Pediatric Rheumatology

Poster presentation

When is CRMO NOT CRMO?

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A 3 year old girl presented with a limp and a hot, swollen ankle. X-Ray showed active osteomyelitis. ESR > 60 mm/hr, Hb 11.3 g/dl, WCC 7.9 × 10^9/L, Platelets 808 × 10^9/L. Intravenous antibiotics were commenced. One week later, the left ankle became swollen, X-Ray showed osteomyelitis. Bone scan showed several areas of increased uptake, right femoral neck, both knees, both ankles, and scapula. A presumptive diagnosis of chronic recurrent multifocal osteomyelitis was made. Management was with intravenous followed by oral antibiotics. Upon rheumatology review 4 months later, she had clinically improved, non-steroidal anti-inflammatory agents were advised, it was felt a bone biopsy was not indicated.

2 months later, she had developed episodic lower back pain, both day and night. She did not like walking and had lost weight. She was pale and had developed a kyphosis in L2–3 region with a scoliosis. Spinal X-Ray revealed multiple crush fractures with marked osteopenia. Repeat bloods showed Hb 7.0 g/dl, WCC 17 × 10^9/L and platelet count of 200 × 10^9/L. Blood film demonstrated multiple lymphoblasts. Bone marrow examination revealed common acute lymphoblastic leukaemia.

At presentation, chronic recurrent multifocal osteomyelitis may mimic acute osteomyelitis; however, definitive diagnosis is with a bone biopsy. Bone scans can be useful to identify additional foci of involvement that can be present concurrently or sequentially. One case report of CRMO following ALL has been documented [1]. This case illustrates a rare presentation of CRMO clinical symptomatology and radiological findings with an underlying diagnosis of ALL.

References

1. Abril JC, Castillo F, Loewinsonh AF, Rivas C, Bernacer M: **Chronic recurrent multifocal osteomyelitis after acute lymphoblastic leukaemia.** *Int Orthop* 1994, **18(2):**126-8.