

Recognizing Inflammatory Arthropathy

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A patient was seen recently in my office for an initial examination with respect to a primary head and back complaint. She self-referred within her insurance network. She reportedly had been evaluated by many other types of providers, yet no clear-cut causation for her pain level had been discovered. Hence, her initial visit to a chiropractor. I would like to present her initial examination findings and laboratory results, which I feel exemplify a chiropractor's formal level of training and skills base.

History of Present Illness

The 36-year-old female patient complaint is upper back swelling and suffusion, accompanied by weakness and fatigue that has reduced her effectiveness as a mother, wife and homemaker. The location of the pain is across the base of the neck and upper back. This pain is constant in nature and worse at the end of the day. The pain level is rated as an 8/10; on a scale of 1-10, with 10 being severe pain with moderate interference in daily activities. She has a 3-year-old daughter whom she is unable to lift, due to pain mechanism. The quality of the pain is burning and aching. Provocative: side-bending activity, straightening up. Palliative: nothing. History reveals that she has experienced back pain in this region; off and on, for two years. Today's subjective complaints were onset within two to three weeks and flared with lifting 35 pounds.

Past Medical History

- *Medications:* Adamant about not taking prescription drugs. Reports that in college, she was on birth control for 15 years and developed "migraines."
- *Surgery:* Meniscectomy and lateral collateral ligament repair with left chondral repair. Midwife-assisted delivery of autistic daughter in a posterior presentation.
- *Injuries:* 1998 motor vehicle accident, rear passenger, five-car pileup; medical intervention brief, consisted of anti-inflammatories. Reportedly sought medical care and obtained cervical series that demonstrated a fracture of the vertebral body. Denies any work-related accidents. Football injury with twisting mechanism pallectomy, meniscectomy, and subsequent contralateral involvement. Underwent surgery.
- *Family History:* Adopted and unaware of family history.
- *Occupation:* Approximately eight years employed as information specialist; flight travel and computer entry.

Review of Systems

- *Ears, Nose, Mouth and Throat:* Denies ringing in ears, reports middle-ear infection in 2000 that she never quite got over. Reported difficulty in self-popping ears. Wore braces for four years as child - uneventful.
- *Musculoskeletal:* Spinal spasm at end of day, stiffness in neck. Migraine described as retro-orbital, denies lacrimation increase, no prodrome.
- *Endocrine:* Reports past history of low blood sugar, contributory to migraines. Reports cold hands and feet. Reported multiple testing for thyroid function in past has all been normal.
- *Psychiatric:* Reports increased stress and anxiety over challenges faced with daughter, emotional liability over domestic relationship.

- *Hematologic/Lymphatic*: Denies anemia, blood-clotting disorders, HIV or HBV, or immunocompromise; notes exhaustion build up with life issues.

Physical Examination

- *Height*: 5'1"
- *Weight*: 100
- *Vital Signs*: P: 88; RR: 18
- *Inspection*: Splints all motion of upper extremities; appears winging bilateral. Observed carrying large bag/purse over right shoulder, right hand dominates. Postural altered shoulders inclined. On handshake, presents with warm, swollen, metacarpophalangeal and proximal interphalangeal joints of both hands. Slight ulnar deviation to both hands. Taut skin over the dorsum of both hands.
- *Palpation*: Myospasm at right infrascapular, cervical SCM, rhomboids, SITs muscles and levator. Active trigger points, myofascial points and ropey band contractures prominent right infrascapular. Upper cervical rotatory segmental dysfunction, postural disorder. Right EAM clear, dull, palpation of facial pain at right maxilla. Pinna tug negative. AROM cervical spine normal. Thoracic spine reduction in Extension 22/30.
- *Myotone or Motor Tests*: Right C5 shoulder abduction 4/5.

Radiological Findings

Cervical and thoracic limited study obtained on this date: Bone density and soft-tissue structures are unremarkable. The curvature is hypolordotic in the cervical region and thoracic kyphosis is maintained. There are no obvious wedge findings to the vertebral bodies or signs of previously healed fracture sites. The disc spaces are narrowed and the cartilage is thinning at the fifth and sixth cervical level, and third and fourth thoracic level. There is associated facetar sclerosis. Most apparent is a small erosion of the facetar region at this level. There is a rotary listing position of the cervical spine involving the atlantoaxial spinal region. There is no further evidence of any further gross pathology, congenital findings or obvious fracture. *Radiographic interpretation*: Spondylosis cervical spine C5, C6, and mild upper thoracic degenerative disc disease. Clinical correlation for inflammatory arthropathy.

Diagnoses

1. thoracic sprain, right paraspinous, with dominant right-shoulder tendonitis;
2. muscle tension headaches, with possible intermittent sinus headaches;
3. cervical capsulitis with myospasm vs. facetar inflammatory arthropathy (RA variant); and
4. myofascial pain syndrome (clinical correlation for connective tissue syndromes, sicca complex and myositis).

Discussion

The focus of care is to reduce the inflammatory effect of the cervical capsules or facetar region, which may traction the adjacent spinal nerve roots and centralize the diffuse pain picture. Emphasis on patient education is required. The postural changes we see may be of a cumulative nature and contribute to mid-back pain as a tendonosis strain and ligamentous sprain, also due to her tiny size in repeated lifting attempts. Synovitis of a rheumatoid arthritic nature, or member of an inflammatory arthropathy family, is strongly suspected. Additionally, if the antinuclear antibody titer is high, systemic lupus is suspected. If she develops dry mouth, dry eye, dry cough or sicca syndrome, present with a rheumatism, SLE or connective-tissue disease, we may have an overlap in conditions. Similarly, myositis is frequently a part of inflammatory arthropathies. Thus, my clinical differential diagnosis would be a form of rheumatoid arthritis. A patient such as this should acquire baseline erythrocyte sedimentation rate (ESR), rheumatoid factor (RA), antinuclear,

antibody test and a HLA-B27 antigen test, which is most frequently positive with seronegative spondyloarthropathies.

Treatment Plan

Included brace instructions when lifting, but prefer anatomical rest. No lifting; gym activity should be only light circuit for stress reduction. Ice/topical instructions with samples. Limited cervical and thoracic radiographs to rule out osteopathoanatomy.

Chiropractic Technique: Diversified nonforce technique and diversified flexion/distraction short trials to monitor response. She did follow up with our facility within 10 days to obtain laboratory studies at a local outpatient collection site, in conjunction with her network participation.

Laboratory Results: CPT Code 86431; RA Factor positive. Rheumatoid factors are antibodies directed against the Fc fragment of IgG. These are usually IgM antibodies, but may be IgG or IgA. Rheumatoid factor is present in the serum of a majority of patients with rheumatoid arthritis, depending in part on what method is used. CPT Code 86225; 86235; antinuclear antibodies positive. Use is to detect antibodies associated with SLE and mixed connective-tissue disease. The patient was referred for a medical evaluation and requested to remain a chiropractic patient.

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