physiotherapy, discontinued 5 months earlier due to a suspected gluteal hematoma. He also reported a 9 kg weight loss over a year. Pelvic X-ray revealed erosions of the left greater trochanter (Figure 1-A). Magnetic Resonance Imaging showed a



241 – Figura 1. :(A): X-ray;(B): US-guided biopsy;(C): Left hip and thigh MRI coronal STIR1 sequence;(D) and (E): T1 FS and T1 weighted.

poorly defined collection contiguous with the erosion, extending to the lesser trochanter, with a thickness of 11 mm, and a second multiloculated collection 15 cm in length (Figure 1 C–E), suggesting a chronic infectious process. Laboratory revealed elevated ESR (56 mm/h) and CRP (3.12 mg/dL), and a positive IGRA. Ultrasound-guided aspiration was unsuccessful, yielding only sterile lavage. A CT-guided bone biopsy was inconclusive. Given persistent infection suspicion, ultrasound-guided biopsy of both collections was performed (Figure 1-B), revealing necrotizing granulomas. Cultures confirmed drug-susceptible Mycobacterium tuberculosis and treatment was started.

242 - MONOARTRITE POR MICOBACTÉRIA ATÍPICA NA ARTRITE REUMATOIDE

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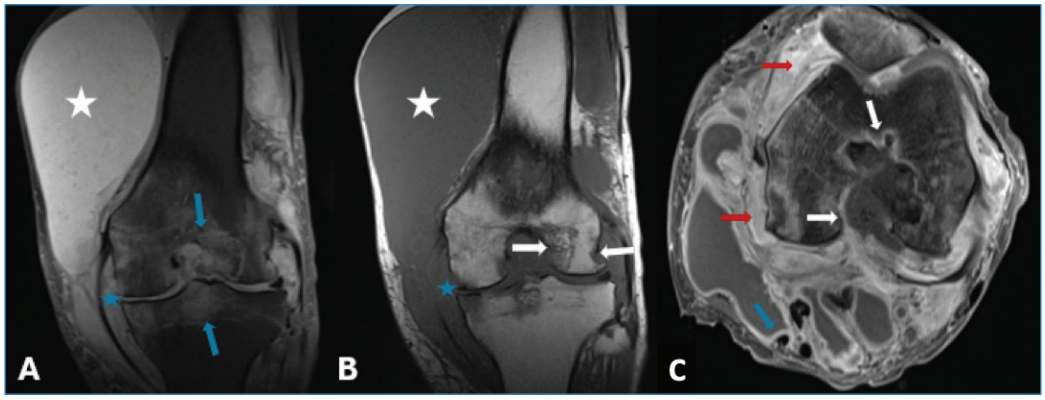
Mulher de 75 anos, com artrite reumatoide (AR) diagnosticada há 30 anos com atingimento de pequenas e grandes articulações, sob metotrexato 20 mg/semana, leflunomida 20 mg/dia e prednisolona 5 mg/dia, com bom controlo da doença. Antecedentes pessoais de hipertensão arterial, dislipidemia, osteoporose fraturária e tuberculose pulmonar diagnosticada e tratada há 17 anos. Imunização e rastreios atualizados e negativos.



242 – Figura 1. Imagens de RMN joelho ponderadas em DP com saturação de gordura: A/B–Corte coronal; C–Corte axial após administração degadolínio

Há 2 anos iniciou dor no joelho esquerdo com tumefação e incapacidade funcional. Artrocenteses diagnósticas com resultados negativos. RMN joelho mostrou volumoso derrame com sinovite ativa, erosões e edema medular ósseos. Estudo de liquido sinovial com pesquisa de DNA de micobactérias por PCR, identificou micobactéria não tuberculosa, Mycobacterium avium. Iniciou terapêutica dirigida com necessidade de drenagem.

A infeção por micobactéria atípica não tuberculosa é uma complicação da AR devido à imunossupressão e deve ser considerada numa monoartrite de instalação indolente.