Undifferentiated Spondyloarthropathy in a Division I Female Rugby Player
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Background: Patient is a 21 year old, female, Division I rugby player. Initial symptoms of persistent pain and edema began after being tackled in a game in late November, 2015. Symptoms resolved after the season ended and activity levels decreased. Symptoms began again in off-season training late February. Evaluation in February showed negative meniscal and ligamentous special tests, generalized pain surrounding the patella, limited AROM and PROM in KF/KE, and RROM KF/KE was WNL. Patient was referred to a physician. Differential diagnosis was meniscus tear, ligamentous injury, and ballotable patella. MRI confirmed a meniscal injury. Conservative treatment consisted of effleurage, Game Ready, Graston Technique ©, and alterations in activity levels. This led to minimal decrease in edema surrounding the knee. Patient was referred back to the physician and then referred to a rheumatologist. Blood work indicated high levels of C-reactive protein, positive HLA-B27 antigen, and positive ANA screen. Follow up blood-work mid-August showed high levels of AST and ALT. Increased activity rates during preseason August, 2016 led to increased edema and pain in right knee, left ankle, and right hand. Currently the patient is no longer participating in activities associated with Division I Rugby, and has changed her goals towards improving function in activities of daily living. Differential Diagnosis: After no change in edema, pain, tightness, and loss of function in the right knee after 4 weeks of conservative treatment, the physician revised the differential diagnosis to Lyme disease, rheumatoid arthritis, autoimmune disease, inflammatory disorder, Hepatitis B, Hepatitis C, and Tuberculosis and ordered blood work. C-reactive protein was found in combination with positive HLA-B27 antigen and positive ANA screen. The differential diagnosis was narrowed to idiopathic autoimmune disease, undifferentiated spondyloarthropathy (USpA), and ankylosing spondylitis, which is the current differential diagnosis. Treatment: Rheumatological findings led to the prescription of Prednisone. After a month of treatment, the patient was switched to Humira administered via self-injection every two weeks. Blood-work August, 2016 showed elevated levels of AST and ALT. The patient was taken off Humira and is now being treated with just Prednisone. AST and ALT levels have normalized, as measured in follow up blood-work fall, 2016. The patient is now fully under the care of the rheumatologist. Long-term treatment will be medication, monitoring symptoms, and follow up blood-work. Prognosis is good as long as symptoms don’t spread. Uniqueness: This case is particularly rare, because most SpA patients are classified into their respective subgroup of SpA based on their clinical presentation of chronic inflammatory back pain (IBP) and articular and extra-articular psoriasis features. About 87.5% of patients who have USpA have IBP and over half of USpA cases have low-grade sacroiliitis. However, this patient showed no symptoms of IBP, psoriasis, or sacroiliitis. The prescription of Humira is also unique, due to the small, but growing research on treating such phenotypically variable diseases with anti-TNF-α drugs. Conclusion: Patient presented with edema, pain, tightness and altered gait as a result of sequelae from a meniscal tear. This sequelae was atypical in duration and magnitude to that of a normal meniscal injury, and it was crucial that this was recognized and the referral process initiated, because it eventually led to important rheumatological findings. This case is important to the athletic training profession, because it shows how improved understanding and awareness of the signs and symptoms of certain inflammatory diseases such as USpA, could lead to an enhanced approach to the referral and treatment procedure of the disorder. Word Count (596)