Ksifodini ile Kendini Gösteren Talasemi Minör

Ksifodini ile Talasemi Minör / Thalassemia Minor with Xiphodynia

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Özet

Anahtar Kelimeler
Ksifodini, Talasemi Minor, Ksifoid Kemik Rezeksiyonu, Göğüs Ağrısı.

Abstract
Xiphodynia describes an uncommon syndrome with group of symptoms ranging from upper abdominal pain, chest pain, throat, head and arm symptoms referred from xiphosternal joint or the xiphoid process. A 37-year-old woman presented with a sharp and persistant pain complaint of chest, mid-dorsal region and arm and anemia. Pain was refractor to medication and xiphoid resection was performed. The patient was diagnosed as thalassemia minor histopathologically. After resection pain was disappeared. At the 6th month follow up patient was asymptomatic and no pain was detected. Surgical resection of xyploid bone may be curable in medically refractor xiphodynia.

Keywords
Xiphodynia, Thalassemia Minor, Xiphoid Bone Resection, Chest Pain.


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Introduction
Xiphodynia describes an uncommon syndrome with group of symptoms ranging from upper abdominal pain, chest pain, throat, head and arm symptoms which are referred from the xiphisternal joint or the xiphoid process [1, 2].

Over a 60 year period 13 citations relating to the terms xiphodynia and xiphoidalgia in the literature. Between 1979 and 1998, 10 cases of xiphodynia were published and all treated by localized injection [1-3].

Patient
A 37-year-old woman was presented to our clinic with a sharp and persistent pain complaint of chest, mid-dorsal region and arm which had been present for 3 years period. The patient also had a feeling of xiphoidal swelling during 1 month. Past medical history was unremarkable. At the physical examination xiphoid bone was 3x2 cm palpable and painful. The patient only had a mild anemia. Chest X-ray and thoracic CT examinations were normal. Patients pain was refractor to medication and xiphoid resection was performed because of that. On histopathological examination hypercellular bone marrow was reported (Figure-1). Hemoglobin electrophoresis demonstrated a hemoglobin A2 level of 6.2%. The patient was diagnosed as thalassemia minor.

After the xiphoid bone resection pain was dramatically disappeared level of 6.2%. The patient was diagnosed as thalassemia minor. Chest X-ray and thoracic CT examinations were normal. Patients pain was refractor to medication and xiphoid resection was performed because of that. On histopathological examination hypercellular bone marrow was reported (Figure-1). Hemoglobin electrophoresis demonstrated a hemoglobin A2 level of 6.2%. The patient was diagnosed as thalassemia minor. After the xiphoid bone resection pain was dramatically disappeared at the 6th month follow up patient was asymptomatic and no pain was detected.

Discussion
In 1955 Lipkin et al. published the first modern paper of 24 patient with hyper-sensitive xiphoid. Lipkin et al. also noted that in 1712 the earliest report of xiphoid disorders was recorded [1, 4]. Mackenzie wrote about the phenomenon of viscerosomatopain referral in 1893 [1, 5]. Kellgren mapped patterns of referred pain from deep structures such as deep fascia, periosteum, and ligaments in the late 1930s [6]. In the late 1940s Travell and Rinzler mapped referral patterns from pectoral muscles that mimicked the symptoms of angina pectoris and myocardial infarction [1, 7].

Musculoskeletal chest wall syndromes masks cardiac chest pain [2]. The reason of most of these are perichondritis of costochondral, sternoclavicular, manubriosternal, and xiphisternal junctions (Tietze’s syndrome) [2]. The diagnosis of xiphodynia was usually reported in the patients that had myocardial infarction in the past medical history [referans verilmemiş].

A history of trauma like acceleration/deceleration injuries, blunt trauma, heavy lifting and aerobics could be accused in the etiology of trauma [1]. Sharp and persistent pain in the xiphoidal region aggravated by local compression, xiphoid tenderness, neutrophilic leukocytosis, and a good response to nonsteroidal anti-inflammatory drugs are the objective criteria of this syndrome [2]. Cardiac chest pain, epigastric pain, nausea, vomiting and diarrrhea, radiating pain into the back, neck, shoulders, arms and chest wall also could be seen in this syndrome [1]. Myocardial infarction, ruptured aortic aneurism, aortic dissection, perforated ulcer, pancreatitis, strangulated hernia and pericardial effusion should be assessed in the differential diagnosis [2].

The incidence and prevalence of xiphodynia is not clear. Lipkin et al. say that it is a frequent disorder in about 2 percent of the population of a general-hospital but most authors recorded the syndrome uncommon [1, 4].

Xiphodynia is usually suggested a self-limiting disorder and usually treated with analgesics, elastic belt, topical heat and cold, local anaesthetic and steroid injection, course of ultrasound and laser [1, 2]. According to some cases xiphodynia may not be self-limiting. Xiphoid injection had some risks like pleural or peritoneal perforation, pneumothorax, or infection. Conservative physical therapies are usually not effective [1].

Thalassemia is a common hereditary disease in Mediterranean and up to 15% of the population carry the gene [5, 8, 9]. Thalassemia rarely involved thorax [8]. Pleural effusion, massive hemmothorax, pleural mass lesion, mediastinal lymphnodes or dyspnea may be seen secondary to lung involvement [9]. Xiphodynia as a symptom of thalassemia was not published before.

Due to extra-medullary haematopoiesis secondary skeletal deformity occurs [5]. The ribs are sometimes affected and the posterior elements expand dorsally. Spinal cord compression and vertebral fractures may occur most commonly in the thoracic spine [5].

In conclusion, in endemic regions, in patients with nontraumatic xiphodynia associated with anemia, thalassemia should also be kept on mind by physicians. While the pain is persistent for a long time and refractor to medication or other conservative methods surgical xiphoidal resection may be workable.

References