

## AN UNDERREPORTED COMPLICATION OF ANKYLOSING SPONDYLITIS: SCOLIOSIS

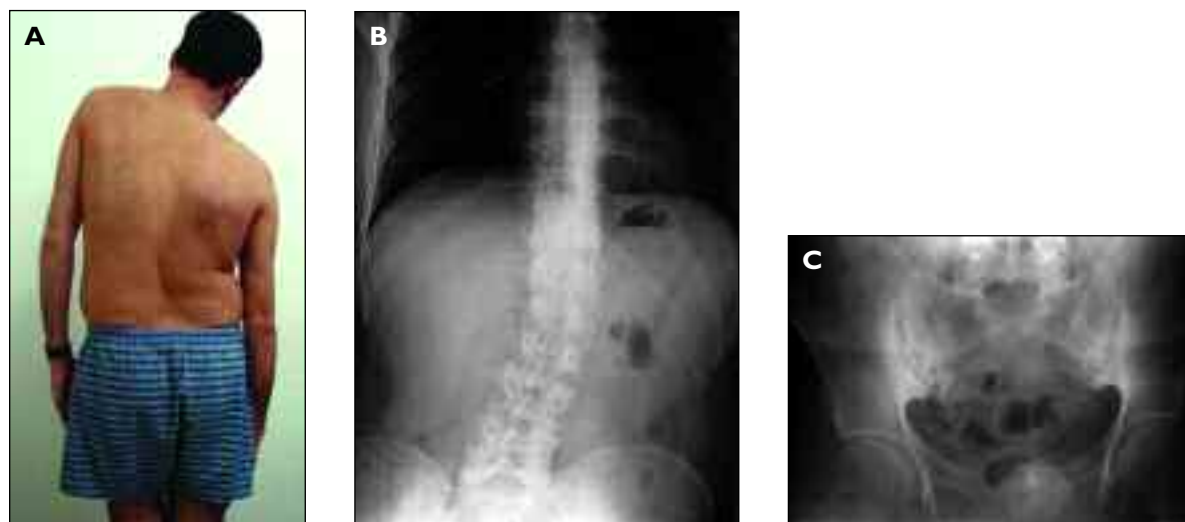
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To the editor,

A 27-year-old male was seen due to low back and hip pain radiating to the right thigh for the last four years. He declared that rest did not alleviate his complaints and he also described a morning stiffness of 30 minutes. He was concerned because of restricted lumbar motion and curving of his spine to the left side. His medical history was otherwise noncontributory. Physical examination revealed a semi-flexed posture, mild dorsal kyphosis and scoliosis (Figure 1A). Lumbar Schober was 1 cm, chest expansion 1 cm, finger-foot distance 42 cm, chin-sternum distance 3 cm, and occiput-wall distance 3 cm. Sacroiliac compression tests were bilaterally positive. Radiological evaluation yielded scoliotic shifting 28 degrees (leftward) in the lumbosacral

region, and 20 degrees (rightward) in the dorso-lumbar region, stage 2 rotation of the pedicular shadows, syndesmophytes at several thoracolumbar vertebrae (Figure 1B) and bilateral sacroiliitis (Figure 1C). Laboratory test results were as follows: C-reactive protein: 12 mg/L (N < 9 mg/L), erythrocyte sedimentation rate: 13 mm/h, and HLA B27 (+). The patient was diagnosed to have ankylosing spondylitis and scoliosis and started on indomethacine-sulphasalazine and exercise therapy (home-based stretching and strengthening exercises for the back region).

According to its etiology, scoliosis can generally be classified as congenital, idiopathic, developmental and acquired (due to various secondary causes).<sup>1</sup> Degenerative or osteolytic pathologies



**Figure 1.** Photograph of the patient demonstrating the scoliotic posture from his back (A), anteroposterior radiographs demonstrating thoracolumbar scoliosis and syndesmophytes at several vertebrae (B) and bilateral stage 3 sacroiliitis (C).

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have been reported to cause secondary scoliosis, whereas ankylosing spondylitis cause dorsal kyphosis and restriction of spinal motions. Associated scoliosis has not been mentioned in the relevant literature. In our case, scoliosis was present with a concavity towards the left side at the lumbosacral region and with a right concavity at the dorsolumbar region. As the patient's low back pain was predominant on the right side and the syndesmophytes on the left side, we believe that the asymmetric axial involvement might have contributed to the scoliotic process. Therefore, in patients with asymmetric axial disease and/or accompanying antalgic posture, we advise physicians for the risk of scoliosis during the follow up.

This would also be noteworthy as the components of the exercise regimens will then need to be tailored to encompass those for scoliosis.

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**Brest, França  
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## **Curso de Reumatologia dos HUC**

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