

ANSWERS TO FELLOW'S CHALLENGE [MAY-JUNE 2004 PROJ](#)

Charles H. Spencer

1. SLE: B, D,P, U, V, bb, cc, ee
2. JIA-systemic: C, F. ee
3. JIA-poly: B,D, E, F, S, U
4. JIA-oligo: D, E, Q
5. JIA-psoriatic: D, E, M, U
6. JIA-spondyl: F, ii
7. Reiter's: Z
8. Crohn's: E, T, ee
9. JDM: A, C, D, T, aa
10. Systemic scleroderma: A, D, T, W, aa, cc
11. Local scleroderma: D, O
12. MCTD: A, B, C, D, P, aa, cc, ee
13. HSP: L
14. Sarcoid: E, J, N
15. Takayasu's: hh
16. PAN: C, P, S, ee
17. Wegener's: S, T, Y
18. Isolated CNS vasculitis: gg
19. Behcet's: E, gg
20. Rheumatic fever: S
21. Lyme disease: D, jj
22. Leukemia (ALL): D, H, N, ee
23. Neuroblastoma: N, dd
24. Osteogenic sarcoma: N, X
25. SCFE: F, G
26. Fibromyalgia: G, R, U
27. RSD: G, K
28. AVN: F, G, I

29. periodic fever syndrome: ff

Potential questions/controversies regarding disease characteristics\* and optimal matching answers:

- 1) Increased aldolase: We have seen it in not only JDM but systemic JIA, MCTD, and PAN reflecting myositis in these entities.
- 2) ANA + 1:160 is very non-specific in this low titer and can be seen in JIA poly and oligo, SLE, JIA-psoriatic, Crohn's, JDM, systemic scleroderma, local scleroderma, MCTD, Lyme disease and leukemia.
- 3) Chronic uveitis can occur in many diseases in rheumatology but is common in children with oligoarticular and polyarticular JIA (not systemic), sarcoid, psoriatic arthritis, Crohn's disease and Behcet's (major criterion). Chronic uveitis can be seen in Lyme disease and MCTD, but infrequently. JIA-spondy and Reiter's syndrome usually are associated with an acute uveitis. Other causes of uveitis not mentioned in this exercise include CINCA/NOMID syndrome and Kawasaki disease.
- 4) HIP pain/loss of ROM common - So what diseases in our neighborhood commonly attack the hip? Certainly systemic and polyarticular JIA often involve the hips of children as well as psoriatic arthritis and spondyloarthropathies (here JIA-spondyl and Reiter's). SCFE always involves the hips and AVN frequently. ALL, Crohn's, UC, MCTD, and sarcoid arthritis may involve the hip but we would argue that these involvements are not "common".
- 5) So who comes into your clinic as a new patient in a wheelchair? This is typical for severe pain augmentation syndromes such as reflex sympathetic dystrophy and fibromyalgia. Anyone with severe hip disease may come to the first clinic visit in a wheelchair, but this is more typical of AVN and SCFE than JIA. The JIA patients must have very severe disease for a number of years to have such severely involved hips and are not often new patients in your clinic. ALL as well as neuroblastoma and

osteogenic sarcoma patients may come into your clinic in a wheelchair as they often have severe bone pain and much functional loss. In all of the other listed diseases, children with very severe disease might come in using a wheelchair but we would argue that those episodes are very infrequent. What's the purpose of this question?... New patient in a wheelchair, think pain syndrome, malignancy, hip disease.

- 6) Night pain and low platelets: suggestive of ALL.
- 7) AVN can occur without prednisone in SLE, perhaps due to APLA, vasculitis, or other SLE mechanisms.
- 8) Arthritis in one or more toes with an isolated finger is very suspicious for psoriatic disease and rarely happens with classic JRA subtypes.
- 9) Shrunken finger with a hard line down palm is seen with severe linear scleroderma that produces very severe lesions.
- 10) Out of school for long periods is very suggestive of fibromyalgia. JIA kids seem to be less disabled functionally.
- 11) Very large skin ulcerations are classic for JDM and not infrequently seen in Crohn's and Wegener's as opposed to the smaller skin ulcers of SLE and systemic scleroderma.
- 12) Mother and daughter have the same disease: I favor psoriasis the most here, but certainly SLE and rheumatoid factor JRA have to be mentioned, as well as fibromyalgia.
- 13) Headaches, coma, abnormal MRI, brain biopsy: Isolated CNS vasculitis would be the first thought but Behcet's, and rarely SLE, might cause this clinical scenario.

The winner of this fellow's challenge is:

Christine Bernal, M.D.

Fellow, Baylor College of Medicine

\*Disease Characteristics:

A.	calcinosis seem commonly
B.	+ RF of 300 IU possible
C.	increased aldolase common
D.	+ ANA 1:160 possible
E.	chronic uveitis common complication
F.	hip pain/loss ROM common
G.	in clinic in wheelchair for 1 <sup>st</sup> visit
H.	night pain, low normal platelet count
I.	complication of SLE, even without prednisone
J.	papules, iritis, proliferative arthritis
K.	swelling, hyperaesthesia of foot
L.	IgA nephropathy associated
M.	arthritis in two toes, one PIP
N.	bone pain severe
O.	shrunken finger with hard line down palm
P.	hypertension common clinical problem

Q.	contracture of a knee with leg length difference
R.	out of school for weeks or months
S.	nodules typical
T.	large vasculitis skin ulcers severe complication
U.	mother and daughter have same condition
V.	vasculitic spots on palms and soles
W.	small oral aperture, tight skin on hands
X.	swollen knee, lytic lesion in femoral metaphysis
Y.	sinusitis, nasal disease common
Z.	episodic arthritis, conjunctivitis
aa	papular rash on PIP's, MCP's
bb.	Ulcers on hard palate
cc.	Raynauds characteristic
dd.	VMA, HMA increased in urine
ee.	weight loss, fever, arthritis
ff.	mouth ulcers, lymph nodes, fevers, pharyngitis
gg.	headache, coma, abnormal MRI, brain biopsy

hh.	chest pain, back pain, fatigue, ESR 120, Hgb 8
ii.	age 12, male, swollen ankles, swollen knees
jj.	camping trip, swollen ankle 5 months later