ADARCC 2023 Best Image Competition

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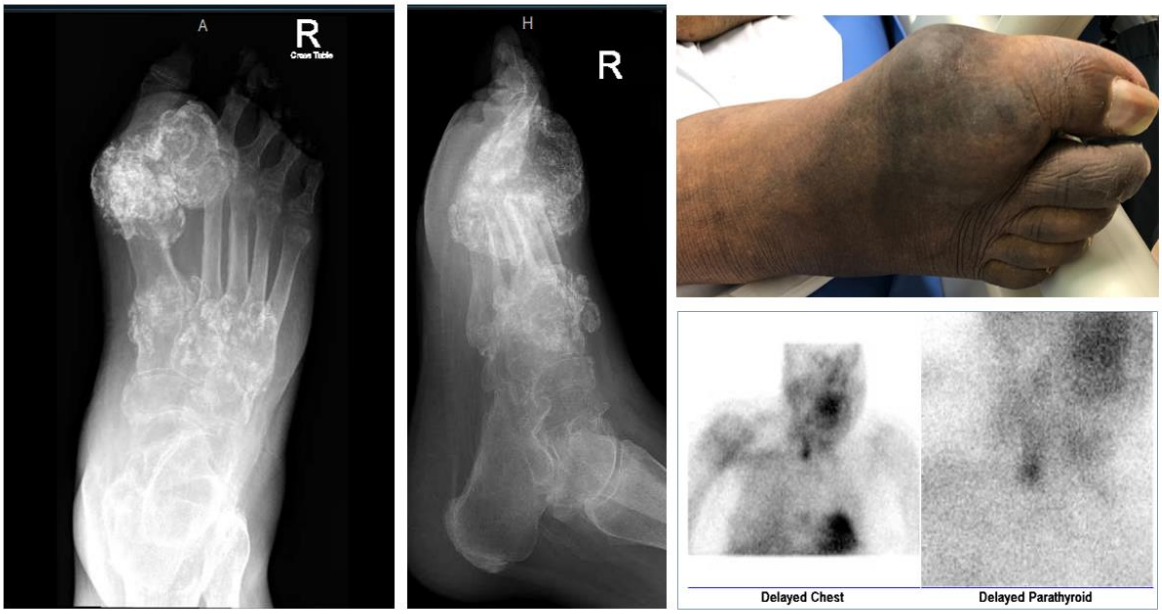
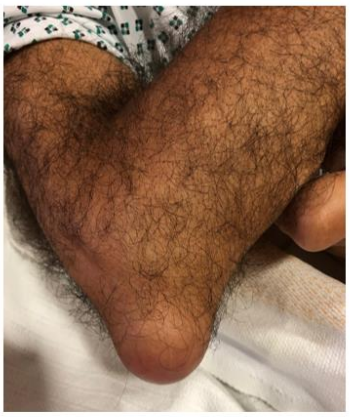
Chronic Gouty Arthritis and Hypercalcemia

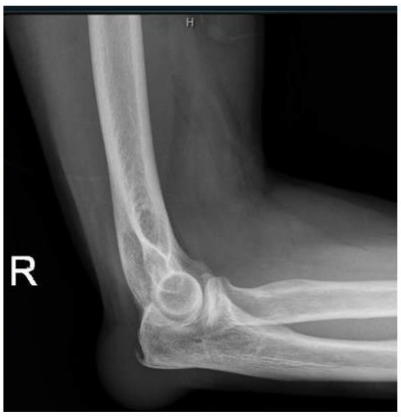
58 years old male, bedbound post ischemic stroke with left sided hemiplegia. He also has hypertension, diabetes mellitus, dyslipidemia, morbid obesity, hyperuricemia and chronic kidney disease stage IV. He presented to hospital 2 days history of fever URTI symptoms , cough and tonic clonic episode of seizure prior to admission. Laboratory investigations showed acute kidney injury (creatitine 400 micromol/L) on top of CKD, metabolic acidosis, lactic acidosis, hypercalcemia (2.97 mmol/L), and elevated uric acid 603 micromol/L. He was diagnosed with acute influenza A infection leading to seizure. He also had chronic right foot pain with deformity and touphus deposition. (image 1) Xray of right foot ruled out fracture, but showed large calcified nodule is are noted predominantly around the first MTP joint and the TMT joints. (image 1)Evaluation of hypercalcemia revealed high PTH 172.0 pmol/L, normal phosphate level 1.08 mmol/L, and NM parathyroid scan showed: Parathyroid adenoma posterior to the lower pole of the right thyroid lobe. (image 1). He was managed with Tamiflu, intravenous hydration, and Cinacalcet 30mg.

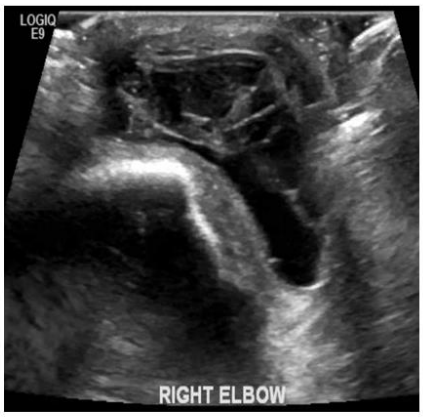


Right Hemorrhagic Olecranon Bursitis

A 70 years male, had significant comorbid conditions including Diabetes mellituts , hypertension, dyslipidemia, chronic kidney disease (CKD) stage IV, chronic anemia and multiple ischemic strokes with mild neurological weakness. He presented to hospital with few days history of progressive fatigue, dizziness, and fall on his right body side. Investigations revealed acute kidney injury on top of CKD, and acute on chronic anemia hemoglobin 7.7g/L. He denied bleeding site and there was no evidence of new stoke on brain imaging. He was managed with blood transfusion and underwent upper endoscopy showed atrophic gastritis. During hospital course, he spiked fever and had pain and limitation in right elbow movement. Clinical and radiological studies were suggestive of olecranon bursitis. (image 1) He underwent aspiration of bursa which revealed bloody aspirate (RBC: 440,000 Cells/mm3, WBC: 680, segment: 32, lymphocytes : 22, uric acid: 392). The serum uric acid level was mildly elevated 432 micromol/L and blood and fluid cultures were negative. The final diagnosis is post traumatic olecranon bursitis due to anticoagulation therapy. His clinical course improved with pain management.

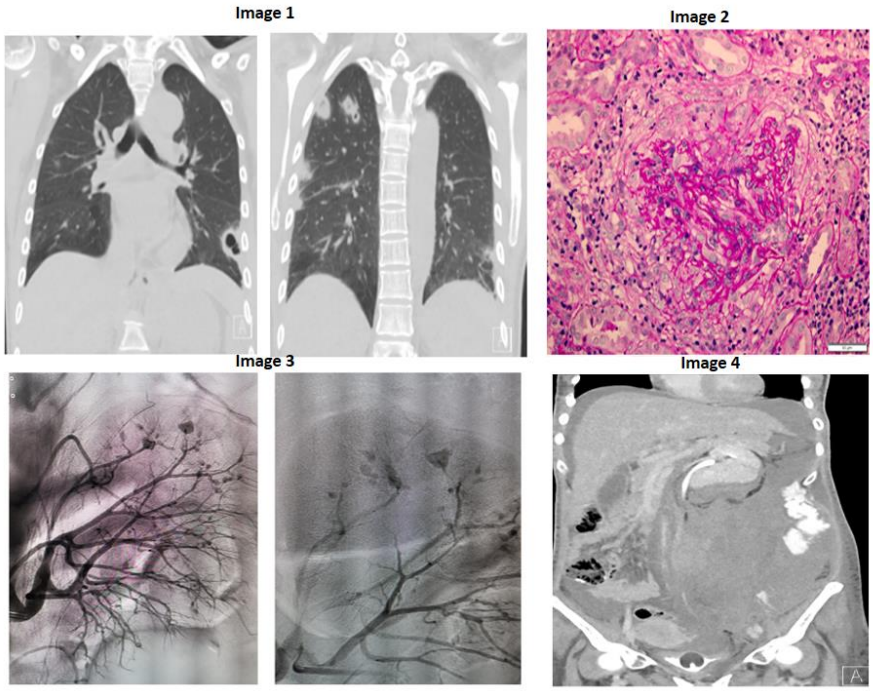






Challenging Case of Severe PR3-ANCA Vasculitis with Life Threatening Aneurysmal Bleeding

37 years old Indonesian female, previously healthy. She presented with progressive bilateral lower limb weakness and numbness associated with fever, and cough. Labs were significant for acute kidney injury (creatinine 259 micromole/L), leukocytosis WBC 23x10^9, anemia 6.9g/L, mild proteinuria and microscopic hematuria. The chest X ray and CT scan revealed bilateral cavitary lung lesions and nodules. (image1) She had staphylococcus bacteremia and antibiotics were initiated. She underwent kidney biopsy which revealed pauci immune crescentic glomerulonephritis and the serum titer of C-ANCA (PR3) was elevated (> 200 RU/ml). She was diagnosed with Granulomatosis with polyangiitis (GPA) vasculitis and started on pulse steroid in combination with oral cyclophosphamide. Four hours post kidney biopsy she developed acute anemia, severe left flank pain and urgent ultrasound showed left renal hematoma (6x10cm). Blood transfusion and fluid resuscitation was initiated and her clinical condition stabilized. On day 5, post kidney biopsy she developed severe left flank pain, with hemorrhagic shock (Hb dropped to 6 g/L) and urgent IR angiography revealed multiple small and medium sized non-bleeding aneurysms in liver, renal and mesentery. (image 3) Post angiography patient remained hypotensive despite blood transfusion and urgent CT angiography showed large retropeitoneal hematoma in left side (20 x 12 cm) with active bleeding from left lower lumber artery aneurysm. (image 4)



Right Hand Pressure Ulcer

52 years old male, from Sudan, had long standing uncontrolled diabetes mellitus type 2 since 20years on insulin Mixtard and had right below knee imputation done more than 10 years ago. He was brought to ER with few days' history of severe constipation, abdominal pain, fatigue, and hyperglycemia. He has significant weight loss for last 6 months due to financial crisis and poverty. He has chronic pressure ulcer in the palm of hand due to crutches used for ambulation. (Image 1) the inflammatory makers were normal and blood and wound cultures were negative. Plastic surgery team advised for wound care, reduce pressure on hand ulcer and control of hyperglycemia.