Reumatismo, 2023; 75 (4): 234-236

Lumbosacral pain in a patient with psoriatic arthritis: when the rheumatic disease is innocent

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SUMMARY

Lumbar pain is a very common symptom that derives from benign musculoskeletal conditions, rheumatic inflammatory diseases, neoplasms, and referred and/or nociplastic pain. A 70-year-old man with psoriatic arthritis presented with early-onset lumbosacral pain without evident red flags. Symptomatic treatment was unhelpful. Radiographic imaging showed subtle signs of a disease that could easily be missed. Magnetic resonance imaging revealed a massive prostatic malignancy with bone (sacral and iliopubic) metastasis. Awareness must be given not to disregard every lumbar pain as part of the preexisting rheumatic inflammatory disease (spondyloarthropathy in this case) or a common muscle/ligament/articular disarrangement. Persistence of pain, albeit not inflammatory nor sharp in nature, despite adequate treatment might be just as important as an acute red flag and requires proper follow-up.

***Key words**: Malignancy, lumbar pain, imaging.*

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INTRODUCTION

Lumbar pain is a very common symptom that can be caused by benign musculoskeletal conditions, rheumatic inflammatory diseases, neoplasms, and referred and/or nociplastic pain. Here, we describe the case of a 70-year-old man with psoriatic arthritis who presented early-onset lumbosacral pain without evident red flags.

RADIOLOGICAL VIGNETTE

A seventy-year-old man, followed for psoriatic arthritis with rheumatology consultations, was observed for left lumbosacral pain with a 1-month history, a mechanical rhythm, and buttock irradiation. There were no signs or symptoms identifiable as red flags, namely constitutional symptoms, night or severe pain, or neurologic deficits. The rheumatic disease was not diagnosed until the patient was 64 years old. It was characterized by peripheral, distal, symmetrical, and polyarticular involvement, along with the extra-articular features of dactylitis and nail and cutaneous psoriasis. It was in clinical and laboratory remission with oral methotrexate at 17.5 mg/week. During the physical examination, there was mild pain upon direct palpation of the left sacroiliac joint, but no positive sacroiliac maneuvers. The patient was then treated with a non-steroid anti-inflammatory drug and a muscle relaxant, but they had little positive effect.

The radiography showed a lytic lesion of the left wing of the second sacral vertebra (Figure 1, dotted black arrow), with a regular contour and well-defined margins, involving the sacral foramina. It also showed an outline of a lytic lesion at the left iliopubic ramus (Figure 1, dotted white arrow) and an erasure of the rectum's left contour, suggesting the presence of a mass contiguous to its wall (black arrow). The presence of air in the rectum's lumen and fat in its surroundings allows for the delimitation of its right contour, which was normal. During a subsequent consultation, apart from the persistent osteoarticular symptoms, the pa-

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Figure 1 - The radiogram shows a lytic lesion (black dotted arrow) on the left wing of the second sacral vertebrae. It has a regular shape and well-defined edges, and it involves the sacral foramina. It also shows an outline of a lytic lesion at the left iliopubic ramus (white dotted arrow) and an erasure of the rectum's left contour, suggesting the presence of a mass contiguous to its wall (black arrow).

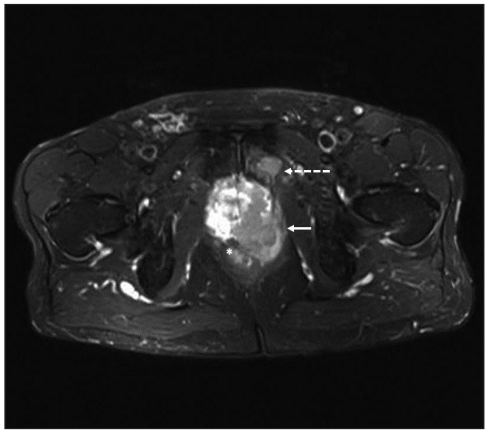

Figure 2 - Fat suppressed axial T2 magnetic resonance imaging sequence: extensive lesion on the left lobe of the peripheral region of the prostate (white arrow) with signs of invasion of the prostate's transition zone (anteriorly) and periprostatic fat (posteriorly). This lesion is in contact with the left contour of the rectum's wall (asterisk), indicating its probable invasion. A lesion at the left iliopubic ramus with enveloping bone marrow edema (white dotted arrow) is also visible.

tient complained of a disturbance in his usual gastrointestinal transit pattern, now with a constipating tendency.

Further radiological characterization was performed with a pelvis and sacroiliac joints' high-field magnetic resonance imaging, which showed the aspects described below.

On T2 axial sequencing with fat suppression, there was an extensive lesion on the left lobe of the peripheral region of the prostate (Figure 2, white arrow) with signs of invasion of the prostate's transition zone (anteriorly) and periprostatic fat (posteriorly), which are characteristic of a highly aggressive lesion. It is in contact with the left contour of the rectum's wall (Figure 2, asterisk), indicating a probable invasion. There was also a lesion at the left iliopubic ramus with enveloping bone marrow edema (Figure 2, dotted white arrow). In addition, there was a hyperintense (Figure 3, orange arrow) lesion at the left wing of the second sacral vertebra, involving and obliterating the sacral foramina, with transarticular involvement of the ilium, indicating a massive metastasis.

On T2 coronal sequencing with fat suppression, besides this metastasis (Figure 4, red arrow), the prostatic lesion (Figure 4, red asterisk) compatible with the primary tumor is visible.

Based on these results, which are highly remarkable for a prostatic cancer with bone

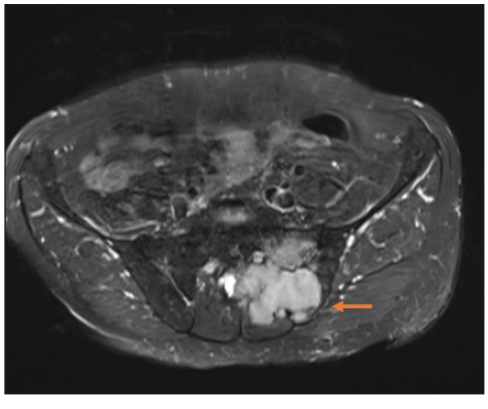

Figure 3 - Fat suppressed T2 magnetic resonance imaging sequence: hyperintense (orange arrow) lesion at the left wing of the second sacral vertebra, involving and obliterating the sacral foramen, with transarticular involvement of the ilium, denoting a massive metastasis.

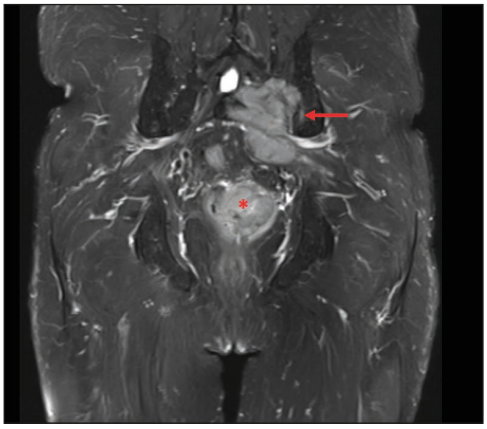

Figure 4 - Fat suppressed coronal T2 magnetic resonance imaging sequence: metastasis (red arrow), and prostatic lesion (red asterisk) compatible with the primary tumoral lesion are visible.

metastasis, we requested an urgent urology consultation, which awaits further resolution.

CONCLUSIONS

Proper awareness should be given to musculoskeletal symptoms, which are sometimes non concordant with the patient's previously known condition, recognizing that the absence of red flags does not always indicate a more benign status.

Contributions
All the authors made a substantive intellectual contribution, read and approved the final version of the manuscript, and agreed to be accountable for all aspects of the work.

Conflict of interest
The authors declare no potential conflict of interest.

Ethics approval and consent to participate
No ethical committee approval was required.

Patient consent for publication
The patient gave his informed consent for the publication of this paper.

Funding
None.

Availability of data and materials
Data is available from the corresponding author upon request.