Ksifodini ile Kendini Gösteren Talasemi Minör

Thalassemia Minor Presenting with Xiphodynia

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Özet

Ksifodini, ksifoid kemik veya ksifosternal bileşkeye bağlı olarak ortaya çıkan üst abdominal ağrı, göğüs ağrısı, boğaz, baş ve kola yayılabilen ağrı ile karakterize bir grup semptomu içeren nadir bir sendromu tarif eder. Otuzyedi yaşında kadın hasta göğüs sırt, orta kesimi ve kola yayılan keskin vebatıcı tarzda ağrı ve anemi ile başvurdu. Ağrı medikal tedaviye dirençli olup ksifoid kemik rezeksiyonu uygulandı. Histopatolojik olarak hastaya thalasemi minor tanısı kondu. Rezeksiyon sonrası ağrı kayboldu. Altıncı ay takibinde hasta asemptomatik ve hiç ağrısı yoktu. Ksifoid kemiğin cerrahi rezeksiyonu medical olarak dirençli ksifodinide tedavi edici olabilir.

Anahtar Kelimeler

Ksifodini, Talasemi Minor, Ksifoid Kemik Rezeksiyonu, Göğüs Ağrısı.

Abstract

Xiphodynia describes an uncommon syndrome with group of symptoms ranging from upper abdominal pain, chest pain, throat, head and arm symptoms referred from xiphosternal joint or the xiphoid process. A 37-year-old woman presented with a sharp and persistant pain complaint of chest, mid-dorsal region and arm and anemia. Pain was refractor to medication and xiphoid resection was performed. The patient was diagnosed as thalassemia minor histopathologically. After resection pain was disappeared. At the 6th month follow up patient was asymptomatic and no pain was detected. Surgical resection of xyphoid bone may be curable in medically refractor xiphodynia.

Keywords

Xiphodynia, Thalassemia Minor, Xiphoid Bone Resection, Chest Pain.

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Introduction

Xiphodynia describes an uncommon syndrome with group of symptoms ranging from upper abdominal pain, chest pain, throat, head and arm symptoms which are referred from the xiphisternal joint or the xiphoid process [1, 2].

Over a 60 year period 13 citations relating to the terms xiphodynia and xiphoidalgia in the literature. Between 1979 and 1998 10 cases of xiphodynia was published and all treated by localized injection [1-3].

Patient

A 37-year-old woman was presented to our clinic with a sharp and persistant pain complaint of chest, mid-dorsal region and arm which had been present for 3 years period. The patient also had a feeling of xiphoidal swelling during 1 month. Past medical history was unremarkable. At the physical examination xiphoid bone was 3x2 cm palpable and painful. The patient only had a mild anemia. Chest X-ray and thoracic CT examinations were normal. Patients pain was refractor to medication and xiphoid resection was performed because of that. On histopathological examination hypercellular bone marrow was reported (Figure-1). Hemoglobin electrophoresis demonstrated a hemoglobin A2 level of 6.2%. The patient was diagnosed as thalassemia minor. After the xiphoid bone resection pain was dramatically disappeared .At the 6th month follow up patient was asymptomatic and no pain was detected.

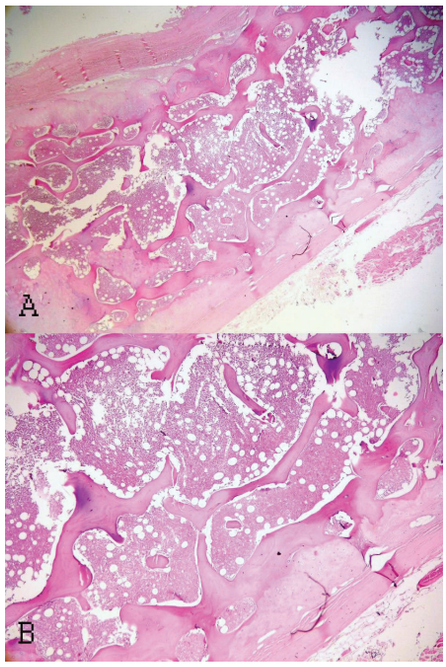

Figure1. (A) Panoramical view of xiphoid bone specimen including hypercelluler bone marrow [HE X5], (B) More closely view of hypercelluler bone marrow [HE X10].

Discussion

In 1955 Lipkin et al. published the first modern paper of 24 patient with hypersensitive xiphoid. Lipkin et al. also noted that in 1712 the earliest report of xiphoid disorders was recorded [1, 4]. Mackenzie wrote about the phenomenon of viscero-somato pain referral in 1893 [1, 5]. Kellgren mapped patterns of referred pain from deep structures such as deep fascia, periosteum, and ligaments in the late 1930s [6]. In the late 1940s Travell and Rinzler mapped referral patterns from pectoral muscles that mimicked the symptoms of angina pectoris and myocardial infarction [1, 7].

Musculosceletal chest wall syndromes masks cardiac chest pain [2]. The reason of most of these are perichondritis of costochondral, sternoclavicular, manubriosternal, and xiphisternal junctions (Tietze's syndrome) [2]. The diagnosis of xiphodynia was usually reported in the patients that had myocardial infarction in the past medical history [referans verilmemiş].

A history of trauma like acceleration/deceleration injuries, blunt trauma, heavy lifting and aerobics could be accused in the etiology of trauma [1]. Sharp and persistent pain in the xiphoidal region aggravated by local compression, xiphoid tenderness, neutrophilic leukocytosis, and a good response to nonsteroidal anti-inflammatory drugs are the objective criteria of this syndrome [2]. Cardiac chest pain, epigastric pain, nausea, vomiting and diarrhoea, radiating pain into the back, neck, shoulders, arms and chest wall also could be seen in this syndrome [1]. Myocardial infarction, ruptured aortic aneurism, aortic dissection, perforated ulcus, pancreatitis, strangulated hernia and pericardial effusion should be assessed in the differential diagnosis [2].

The incidence and prevalence of xiphodynia is not clear. Lipkin et al. say that it is a frequent disorder in about 2 percent of the population of a general-hospital but most authors recorded the syndrome uncommon [1, 4].

Xiphodynia is usually suggested a self-limiting disorder and usually treated with analgesics, elastic rib belt, topical heat and cold, local anaesthetic and steroid injection, course of ultrasound and laser [1, 2]. According to some cases xiphodynia may not be self-limiting. Xiphoid injection had some risks like pleural or peritoneal perforation, pneumothorax, or infection. Conservative physical therapies are usually not effective [1].

Thalessemia is a common herediter disease in Mediterranean and up to 15% of the population carry the gene [5, 8, 9]. Thalessemia rarely involved thorax [8]. Plevral effusion, massive hemothorax, pleural mass lesion, mediastinal lymphnodes or dyspnea may be seen secondary to lung involvement [9]. Xiphodynia as a symptom of thalessemia was not published before.

Due to extra-medullary haematopoiesis secondary skeletal deformity occurs [5]. The ribs are sometimes affected and the posterior elements expand dorsally. Spinal cord compression and vertebrae fractures may ocur most commonly in the thoracic spine [5].

In conclusion, in endemic regions, in patients with nontraumatic xiphodynia associated with anemia, thalassemia should also be kept on mind by physicians. While the pain is persistant for a long time and refractor to medication or other conservative methods surgical xiphoidal resection may be workable.

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