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Swan Neck Deformities with Gout: An Unusual Presentation

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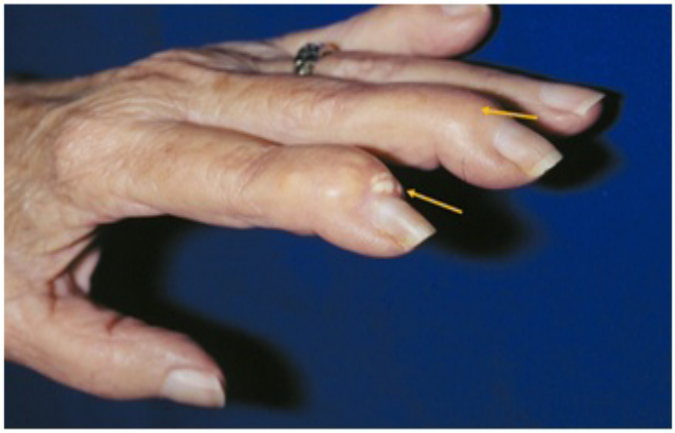
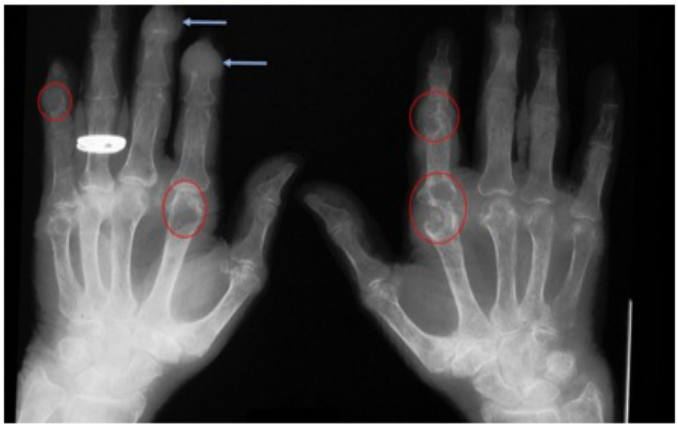
A 72-year-oldlady with history of hypertension presented with chronic bilateral hand pain, which had been gradually worsening for the past several months. Her exam revealed distal interphalangeal (DIP) joint tophi (Figure 1, arrows). She also had hyperextension of the proximal interphalangeal (PIP) joints and flexion of DIP joints, consistent with swan neck deformities in the left 2nd, 3rd and 5th digits (Figure 1).





redemonstrated the tophi (arrows) and revealed multiple punched out osseous lesions (red circles). Serum uric acid level was 8.5 mg/dL (normal 2.4-6.0 mg/dL). Based on the constellation of clinical, laboratory and radiologic findings, she was diagnosed with chronic tophaceous gout. She was started on allopurinol and colchicine, with significant symptom improvement noted on follow up visits.

Swan neck deformities are most commonly seen in rheumatoid arthritis (RA) [1]. In fact, swan neck deformities complicate about a quarter of all RA cases [2]. Other common causes of swan neck deformities include systemic lupus erythematosus, chronic rheumatic fever and juvenile chronic arthritis [3]. Although chronic gout can sometimes mimic RA with proximal synovitis and some deformities (e.g. subluxations); true swan neck deformities as present in our patient are rarely seen with gout. Clinicians need to be mindful of the broad differential diagnoses of swan neck deformities, else some of these patients may wrongly be diagnosed as RA. While medical management may halt further progression of swan neck deformities, advanced cases with significant disability need surgical correction [4].

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