E-Poster

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Unraveling Crural Pain Etiology – A Clinical Vignette of the Importance of Anamnesis and Physical Examination

Topic: Diagnosis

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BACKGROUND

Crural pain is a common symptom in active adults, with various causes, commonly related to the musculoskeletal system. However, neurological diseases involving the central and peripheral nervous system should not be excluded. A detailed clinical assessment, including the patient's current illness history, medical background, and medication use, is essential for guiding the physical examination and further tests.

CASE DESCRIPTION

A 42-year-old male patient with a history of diabetes and dyslipidemia, followed in a Neurology-Neuromuscular outpatient clinic due to a conus medularis lesion of presumed inflammatory etiology. The clinical presentation began in December of 2022, with bilateral crural paresthesia and numbness in the inguinal, perineal, gluteal, and posterior thigh regions, along with neurogenic bladder symptoms. Complementary studies included a neuroaxis MRI which revealed a hyperintense signal in the conus medullaris on T2-weighted images. CSF and serum studies, and electromyography/nerve conduction studies were normal. Treatment included intravenous corticosteroids, followed by daily oral corticosteroids (from June of 2023 to February of 2024) and monthly IV immunoglobulin (from August of 2023 to February of 2024).

In December of 2024, during a multidisciplinary observation (Neurology and PM&R), the patient reported right hip pain and weakness in the lower limb with a four weeks course, with additional functional limitations, including gait difficulties and trouble with transfers. Physical examination revealed aggravated right hip pain with internal rotation and positive Patrick's and FADIR tests. The patient was admitted to the Neurology inpatient unit for further studies and treatment optimization. All complementary tests, including brain and thoracolumbar MRI, cerebrospinal fluid and autoimmune studies, were normal. MRI of the right hip revealed AVN of the femoral head without fracture or subchondral collapse. Partial weight-bearing and rest were recommended, along with a referral to Orthopedic surgery.

DISCUSSION

This case highlights corticosteroid-induced AVN after an eight months regimen of high dose corticosteroid, discontinued approximately 10 months before. The patient's progressive hip pain, initially masked by neurological symptoms, emphasizes the challenge of early diagnosis. A differential diagnosis with L2-L3 radiculopathy was crucial. This case underscores the importance of cautious corticosteroid use and multidisciplinary follow-up to balance neurological treatment with musculoskeletal risks.

CONCLUSION

This case underlines the risk of corticosteroid-induced AVN. Early recognition through MRI is crucial to prevent joint deterioration. A multidisciplinary approach is essential to balance immunosuppressive therapy with musculoskeletal health, ensuring optimal long-term outcomes for patients requiring prolonged corticosteroid use.

Statement of Disclosures

None

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