arthrosis is usually a silent disease that is discovered at late stages as it causes pain when the patient mobilizes the affected articulation. Out of the 291 conditions that contribute to disability, hip and knee osteoarthrosis are ranked 11th, knee arthrosis affecting more the 250 million people, based on a 2010 statistic (about 3.6% of the population)

Case report. The patient, a 63 years old woman, was admitted to the Orthopedics and Traumatology clinic at the Emergency County Hospital on 26th of February accusing pain at the right knee and functional impotence. The primary diagnosis of the patient was gonarthrosis secondary to varus angular deformity, but also suffering arterial hypertension, being under treatment with Ramipril, having an ASA score of II. The surgical procedure took place on the 3rd of March and consisted of cemented total knee arthroplasty which represents the gold standard in such interventions. Because of the deformity of the knee, the ligamentar balancing is much harder to obtain than in a non-deformity patient. The patient is now recovering and is waiting for discharge.

Conclusions. The arthrosis of the knee is a medical condition that affects the mobility of the patient and disables him in his daily routine. The gold standard in treating such conditions consists of a cemented total knee replacement.

Key words: gonarthrosis, osteotomy, arthroplasty

40. A CASE OF CARPAL TUNNEL SYNDROME IN PATIENT WITH RHEUMATOID ARTHRITIS

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Background. Carpal tunnel syndrome (CTS) is the most common entrapment neuropathy caused by compression of the median nerve at the wrist, and most likely the most common peripheral neurological involvement in patients with rheumatoid arthritis. It is manifested withpain and/either paresthisias at night associated with weakness, loss of dexterity and even thenar atrophy.

Case report. We report a case of a female patient GN, 42y.o., with established seropositive (FR-153 IU/L; anti-CCP – 340 U/ml), highly active (DAS28-5.47) Rheumatoid Arthritis. Now she presented with inflammatory joint pain and swelling in 11 joints (including elbow bilaterally, wrist bilaterally, metacarpophalangeal, and proximal interphalangeal joints), morning stiffness is more than2 hours, additionally she reports numbness, tingling and burning in the 1,2 and 3rd fingers of the left hand. Carpal tunnel syndrome was suspected. Both Tinel's (paresthesia in a median nerve distribution, after percussion of the median nerve at the wrist) and Phalen's (paresthesia in a median nerve distribution, after passive flexion of the hand at the wrist) signs were positive. The patient recalls having similar symptoms in the right hand 3 years ago. An EMG exam performed at that time was showing: Prolongation of the median motor distal latency and median F-wave abnormalities. A diagnosis of carpal tunnel syndrome was established the patient being treated with surgical approach by neurolysis of the median nerve. Considering thatthe patient presented with swelling in the left wrist joint, it was decided to do an infiltration of corticosteroids. The patient had a satisfactory recovery with resolution of all carpal tunnel symptoms within 1 week. When looking for a detailed history of disease it

was concluded that the carpal tunnel syndrome in the right hand occurred most likely also as a consequence of joint swelling which is frequently disregarded as an important and easily treatable cause of carpal tunnel syndrome. However, the situation was less clear due to the fact that it occurred at the onset of rheumatoid arthritis.

Conclusions. Carpal tunnel syndrome is the most frequent nerve entrapment condition associated with RA. Although diagnosis is at time tricky, one shouldn't prompt surgical approach since most cases are caused by flexor tenosynovitis which responds well to injections with corticosteroids. However to prevent development of such complication, effective disease modifying therapy should be in place.

Key words: arthritis, carpal tunnel syndrome, neurolysis

41. FAMILY CASE WITH FAMILIAL MEDITERRANEAN FEVER (FMF)

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Background. Familial Mediterranean fever (FMF) is an auto-inflammatory disease characterized by periodic episodes of fever and recurrent polyserositis. It is caused by a dysfunction of pyrin (or marenostrin) as a result of various mutations within the MEFV gene, some causing very severe cases, while others may result in milder signs and symptoms.

Case report. We report the case of a family in which 4 members displayed similar symptoms and were confirmed genetically with mutations characteristic for FMF. The 4 members displaying signs of FMF are the father and the 3 out of 6 siblings (2 males and 1 female). The main presenting complaint in all members is the recurrent abdominal pain. The father which tested genetically as follows - FMF-V726A carrier; FMF-E148Q homozygote, at the age of 45 started having recurrent attacks of unspecified abdominal pain, followed by diarrhea, and he was diagnosed with FMF, based on a family history of FMF in his brother. Later on the disease was confirmed genetically. Although, the onset is considered to be at the age 45, there is a history of left knee effusion at age 18 due to strenuous exercises in the army. Additionally he presents with polyarthralgia and stiffness over the day especially in left knee, both elbows and interphalangeal joints. Sibling no.1 – a 27 y.o. male with onset of disease at age 27 presents with attacks of appendicitis-like pain, cramps and flatulence, without diarrhea associated with recurrent left knee arthralgia. Average duration of attacks is of 2-3 days a month with milder symptoms after starting colchicine use. Has a history of knee arthritis at the age of 10, chest stabbing pain during deep breath (pleuritic chest pain), and one episode of erythema nodosum on both shins resolved within a couple of weeks after the attack. Genetic testing revealed FMF-V726A heterozygote; FMF-E148Q heterozygote. Sibling no.2 – a 26 y.o. male with disease onset at the age 23 with attacks of generalized peritoneal pain followed by diarrhea, stabbing chest pain aggravated by deep breath (pleuritic chest pain), no joints symptoms. Genetic testing revealed FMF-V726A heterozygote; FMF-E148Q heterozygote. Sibling no. 3 – a 15 y.o. female with onset of disease at age 9, with menstruation related attacks of generalized peritoneal pain followed by diarrhea, pain in both knees and generalized weakness. Genetic testing revealed FMF-V726A heterozygote; FMF-E148Q heterozygote. All patients manage to control the disease with diet and colchicine.