

Masquerading Back Pain in a Middle-aged Male



CASE PRESENTATION

A 59-year-old man presented to his primary care provider for chronic right buttock pain radiating to the right thigh and significantly affecting his mobility. He was treated with numerous lumbar epidural steroid injections without much improvement. He denied early satiety, nausea, vomiting, flank pain, abdominal pain, groin pain, or leg edema. His past medical history included diabetes mellitus, hypertension, hyperlipidemia, obesity, and paroxysmal atrial fibrillation. He had a remote smoking history over 20 years ago and did not drink alcohol. He admitted to a sedentary lifestyle. His family history was unremarkable.

PHYSICAL ASSESSMENT

Vital signs were as follows: blood pressure 154/78 mm Hg; heart rate 80 beats/min; respirations 15 breaths/min; and temperature 98.4°F. The patient was alert and oriented with good mental function and without memory deficits. Central nervous system evaluation revealed normal cranial nerve function and no motor or sensory deficits. Examination of the skin, head, eyes, ears, and throat was normal. The thyroid was not enlarged and there was no evidence of a neck mass, neck vein distention, or hepatjugular reflux. The carotid pulses were equal bilaterally without carotid bruits. The cardiac examination demonstrated normal apical impulses with a normal first and second heart sound and a grade 2/6 systolic murmur. The lungs were clear to percussion and auscultation. The abdomen was soft without tenderness, mass, hepatosplenomegaly, or abdominal bruits. Pain was not elicited with palpation over the vertebral column and straight leg raises were negative. Distal pulses were equal bilaterally with mild edema.

DIAGNOSTICS

Labs

Complete blood count, comprehensive metabolic panel, and thyroid levels were normal. Triglycerides, total cholesterol, and low-density lipoprotein were elevated. High-density lipoprotein was low. Glycated hemoglobin was 6.4.



IMAGE OF THE MONTH

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Lumbar Spine X-ray

Lumbar spine radiography showed a mild left convexity midlumbar scoliotic deformity. An aneurysmal dilation of the aorta with a minimal dimension of approximately 6.8 cm was seen (Figure 1). A computerized tomography (CT) scan of the abdomen and pelvis was recommended to evaluate further for significant abdominal aortic aneurysm (AAA).

Abdominal CT

Vascular calcifications involving the arterial system were noted. The aorta in the upper abdomen had a caliber of about 2.5 cm, and below the renal arteries there was a fusiform dilation with an anterior posterior diameter of 5.5 cm (Figure 2), without periaortic mass or fluid collection or extension into the common iliac arteries.

Figure 1. Lumbar spine radiography demonstrating calcification of abdominal aorta with aneurysmal dilatation (white arrows).

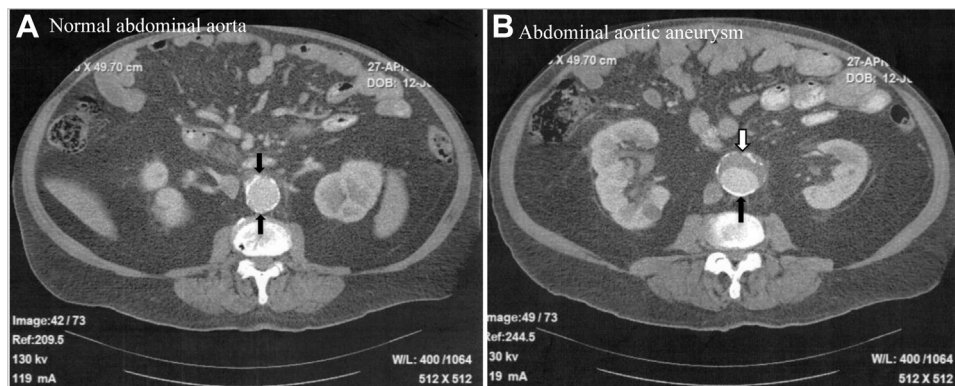


ETIOLOGY OF AAA

An AAA is defined as an abdominal aortic dilation of ≥ 3.0 cm.¹ Aneurysms develop as a result of degeneration of the arterial media and elastic tissues due primarily to atherosclerosis, but also from inflammatory changes, vasculitis, connective tissue disorders,

mycosis, or traumatic pseudoaneurysm. AAA is uncommon in persons < 50 years old and the incidence of this disorder increases with age. Key risk factors include male gender, family history of AAA, smoking, age > 65 , coronary artery disease, hypertension, previous myocardial infarction, and peripheral arterial

Figure 2. Computed tomography of abnormal aorta (A) and abdominal aortic aneurysm (B). Dark arrows: normal aortic wall; white arrow: aortic aneurysmal wall.



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