CASE PRESENTATION

PRESENTER – DR. NOOR

- Patient name- Ramesh Chand
- 62 y / M
- Resident of – c-226/11, Udyog Bhawan, New Delhi
- Socio economic status (to be mentioned)

CHIEF COMPLAINT

- Pain over his R knee – 3 months
- Swelling over his R knee – 3 months
- Difficulty in bearing weight – 3 months.

HISTORY OF PRESENTING ILLNESS

- Apparently well 3 month back , when he noticed pain over his R knee which was insidious in onset,
- gradually progressive over a period of 3 months. Initially pain use to subside on over the counter pain medications but for last 2 weeks pain is not relieved on pain medications also.
- Dull aching in nature
- Not radiating to rt hip or back or any other joint
- No diurnal variation
- Increased on weight bearing and exertions
- Relieved on lying down

- It was associated with **swelling over his Rt knee** for 3 months
- which was initially of lemon size but progress over a period of 3 months to current size of orange.
- No history of similar swelling anywhere else in body
- No history of previous aspiration of swelling.

- Pt also complaint of **difficulty in walking** for past 3 months.
- Initially he was able to walk with some difficulties but for last 2 weeks he needed walker for support.
- Now pt is not able to run , walk without support, sit cross leg or use bicycle for his daily commute

- No history of similar episode in past
- No history of morning stiffness, multiple small joints involvement
- No history of Fever , prolonged cough, Night sweat, weight loss
- No history of any significant trauma
- No history of pain over great toe
- No history of back pain, neck stiffness ,visual difficulties
- No history of bleeding diathesis
- No history of altered bowel habits
- No history of any skin lesion

- No significant past history
- PERSONAL HISTORY- Pt is vegetarian by diet, non smoker, non alcoholic, normal sleep wake cycle
- FAMILY HISTORY – No similar complaint in any other family member

EXAMINATION

General examination , vitals and systemic examinations are normal

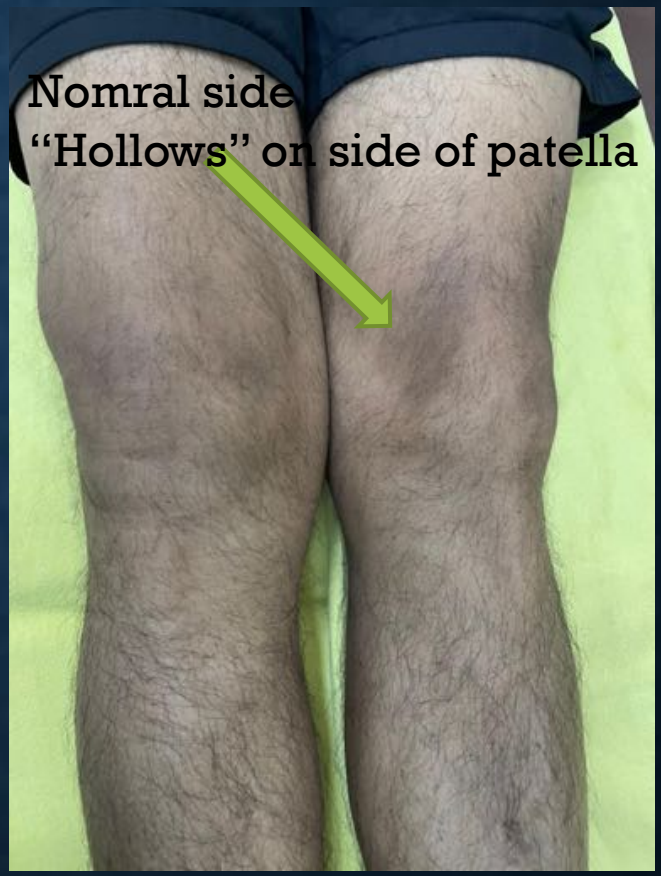
(comment on Chest examination must; as TB would be a differential)

- GAIT – Antalgic gait

- ATTITUDE- pt is lying comfortably on firm bed with both ASIS are at same level. Hip is in extension . Rt knee appears to be in slight flexed as compared to left side. Patella Looking forward with both foot in neutral position

INSPECTION

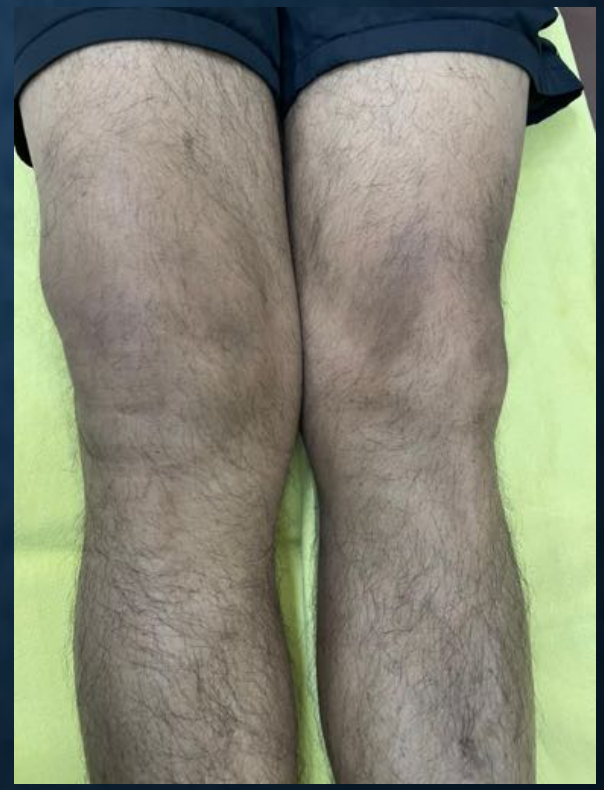
- On inspection from front while pt is standing, sitting and supine
- Both medial joint lines are at same level
- There is no Outward or Inward deviation of patellae
- There is obliteration of the normal hollows around the patella on the affected side
- Visible Localized Swelling / fullness over Rt knee of approx. 8x8 cm ,circular in shape ,with fullness extending from knee joint to suprapatellar fossa.
- Skin overline swelling appears to be normal.
- There is no scar, sinus or fistulas



- On inspection from side and back-
- No similar swelling on sides (a meniscal cyst) or over popliteal fossa (Baker cyst)
- No visible scar, sinus or fistula
- FFD of 10 degree visible

PALPATION

- All inspector findings confirmed over palpation
- No local rise of temperature overline swelling
- Tenderness present overline swelling on deep palpation.
- There is no joint line tenderness neither medially laterally nor overline extensor apparatus and over both femoral and tibial condyle.



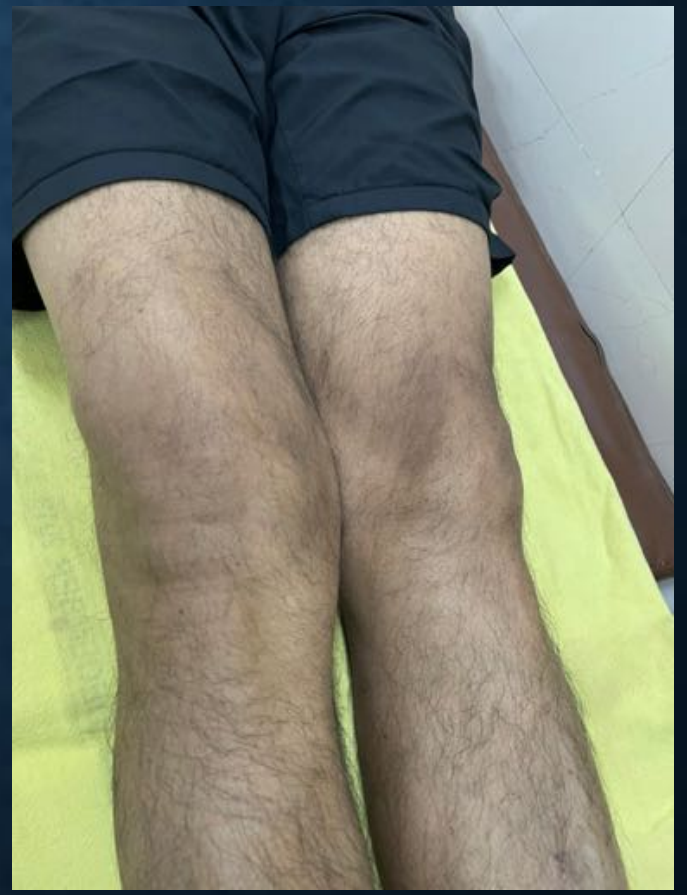
Bulge sign- Positive

Cross Fluctuation test/ Tap test – positive overline swelling

Ballotable Patellar sign – Positive overline swelling

Transillumination test – negative (PVNS ruled out)

On palpating the swelling – it feels to be doughy thickening which rolls under finger



ROM AND DEFORMTIES

Pt is having fixed flexion deformity of 10 degree on right knee with further flexion possible from 10-100 degree.

Movement is essentially painless but has pain over terminal range of motion

HIP		RIGHT		LEFT
	FLEX	0-110		0-110
	EXT	0-10		0-10
	ABD	0-45		0-45
	ADD	0-30		0-30
KNEE				
	FLEX	10-100		0-140
	EXT	--------		140-0

MEASUREMENT

- Apparent length are equal bilaterally
- Circumferential length- Thigh circumference – quadricep wasting seen over rt thigh, with difference of 3 cm
- Distal neurovascular status intact bilaterally with ATA ,PTA , Popliteal pulses palpable bilaterally
- Sensory and motor distribution of tibial, common peroneal nerve and femoral nerve intact

SPECIAL TEST

- Varus &valgus stress test – negative bilaterally
- Anterior drawer & Lachman test – negative
- Pivot shift test - negative
- Posterior drawer test – negative
- Mcmurray test –negative bilaterally
- Apley grinding test – negative
- Apprehension test – negative

- Inguinal and popliteal lymph nodes not palpable.

PROVISIONAL DIAGNOSIS

My patient Ramesh Chand is a case of chronic synovitis of knee secondary to

- Low grade infection (possibly Tuberculosis)
- Inflammatory arthropathy (possibly Reactive arthritis or Monoarticular RA)
- Crystalline arthropathy (Pseudogout or Gout)
- Pigmented Villo nodular synovitis (PVNS)

ARTHROCENTESIS

Synovial Fluid Analysis

	WBC/mm³	Color	Viscosity
Normal	< 150	Colorless/Straw	High
Noninflammatory	< 3,000	Straw/Yellow	High
Inflammatory	> 3,000	Yellow	Low
Septic (purulent)	> 50,000	Pus/Mixed	Mixed
Hemorrhagic	Similar to blood	Red	Low