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Tietze syndrome - a case report of 20 year old male patient with steroid induced tinea incognito

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Abstract

Tietze syndrome is a self-limiting, rare and benign condition that might be mistaken with potentially fatal chest diseases and misdiagnosed mostly as costochondritis. This disease is most often diagnosed in young individuals under the age of 40, with painful, localized inflammation.Tinea incognito is a ringworm infection that has been altered by corticosteroids and other immunosuppressive medications. Corticosteroids are administered for pre-existing illness or are used incorrectly for the treatment of tinea. We report a case of 20years old male patient admitted in emergency department with complaints of chest pain and SOB with normal ECG while neutrophils, ESR, CRP have found to be abnormal. Patient has been using steroids and itraconazole for maculopapular rashes in lower limb since 1year. Other diagnostic methods such as CT, MRI should be performed to avoid misdiagnosis. He was prescribed with NSAIDS, antifungals, antihistamines and other supportive measures which helped him to relieve from pain. Proper diagnostic criteria and early diagnosis remain challenging tasks, resulting in undue treatment costs for patients. Before confirming a diagnosis, other underlying diseases should be ruled out.

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Introduction

Tietze syndrome is a rare and benign condition that might be mistaken with potentially fatal causes of chest discomfort such as angina pectoris, pulmonary embolism, aortic dissection, or cancer. Chest discomfort has a wide differential diagnosis, and many Tietze syndrome patients are misdiagnosed with mastalgia or costochondritis. Tietze syndrome is most often diagnosed in young individuals under the age of 40, with painful, localized inflammation of the costosternal, sternoclavicular, or costochondrial joints, generally of the second and third ribs. The severity of the condition is related to palpable lesions. Symptoms are often limited to a single rib (70 to 80 percent of the time) and are frequently accompanied by radicular arm discomfort. This typical clinical picture and the elimination of alternative causes of chest discomfort are used to make the diagnosis [1].

Despite the fact that it is a self-limiting ailment, analgesics, avoidance of stressful activities, administration of heat to the affected region, and total rest are all recommended [2].

Tinea incognito is a ringworm infection that has been altered by corticosteroids (systemic or topical) and other immunosuppressive medications. Corticosteroids are administered for pre-existing illness or are used incorrectly for the treatment of tinea. The history is typical; the patient is frequently initially delighted with the therapy, but the eruption recurs with varied speed once the medication is discontinued. Tinea incognito has a wide range of clinical manifestations and can be mistaken for other skin disorders such as Systemic Lupus Erythematosus (SLE), eczema, purpura, seborrhoic dermatitis, lichen planus, contactdermatitis, psoriasis, and erythema migrans [3].

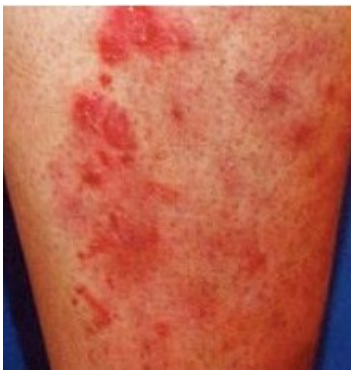

Fig 01: Tinea incognito

Case Report

Patient information

A 20 year old male patient presented with the complaints of chest pain and shortness of breath since 5 days with the history of anorexia and vomiting. patient was apparently asymptomatic 5 days back then developed a chest pain at 2nd intercostal chondral joints.it aggravates on taking breath then relives only on taking medication. He had a past illness of shortness of breath while talking due to chest pain. He had a past history of repeated episodes of costochondrial pain and he also had bilateral pitting edema up to knee and patient has been using steroids and itraconazole for maculopapular rashes in lower limb since 1year.

Clinical findings

On physical examination his temperature was afebrile and presented with neutrophilia and proteinuria. Erythrocyte sedimentation rate and C-reactive protein levels were high and all other lab values have been found to be normal. Local rise in temperature, burning, and tenderness at costochondrial joint is seen.

Diagnostic Assessment

CRP and ESR test are done to find out the infections or disease which cause inflammation.

Parameters	Abnormal Values
Haematology	
Neutrophils	88%
Lymphocytes	10%
Differential Count	
ESR	50mm/hr
Microbiology	
C- Reactive Protein	2.4mg/dl
Bhiochemistry	
Blood Urea	0.8mg/dl
Protein Spot Urine	16.7mg/dl

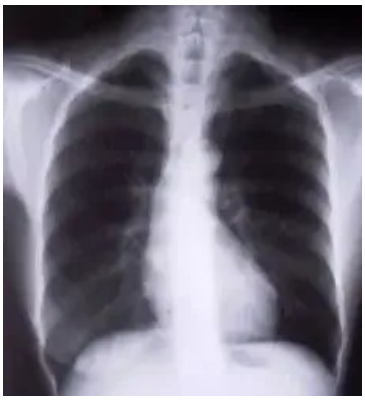

Fig 02: Chest X-ray

Electrocardiogram (ECG) was performed to evaluate the reason for SOB and chest pain and was normal indicating there was no chances of cardiac abnormality. Chest x- ray shows swelling in the ribs eliminating prospective of costochondritis.

Therapeutic interventions

He was prescribed with Tab.Ultracet(Tramadol and Acetaminophen)-325mg,Tab. Diclofenac-50mg, TAB. Alcros(Itraconazole)-100mg, Tab. Atarax(Hydroxyzine)-10mg and Zoderm-E Cream(Oxiconazole), Moisturex Cream(Propylene Glycol). Patient was advised to take complete rest and decrease the limb movements to avoid further proliferation of rashes.

Follow up

The patient was instructed to take the recommended medications and return in one month for an evaluation.

Discussion

Tietze syndrome is most often diagnosed in young individuals under the age of 40. This article also contains the precise diagnosis and treatment of Tietze

syndrome. Tietze syndrome is a diagnosis of exclusion made after a thorough workup of potentially fatal or more common illnesses has been done. The importance of timely diagnosis cannot be overstated. All patients who come with chest discomfort should have an ECG examined. The lab findings for this condition are distinct. CBP was performed, and it was observed that the neutrophil count, lymphocyte count, CRP, and ESR were all abnormal. It shows the presence of inflammation, which indicates tinea incognito. Although the appearance of Inflammation on a chest x-ray
Helps distinguish Tietze disease from costochondritis, other diagnostic techniques such as CT and MRI should be used to avoid incorrect diagnosis. Other underlying problems should be checked out as well. Since one year, the patient has been taking steroids and itraconazole for maculopapular rashes. Initially, the use of steroids improved the patient's health, but once the steroids were withdrawn, the patient experienced a relapse of rashes.

Conclusion

Tietze syndrome is an idiopathic chronic pain illness that is unusual in emergency departments. It is characterised by severe chest discomfort and localised inflammation of the anterior chest wall. Proper diagnostic criteria and early diagnosis remain challenging tasks, resulting in undue treatment costs for patients. Though not commonly utilised at the moment, imaging methods such as CT, MRI, and ultrasound may become a regular tool in the workup of Tietze syndrome in the future. Before confirming a diagnosis, other underlying diseases should be ruled out.

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