SHORT COMMUNICATIONS

PSEUDO-AINHUM ASSOCIATED WITH SPINA-BIFIDA OCCULTA AND HEMIVERTEBRA

I had seen this case in 1986, while working at Pune. A 4½-year-old boy had a verrucous growth on the dorsal aspect of the second and third toes and spontaneous loss of the distal phalanx of the second toe of the right foot since the last four months. There was no history of injury and no family history of congenital anomalies, syphilis, diabetes mellitus, palmo-plantar keratoderma. The nail of the right second toe was rudimentary, fifth toe was deformed with dystrophic nail and there was associated flat foot deformity in the right foot. There was no groove at the base of the toes, no palmo-plantar keratoderma, no peripheral nerve thickness and no muscle weakness. However, the child had loss of pain sensation on the right leg and right foot in L5 and S1 dermatomes. He also had kyphoscoliosis in the thoracic region and a dimple on the coccygeal region. Later during follow-up, the child developed erythematous swelling of the third digit of the right foot spontaneously. Haemoglobin, total and differential leucocyte counts, sedimentation rate, urinalysis, Mantoux test and X-ray chest were normal. X-ray of the spine showed scoliosis at D5 to D8 with hemivertebrae D5 to D12 and enlargement of the spinal canal in this region. X-ray of the right foot showed resorption of the distal phalanx of the second toe.

Thus, pseudo-ainhum of the right second digit associated with hemivertebrae D5 to D12 and analgesia in the L5 and S1 dermatomes in our case possibly represents a neurotrophic change rather than an underlying mesenchymal developmental defect as has been suggested by Sharma et al.[1] This is more so when many other diseases causing neuropathies like diabetes mellitus, leprosy, syphilis, syringomyelia, spinal cord tumours etc have also been reported to be associated with pseudo-ainhum.[2]

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References

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