CLINICAL PICTURE

Multiple myeloma and pepperpot skull

A 66-year-old gentleman presented with backache for 5 months duration. The pain was generalized over the vertebral column, it was persistent, progressive, aggravated by physical exertion and often got him awake from sleep. He also gave a history of loss of appetite and easy fatigability. There was no history of trauma, fever or peripheral joint pain. On examination, he had pallor and tongue was dry but rest of the physical examination was unremarkable. His skeletal survey showed multiple radiolucent, lytic lesions in the pelvic bone, thoracolumbar vertebra and skull (Figure 1). Further Investigations showed, anemia (Hb 82 g/l), raised creatinine (2.7 mg/dl) and hypercalcemia (13.7 mg/dl). Bone marrow biopsy, showed 70% clonal plasma cells, confirming the diagnosis of multiple myeloma. Serum and urine electrophoresis revealed monoclonal protein. The patient was managed with rigorous hydration, forced diuresis and dexamethasone. Subsequently, he received bortezomib, thalidomide and dexamethasone (VTd). Two months later, on follow up, he was asymptomatic.

Musculoskeletal pain has a prevalence of 65–85% in elderly, and 36–70% of them have back pain.1 The back pain in the elderly can be viscerogenic, psychogenic or spondylogenic. The common causes of spondylogenic pain include trauma, degenerative disc diseases, metabolic disorders, inflammation, infection and neoplasms. Malignancy constitutes 1–7% of all causes.1,2 X-ray of the spine is the conventional first-line investigation and treatment depends upon the underlying cause. Multiple myeloma (MM) presents at an average age of 70 years. It accounts for 1–2% of all malignancy.3 Lytic lesions of bone are the hallmark of MM and are seen in 80% of patients at presentation. Lytic lesions can also be seen in hyperparathyroidism and skeletal metastasis.4,5 The presence of extensive osteolytic lesions and hypercalcemia portends a poor prognosis in MM.6 Presence of more than 10% clonal plasma cells in bone marrow, and monoclonal proteins in serum and urine confirm the diagnosis. The treatment includes chemotherapy and stem cell transplant along with bisphosphonates for bone health.

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Conflict of interest: None declared.

References