

[PICTURES IN CLINICAL MEDICINE]

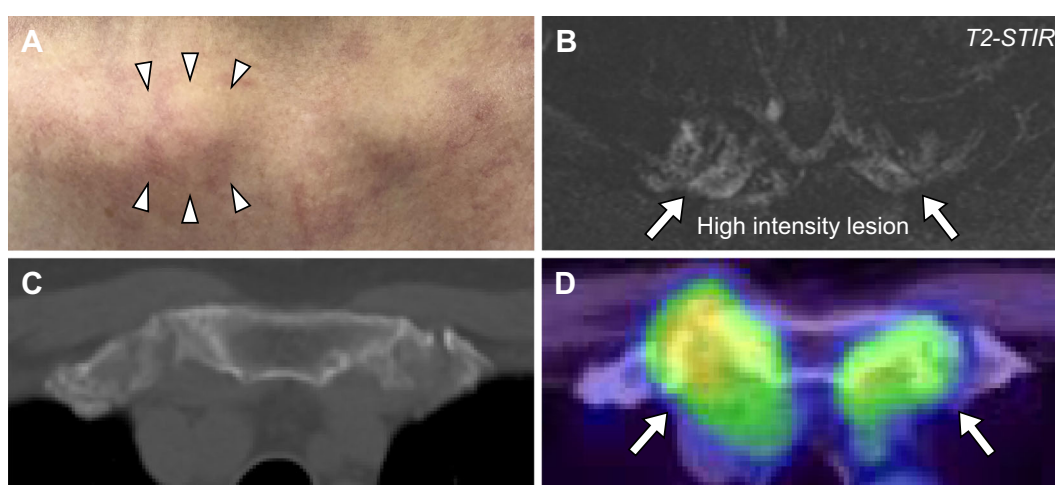
Sternoclavicular Joint Hypertrophy Involved in Polymyalgia Rheumatica

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Key words: giant cell arteritis, polymyalgia rheumatica, 18-fluorine-positron emission tomography/computed tomography, and sternoclavicular joint arthritis

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Picture.

A 70-year-old woman presented with polymyalgic symptoms, jaw claudication, and a remarkably swollen right sternoclavicular joint (SCJ) without any tenderness and the symptoms had persisted for six months (Picture A). She had no history of either spondyloarthritis or palmoplantar pustulosis. The serum C-reactive protein level was 13.32 mg/dL, and both rheumatoid factor and anti-cyclic citrullinated peptide antibody were negative. Magnetic resonance imaging (Picture B), computed tomography (CT) (Picture C), and 18-fluorine-positron emission tomography/CT (^{18}F -FDG-PET/CT) (Picture D) revealed bilateral SCJ arthritis. Since a biopsy specimen of the temporal artery demonstrated giant-cell arteritis (GCA), we treated the patient with 0.8 mg/kg/day of prednisolone, and thereafter both the symptoms and inflammation due to polymyalgia rheumatica (PMR)/GCA improved.

PMR/GCA accompanied by SCJ hypertrophy has so far only seldom been reported; however, PMR cases occasion-

ally (11-44%) have SCJ erosions (1) and ^{18}F -FDG accumulation around the SCJ is detected by PET/CT in 43-72% of PMR patients (2). Therefore, SCJ arthritis may be a latent feature of active PMR.

The authors state that they have no Conflict of Interest (COI).

References

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