ATYPICAL MYCOBACTERIOSIS PRESENTING AS FLEXOR TENOSYNOVITIS

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BACKGROUND

Immunosuppressed patients are at high risk for opportunistic infections. We report a case of a 40-year old man with MALT lymphoma and systemic lupus erythematosus (SLE)-like nephritis, with a history of several infectious complications, who presented with a chronic left hand flexor tenosynovitis, diagnosed as atypical mycobacteriosis.

CASE REPORT

A 40-year-old man, followed at our rheumatology outpatient clinic due to SLE-like nephritis since 2013, presented with painless swelling on the volar face of the left wrist, which has progressed slowly in the last two years. On physical examination, he had dactylitis and fixed flexion position of the metacarpophalangeal, distal interphalangeal and proximal joints of the 4th and 5th fingers of the left hand (Figure 1). He had a history of MALT lymphoma, treated with chemotherapy, and persistent hypergammaglobulinemia since 2008; and he was diagnosed with pulmonary infection by *Cryptococcus neoformans* in 2010, treated with long-term antifungal therapy. Previous immunosuppressive treatment for SLE-like nephritis included rituximab and mycophenolate (2014–2015) and current treatment consisted of hydroxychloroquine 400 mg/day, prednisone 7.5 mg/day and leflunomide 20 mg/day. Laboratory tests evidenced high levels of inflammatory markers (CRP 36 mg/L, ESR 76 mm/H) without other clinical and laboratory findings of SLE activity. Ultrasound and MRI scan of the left hand confirmed the hypothesis of proliferative tenosynovitis affecting all deep and superficial flexors of all fingers, more intense in the tendons of the 4th finger (Figure 2). The patient was submitted to tenosynovectomy of the left wrist and tenosynovectomy of the 4th QDE (release of pulleys A1 and A3) (Figure 3). Acid-fast staining of synovial material revealed acid-fast bacilli. Mycobacterial culture from the synovial biopsy was positive for *Mycobacterium kansasii*. He started antituberculosis treatment, still without significant clinical improvement in joint swelling after eight weeks of therapy.

Figure 1. Dactylitis and fixed flexion position of the metacarpophalangeal, distal interphalangeal and proximal joints of the 4th and 5th fingers of the left hand

Figure 2. MRI Scan of the left hand proliferative tenosynovitis affecting all deep and superficial flexors of all fingers, more intense in the tendons of the 4th finger

Figure 3. Tenosynovectomy of the left wrist and tenosynovectomy of the 4th QDE (release of pulleys A1 and A3)

CONCLUSION

Opportunistic infectious diseases are relatively frequent in SLE patients, either due to genetic and immunological defects or secondary to drug immunosuppression. Rheumatologists must be aware of the possibility of infectious aetiology when assessing immunosuppressed patients with refractory monoarthritis or tenosynovitis.

KEYWORDS

Flexor tenosynovitis, Atypical mycobacteriosis, Systemic lupus erythematosus.