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

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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. 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 20 years 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 1 year. 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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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, seborrhoeic dermatitis, lichen planus, contact dermatitis, psoriasis, and erythema migrans [3].

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 2\textsuperscript{nd} 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 costochondral 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 1 year.

Clinical findings
On physical examination his temperature was afebrile and presented with neutrophils 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 costochondral joint is seen.

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

<table>
<thead>
<tr>
<th>Parameters</th>
<th>Abnormal Values</th>
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<tbody>
<tr>
<td>Haematology</td>
<td></td>
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<tr>
<td>Neutrophils</td>
<td>88%</td>
</tr>
<tr>
<td>Lymphocytes</td>
<td>10%</td>
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<tr>
<td>Differential Count</td>
<td></td>
</tr>
<tr>
<td>ESR</td>
<td>50mm/hr</td>
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<tr>
<td>Microbiology</td>
<td></td>
</tr>
<tr>
<td>C-Reactive Protein</td>
<td>2.4mg/dl</td>
</tr>
<tr>
<td>Biochemistry</td>
<td></td>
</tr>
<tr>
<td>Blood Urea</td>
<td>0.8mg/dl</td>
</tr>
<tr>
<td>Protein Spot Urine</td>
<td>16.7mg/dl</td>
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</tbody>
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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.

References