A triad of exophtalmos, pretibial myxedema and acropachy in a patient with Graves’ disease

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Abstract

A classical triad of extrathyroidal manifestations of Graves’ disease known as EMO syndrome (exophtalmos, pretibial myxedema and osteoarthropathy) is a rare condition. This paper presents a 39-year old male patient who underwent chemo- and radiation therapy of the supradiaphragmatic area due to Hodgkin’s disease at the age of 35 and 36 leading to remission. Two years later, the patient developed general symptoms of Graves’ disease and ophthalmopathy, with high thyroid stimulating hormone levels. Four months later, the patient presented with pretibial myxedema. Thirteen months after the onset of the disease, higher levels of thyroxine and decreased levels of thyroid stimulating hormone were registered. The diagnosis of EMO syndrome was confirmed by radiologic and histopathological analyses. Thiamazole and intralesional corticosteroid therapy were administered, resulting in euthyreosis and decrease of pretibial myxedema. The question is whether the autoimmune thyroid disease was triggered by the previous disease, or by chemo- and radiation therapy.

Key words

Graves’ Disease; Exophthalmos; Myxedema; Osteoarthropathy, Primary Hypertrophic; Syndrome

Back in 1786, Parry described the association between exophthalmos and goiter. Apart from these two manifestations, in 1935 Graves described thyrotoxicosis, and in 1840 Basedow described palpitations. Today, this disease is commonly called Graves’, or Graves’-Basedow disease (1).

It is a chronic autoimmune disease characterized by diffuse goiter, hyperthyreosis, ophthalmopathy and dermopathy (2). Hyperthyreosis affects 1-2% of women under the age of 40 years, whereas in men it is about ten times less common. It occurs in 0.3% of the general population, and out of this number, 4.3% have a subacute form of the disease (3).

Not all the abovementioned symptoms are always present, and others may occur as well. Thus, Thomas (in 1933) and Diamond (in 1959) described a triad of exophthalmos, pretibial myxedema and acral osteopathy, while Braun-Falco and Petzoldt suggested the term EMO syndrome (exophthalmos, pretibial myxedema and hypertrophic osteoarthropathy) in 1967 (4).

Out of extrathyroidal manifestations, ophthalmopathy, dermopathy and acropachy are most common. Pretibial myxedema is rarely an initial symptom of Graves’ disease (5). Ophthalmopathy affects about 30% of patients with Graves’ disease, dermopathy about 4%, and acropachy about 1% of patients (6). Symptoms of the disease occur independently of the production of thyroid hormones. Dermopathy was also described in euthyreosis (7, 8), and in hypothyreosis with subsequent hyperthyreosis (9). Cases of exophthalmos and myxedema in Hashimoto thyroiditis were reported as well (10), generally leading to hypothyreosis. There are opinions according to which all autoimmune thyroid
diseases are variants of one disease that has a predominant evolution in one direction or another (2).

**Case report**

This is a report of a 39-year old man, locksmith by profession, who underwent treatment of Hodgkin’s disease at the age of 35 and 36 with ABVD-MOPP [adriamycin, bleomycin, vinblastine, dacarbazine – mustargen (mechloretamine HCl), oncovin (vincristine), procarbazine, and prednisone] principle of chemotherapy (6 cycles), and 10 cycles of radiation therapy of the supradiaphragmatic area (mantle field), 20 sessions of TD=36 Gy (Grays). This treatment regimen showed to be effective in inducing stable remission.

Two years later, the patient presented with eyelid swelling, eyeball protrusion, fatigue, anxiety, insomnia, and normal appetite and body weight. Normal levels of triiodothyronine (T3) and thyroxine (T4) were found, with increased levels of the thyroid stimulating hormone (TSH). Four month later, red lumps appeared on the patient’s shins and dorsal feet. Nine months after that, about 13 months from the onset of the disease, elevated levels of T4 and decreased levels of TSH were recorded. Tiamazol therapy was initiated, 10 mg per day. The patient visited a dermatologist two months later. Skin biopsy was collected from the lesion on the lower leg and a diagnosis of circumscribed pretibial myxedema was confirmed. Apart from exophthalmos and myxedema, the patient presented with lesions on distal fingers and clubbing (Hippocratic) nails. At that time, the patient lost 3kg.

**Objective examination:** the patient was of medium height and a little undernourished. He had bilateral exophthalmos with lid edema (Figure 1). His thyroid gland was firm and nodular on the left side. He also presented with asthenia of the thorax and a narrowed mid-vertebral space. Heart: the patient had extrasystolic arrhythmia, systolic heart murmur at the Erb’s point. Lungs and abdomen: without symptoms.

**Dermatological examination** showed lesions of the lower extremities (Figure 2) and dorsal feet (on the sites of old injury scars). The lesions were almost symmetrical, with clearly defined painless infiltrates and nodules of firm consistency. The skin showed mild erythema, uneven surface with orange peel appearance due to prominent hair follicles. The hair was rough and partly missing. The small hand joints were painful to touch, with drumstick fingers and watch glass nails (Figure 3.).

**Laboratory analyses:** at the onset of the disease the following results were established: T3: 1,9 mmol/l (normally 1,2 – 3,0); T4: 101,0 mmol/l (normally 55.0 – 165.0); TSH: 9,1 U/l (normally 0.17 – 4.05). Thirteen months after onset: T3: 3.2 mmol/l, T4: 257 mmol/l, TSH: 0,14 U/l. After two, three and four months, levels of T3, T4, TSH, thyroglobulin and anti-thyroglobulin antibodies were normal. Other test results were in the normal range.

**Ophthalmologic findings:** exophthalmos and subacute conjunctivitis.

**Radiological findings** of the hands and long bones: the x-ray showed acropachy with hyperostosis of the diaphyseal portion of phalanges of the index and middle fingers (Figure 4), the rest without symptoms. Ultrasound of the thyroid gland: the thyroid gland was of normal size (isthmus 3mm, the right lobe 19x21, the left lobe 17x21), of hypoechogenic and nonhomogenous structure, without visible nodules. Orbital computed tomography: the orbital bone was of normal diameter and contours, without morphologic structural alterations. Both bulbs were of normal position and structure. The retrobulbar spaces were unremarkable, and both optic nerves normal. Hypophyseal computed tomography: sella turcica was of normal diameter with normal bone structures and without densimetric alterations.

**Histopathological findings:** the corneal layer and epidermis were without prominent changes.

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**Figure 1. Exophthalmos**
Figure 2. Pretibial myxedema: bilateral, almost symmetrical, clearly defined painless infiltrates and nodules of firm consistency, showing mild erythema and uneven surface with orange peel appearance (Figure 5). The dermis layer was thickened and collagen fiber networks were cross-linked. Fibroblasts were present, within normal levels, some star-shaped. Mucin dermal deposits were scarce in the papillary and more prominent in the rest of the dermis, presenting between abundant collagen fibers.

Therapy
Favistan® (tiamazol) tablets of 20mg were used, 2 x 1, later 2 x ½. The treatment with topical corticosteroids showed no visible improvement. Intral esional hydrocortisone injections caused reduction of pretibial changes to some extent. Exophthalmos and acropachy remained unchanged. The patient’s general condition was good all the time.

Discussion
The cause of Graves’ disease is unknown. A certain genetic predisposition is indicated by several family members suffering from the disease and its association with other autoimmune diseases, for example endocrine diseases (2).

Apart from heritage, other risk factors are evident as etiologic factors of Graves’ disease: smoking, immunosuppression, stress, some medications (for example amiodarone, interferon, lithium carbonate), iodine contrasts, radiation therapy of the neck, viral and bacterial infections, iodine insufficiency in the diet (4). Hyperthyroidism in Graves’ disease is due to the binding of stimulatory autoantibodies to the TSH receptor (TSHr) on thyroid follicular cells. The stimulation of this G protein coupled receptor by autoantibodies leads to excessive and uncontrolled production of thyroid hormone (11).

Development of extrathyroidal manifestations, such as ophthalmopathy and pretibial myxedema, is associated with positive feedback mechanisms including mechanical (trauma/pressure), immune (accumulation of immune cells, inflammatory citokynes, incresed expression of TSHr) and cellular processes (adipogenesis, incresed production of glycosaminoglycans/prostaglandin E.) (11). “A subclinical systemic inflammatory process might develop in Graves’ disease as activated T cells and
increased expression of TSHr. This increase in target antigen expression might cause further propagation of the immunological process in the orbit and pretibial skin. Increased orbital fat and GAG production would probably cause further impairment of venous and lymphatic drainage from the orbits and lower extremities, resulting in progression of Graves’ ophthalmopathy (GO) and pretibial dermatopathy (PTD)” (11).

Ophthalmopathy is the first extrathyroidal manifestation of Graves’ disease. In a study including 150 consecutive patients with pretibial myxedema, only one patient presented without ophthalmopathy (12). The clinical picture of this manifestation is characterized by proptosis, conjunctival injection, chemosis, diplopia, corneal ulcerations, and extreme cases of blindness due to optic nerve compression (13). Anti-TSHr antibodies correlate with clinical features of Graves’ ophthalmopathy. Anti-TSHr antibodies and orbital TSHr levels are clearly associated with Graves’ ophthalmopathy. The next extrathyroidal manifestation is pretibial myxedema or thyroidal dermopathy, which includes accumulation of GAG (glycosaminoglycans) in the dermis and subcutaneous tissue (15). It accounts for 10-12% of patients with Graves’ ophthalmopathy (12). Early lesions are bilateral, asymmetrical, with firm non-pitting edema, nodules or skin-colored, pink or purple papules. Late lesions develop by confluence of early lesions, symmetrically covering the pretibial region and may result in grotesque involvement of shins and feet. The skin is of orange-peel texture, sometimes even varicose. Depending on the clinical picture, several forms of dermopathy are described: nodular, diffuse and elephantiasic (17).

IgG recognize TSHr expressed in connective tissues. More significant involvement of the orbits and lower extremities might result from the accumulation of edema and inflammatory cytokines in these particular regions. This pooling of inflammatory mediators might be facilitated by unique anatomical and mechanical features if these regions. As fibroblasts from these sites appear to be especially sensitive to cytokine stimulation of metabolic processes, the local production of glycosaminoglycans (GAG) and inflammatory mediators would increase. In addition, cytokines or other local factors might stimulate the differentiation of orbital precursor cells into mature adipocytes with increased expression of TSHr. This increase in target antigen expression might cause further propagation of the immunological process in the orbit and pretibial skin. Increased orbital fat and GAG production would probably cause further impairment of venous and lymphatic drainage from the orbits and lower extremities, resulting in progression of Graves’ ophthalmopathy (GO) and pretibial dermatopathy (PTD)” (11).

Figure 4. X-ray of the hands: hyperostosis of the diaphyseal portion of phalanges of the index and middle fingers

Figure 5. Histopathological finding showing thickened dermis with cross-linked collagen fiber networks and scarce mucin deposits in the papillary dermis and more prominent deposits in the rest of the dermis, presenting between abundant collagen fibers (HE staining x 100)
intravenous immunoglobulins); plasmapheresis and somastatin analogues such as octreotide (insulin-like growth factor type-1-antagonist); systemic immunomodulators are used for regression of skin lesions (18); radiation therapy is also used, while surgical orbital decompression is used in the correction of exophthalmos, and surgery of extraocular muscles in the correction of diplopia (23).

Potent topical corticosteroids under occlusion may be used in the treatment of mild forms of pretibial myxedema. Oral use of pentoxifylline and topical use of clobetasol propionate are recommended for the improvement of myxedema and ophthalmopathy (24). In severe forms of myxedema, intralesional corticosteroids are used, which had positive effects in our patient; compression and complete decongestive physiotherapy are also used (25) as well as CO2 laser (7); surgical ablation and intravenous immunoglobulins are used in severe cases (26). In severe refractory pretibial myxedema, a combination of surgery and octreotide is performed (27), or intralesional octreotide (28).

Anyhow, the course of the disease does not only depend on applied medications, but also on the immune status of patients. Long-term remissions are possible, and in mild cases complete regressions as well.

Conclusion
This is a case report of a patient who developed exophthalmos, pretibial myxedema and hyperthyreosis after chemo- and radiation therapy of the supradiaphragmatic area due to Hodgkin's disease. Osteoarthropathy developed in the end, causing EMO syndrome. The applied therapy induced euthyreosis and regression of myxedema, but did not affect ophthalmopathy and acropachy.

Abbreviations
EMO syndrome - The combination of exophthalmos, pretibial myxoedema and hypertrophic osteoarthropathy
Gy - Gray
T3 - Thyronine
T4 - Thyroxine
TSH – Thyroid-stimulating hormone
TSHr – Thyroid-stimulating hormone receptor
GAG – glycosaminoglycans
GO - Graves' ophthalmopathy
PTD - Pretibial dermatopathy
References


Egzoftalmus, pretibijalni mikedem i akropatija – trijada prisutna kod obolelog od Grejsove bolesti

Sažetak

Uvod: Grejsova bolest je hronična autoimunska bolest koju karakteriše difuzna struma sa hipertireozom, oftalmopatijom i dermopatijom. Hipertireoza se javlja kod 1-2% žena mladih od 40 godina, dok je kod muškaraca veća za oko deset puta. Javlja se kod 0,3% pripadnika opšte populacije, a čak 4,3% ima supkliničku formu bolesti. Od ekstratiroidnih manifestacija najčešće se prvo javlja oftalmopatija, zatim dermopatija, pa akropatija. Retko pretibijalni mikedem može da bude inicijalni simptom Grejsove bolesti. Oftalmopatija se javlja kod 30% bolesnika sa Grejsovo bolesću, dermopatija kod 4%, a akropatija kod 1% bolesnika. Simptomi bolesti se javljaju nezavisno od produkcije tiroidnih hormona. Kompletna trijada ekstratiroidnih manifestacija pod imenom EMO sindrom (egzoftalmus, pretibijalni mikedem, osteoartropatija) u sklopu Grejsove bolesti retko se registruje.

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Prikaz slučaja: U ovom radu prikazan je bolesnik star 39 godina koji je u 35. i 36. godini lečen citostaticima i zračnom terapijom (supradijafragmalna regija) zbog Hočkinove bolesti i nakon toga doveden u stanje remisije. Dve godine kasnije javili su se opšti simptomi Grejvsove bolesti i oftalmopatija. Tada su registrovane i povišene vrednosti tireostimulišućeg hormona TSH. Četiri meseca kasnije nastao je i pretibijalni miksedem. U lečenju Hočkinove bolesti, nastao egzoftalmus, zatim je kasnije nastao egzoftalmus, a onda je registrovana hipertireoza.

Zaključak: Prikazan je bolesnik kod koga je, posle primene citostatika i zračenja supradijafragmalne regije, pojavio se i pretibijalni miksedem. Površina ulakova na leđima su bila dovoljno izražena da bi se moglo primeniti kortikosteroidi pod okluzijom.

Ključne reči
Gravesova bolest; Exophthalmos; Miksedem; Primarna hipertrofna osteoartropatija; Sindrom

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