Cukurova Medical Journal
ÇUKUROVA ÜNİVERSİTESİ TIP FAKÜLTESİ

Cukurova Med J 2020;45(1):395-396
DOI: 10.17826/cumj.664543

EDİTÖRE MEKTUP / LETTER TO THE EDITOR

A case of familial Mediterranean fever presenting with constant side pain

Sürekli yan ağrı şikayeti ile başvuran ailesel Akdeniz ateşi olgusu

Hüseyin Kaplan[1]

[1]Aksaray Üniversitesi Eğitim ve Araştırma Hastanesi, Fiziksel Tıp ve Rehabilitasyon Kliniği, Turkey

Cukurova Medical Journal 2020;45(1):395-396.

To the Editor,

Familial Mediterranean fever (FMF) is a hereditary disease which commonly affects the people of Mediterranean origin such as Turkish, Jewish, Arabic or Armenian. Mutations in the gene encoding for pyrin cause recurrent fever and pain in the abdomen, chest, joints and muscles[1]. Acute FMF attacks generally last 1-3 days and heal spontaneously[2]. Here, a rare FMF case which presenting continuous side pain symptom was reported.

A 31-year-old Turkish origin woman applied to our outpatient clinic with sustained left side pain for 3 years. In medical history; she had many admissions for several departments such as urology, gynecology and physical medicine and rehabilitation because of her pain. No response was obtained with urinary tract infection or non-steroidal anti inflammatory drugs and myorelaxant treatment. We detected that she had recurrent episodes of abdominal pain, chest pain and fever since the age of 13. Constant left side pain began following childbirth three years ago. She reported that her pain exacerbated 3-4 times in a month and chest pain, fever and chills symptoms appeared during this period. The severity of the pain has not changed by eating or drinking. In the physical examination, there were no apparent abdominal findings except minimal tenderness on palpation in left upper quadrant. In laboratory examination; complete blood count, routine biochemistry, urine analysis, markers of hepatitis, brucella and thyroid function tests were normal. Erythrocyte sedimentation rate was 23 mm/h (1-23), C-reactive protein level was 5.90 mg/L (0-5), fibrinogen was 419 mg/dL (200-400). Thracolumbar x-ray and abdominal ultrasound imaging was normal. We considered FMF diagnosis and requested genetic analysis based on the patient's past history. As a result, a heterozygous M680I (G/C) mutation was detected. Colchicine treatment was started 3 times daily. In the first week of treatment, the patient's side pain prominently decreased. After 2 months follow-up, only one FMF attack was observed, attack duration regressed from 4 days to 2 days and numeric rating scale (NRS) for side pain in attack-free period regressed from 10 to 1.

FMF is an autoinflammatory disease characterized by self-limited fever and polyserositis episodes[3]. Sudden onset and short-term abdominal episodes are observed in the majority of FMF patients. Although the pain is commonly local at first, it can be ultimately spread to the whole abdomen[4,5]. One of the important steps in FMF is the detection of the MEFV gene in 1997. The most common mutations in FMF are M694V, M680I, V726A, M694I located on exon 10 and E148Q located on exon 2. The prevalence of the disease in Turks varies between 1/400 and 1/1000[3,6].

Our patient applied to the our hospital with constant left side pain continuing for 3 years. In detailed history, periodic FMF attacks were detected. Genetic analysis supported our diagnosis. Good response was obtained with colchicine treatment.

As a result, FMF should be considered in patients with persistent side and abdominal pain as well as urinary tract and musculoskeletal system pathologies.

Yazışma Adresi/Address for Correspondence: Dr. Hüseyin Kaplan, Aksaray Üniversitesi Eğitim ve Araştırma Hastanesi, Fiziksel Tıp ve Rehabilitasyon Kliniği, Turkey E-mail: hkaplan_87@hotmail.com
Geliş tarihi/Received: 29.12.2019 Kabul tarihi/Accepted: 26.01.2020 Published online: 15.02.2020

Comprehensive history taking is very important to prevent delay in diagnosis.

Yazar Katkıları: Çalışma konsepti/Tasarımı: HK; Veri toplama: HK; Veri analizi ve yorumlama: HK; Yazı taslağı: HK; İçeriğin eleştirel incelenmesi: HK; Son onay ve sorumluluk: HK; Teknik ve malzeme desteği: HK; Süpervizyon: HK; Fon sağlama (mevcut ise): yok.
Hakem Değerlendirmesi: Dış bağımsız.
Çıkar Çatışması: Yazarlar çıkar çatışması beyan etmemişlerdir.
Finansal Destek: Yazarlar finansal destek beyan etmemişlerdir.
Author Contributions: Concept/Design : HK; Data acquisition: HK; Data analysis and interpretation: HK; Drafting manuscript: HK; Critical revision of manuscript: HK; Final approval and accountability: HK; Technical or material support: HK; Supervision: HK; Securing funding (if available): n/a.
Peer-review: Externally peer-reviewed.
Conflict of Interest: Authors declared no conflict of interest.
Financial Disclosure: Authors declared no financial support

REFERENCES

1. Simon A, van der Meer JW, Drenth JP. Familial Mediterranean fever-a not so unusual cause of abdominal pain. Best Pract Res Clin Gastroenterol. 2005;19:199-213.
2. Cakir M, Ozgenc F, Baran M, Arikan C, Sezak M, Tuncyurek M et al. A rare cause of refractory ascites in a child: familial Mediterranean fever. Rheumatol Int. 2010;30:531-4.
3. Alghamdi M. Familial Mediterranean fever, review of the literature. Clin Rheumatol. 2017;36:1707-13.
4. Mor A, Gal R, Livneh A. Abdominal and digestive system associations of familial Mediterranean fever. Am J Gastroenterol.. 2003;98:2594.
5. Ateş İ, Akca Ö, Bülbül İ, Yilmaz N. Case of familial Mediterranean fever presenting with constant abdominal pain. Reumatol Clin. 2016;12:299.
6. Jarjour RA, Dodaki R. Arthritis patterns in familial Mediterranean fever patients and association with M694V mutation. Mol Biol Rep. 2011;38:2033-6.