

Bilateral Calcified Ischiogluteal Bursitis and Shoulder Tendinopathy: A Case Report

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ABSTRACT

The ischiogluteal bursitis which is a rare disorder is irregularly found between the gluteus maximus and ischial tuberosity. A 41-year-old female with bilateral calcifying ischiogluteal bursitis and her right shoulder tendinopathy were presented. She had no related past medical history nor trauma to

the buttock. Ischiogluteal bursitis Aspiration showed calcareous deposits; local injection of corticosteroid helped the patient to get free of symptoms. Calcified ischiogluteal bursitis is a rare condition but simply diagnosed on x-ray. Local steroid injection could provide symptom relief.

Keywords: Calcifying Ischiogluteal Bursitis; Aspiration; Treatment; Shoulder pain; Tendinopathy

INTRODUCTION

Ischiogluteal bursitis is a rare condition in which bursa between the gluteus maximus muscle and ischial tuberosity, which physiologically decreases the frictional force, develops inflammation; this inflammation of the bursa is frequently caused by sitting for a long time on hard surfaces that gives its so-called weaver's bottom. Activities like bicycling may cause local inflammation yielding to tenderness and swelling on buttock and upper posterior thigh as well [1-4].

Gluteal pain could be present owing to several reasons consisting of lumbar discopathy, sciatic nerve derangement, sacroiliitis, ischial bursitis, piriformis syndrome and hamstring muscles tendonitis [2-5].

The most thriving treatment for such bursitis, if sterile, is aspiration and injections into the bursal sac with steroids and local analgesics [6].

Here we introduce rare case of bilateral ischiogluteal calcifying bursitis and calcifying tendinitis of the right shoulder supraspinatus tendon.

CASE REPORT

A 41-year-old otherwise healthy painter female with a complaint of steadily increasing bilateral buttock pain while sitting for 6 months and recurrent right shoulder pain in recent 2 months

was presented to our clinic. The patient reported painful swelling in her both buttocks. The patient had no related past medical history nor recent major trauma. Ischial tuberosities had swelling and tenderness in. Right shoulder had positive impingement tests but full range of motion. Neurologic assessments were unremarkable. Pelvis and the right shoulder x-ray illustrated a calcified lesion in both tuberosities of ischium (Figure 1) and the right supraspinatus tendon (Figure 2). Ultrasonography of the painful region was done and findings were in favor of bursa inflammation. Blood laboratory tests were unremarkable. Hence the diagnosis of bilateral ischiogluteal bursitis and calcifying tendinitis of the right supraspinatus tendon was acknowledged.

As the patient had no complains of her right shoulder, no intervention was done for the right shoulder at that time. Calcareous deposits were easily aspirated via 5-ml-aspiration needle from both ischiogluteal bursas then sent for pathology analysis which was normal; thereafter a mixture corticosteroid plus lidocaine were injected in tender points. Her 3 months follow-up visit was unremarkable and the patient was free of his symptoms. At the 3-month follow-up visit, the patient was free of her symptoms.

DISCUSSION

Ischiogluteal bursa is an adventitial bursa sited

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Figure 1: X-ray of the pelvis illustrating bilateral calcified ischiogluteal bursitis

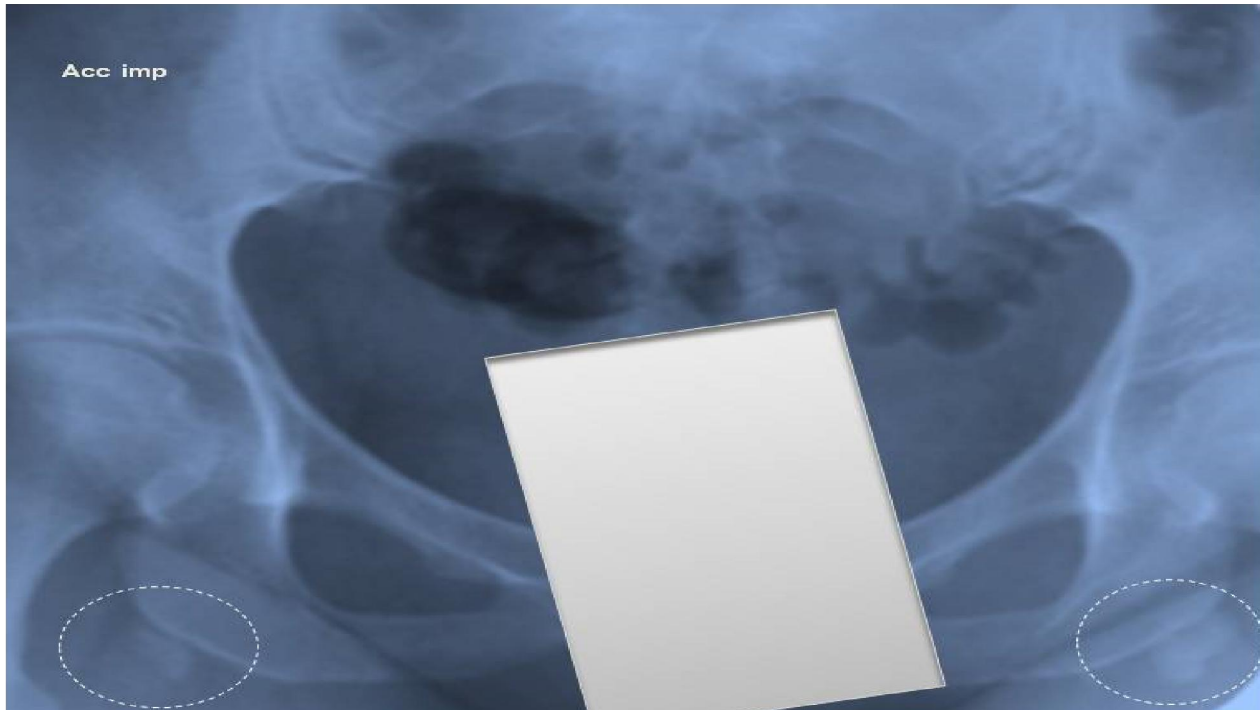
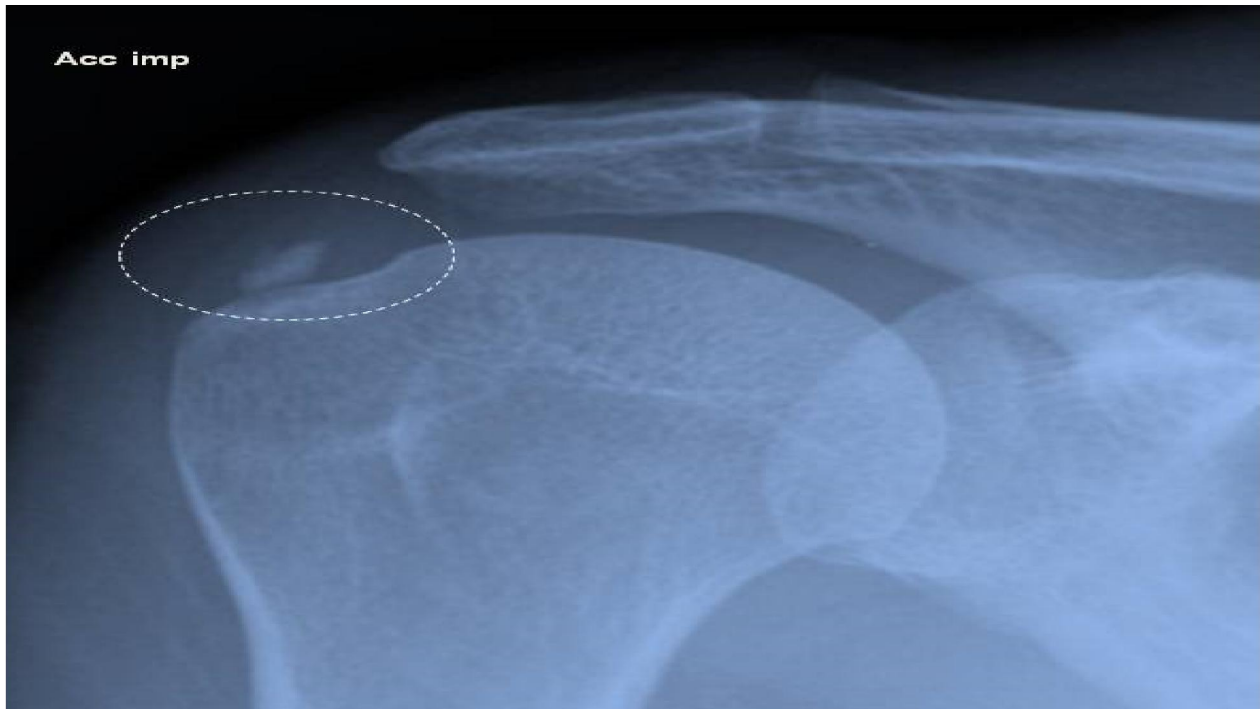


Figure 2: Anteroposterior X-ray of her right shoulder demonstrating calcified supraspinatus tendinopathy



between the gluteus maximus and ischial tuberosity [1-3]. Ischiogluteal bursitis is a rare condition frequently occurs in weavers, due to prolonged sitting position; so that it was named as weaver's bottom. Patients with such bursitis usually complain of pain in the center of buttock, which radiate to thigh or lower part of leg even while rest and night. The pain is more rigorous while sitting or lying on the back exacerbated when standing on tip of toes or bending forward [1-4, 7-11].

On physical examination, pain with straight leg rising is often positive as well as patrick test. On digital rectal examination, a tender bulge might be sporadically felt on the lateral rectal wall [2]. Ultrasonography could be helpful to detect bursitis [1, 8]. Computed tomography and magnetic resonance imaging have been also applied in detection of bursitis [1-3, 8]. The diagnosis of ischiogluteal bursitis would be possible by its typical clinical and imaging features. True malignancies typically contain components of solid soft tissue, but ischiogluteal bursitis consists of liquid enclosed with ad soft tissue restricted to the wall of bursal.

In our present case, we detected a calcifying tendinitis of the right shoulder as well. Regarding such findings, we suggested bilateral ischiogluteal bursitis and there was no need for further diagnostic procedures. Aspiration of both ischiogluteal bursitis showed calcareous deposits which confirmed our diagnosis calcifying lesions. Different etiologies for bursitis have been expressed, including trauma, inflammation e.g. spondyloarthropathies, rheumatoid arthritis and crystal deposition and infection.

To the best of our knowledge, our case is the first report of calcifying ischiogluteal bursitis with simultaneous radiologic features of the shoulder tendinopathy in Iranian population. Several publications have also reported the case ischiogluteal bursitis in other populations [2- 4].

In general, we wholly agree that biopsy or surgical excision is sometimes necessary to establish the diagnosis of ischiogluteal bursitis and sufficient treatment [2, 9] however in this case we did not perform biopsy due to low compliance of the patient and obtaining adequate response after mentioned interventions.

CONCLUSION

When noticing calcification in bursa or tendons, it's reasonable to look for other site of calcium deposition in the body. Aspiration and local steroid injection could give symptomatic relief.

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