Osteoid osteoma masquerading tubercular arthritis or osteomyelitis on MRI: Case series and review of literature

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Abstract

Magnetic resonance imaging (MRI) scans for osteoid osteoma could be misleading and can be misinterpreted as tuberculosis, especially when used as the principal modality of investigation. We retrospectively reviewed cases presenting to our institute for second opinion and selected six cases that were referred to our institute with a provisional diagnosis of tubercular arthritis or osteomyelitis and were identified to have osteoid osteoma. We reviewed the literature on typical and atypical clinical and radiological presentations of osteoid osteoma depending upon their location and present radiological features on MRI that should alert the radiologists toward a correct diagnosis.

Key words: Bone tumor; computed tomography; magnetic resonance imaging; osteoid osteoma; tuberculosis

Introduction

Osteoid osteoma is a common benign osteoblastic lesion comprising 10-12% of all benign bone tumors, most commonly seen in the second and third decades of life. Magnetic resonance imaging (MRI) scans for osteoid osteoma could be misleading and can be misinterpreted as tuberculosis (TB), especially when used as the principal modality of investigation.

MRI has become the investigation of choice for the clinicians in larger centers in India, principally due to improved access with the recent economic growth and also due to the impression that MRI is a “superior investigation.” TB, being highly prevalent in India, is a common radiological diagnosis in cases where MRI reveals juxta-articular marrow edema and soft tissue high signal. It is important for the clinicians and radiologists to be aware of the similarity in the radiological features of TB and osteoid osteoma on MRI scans to prevent misinterpretation. This could prevent unnecessary biopsy or anti-tubercular treatment (ATT) in patients.

We retrospectively reviewed cases presenting to our institute for second opinion and selected six cases that were referred to our institute with a provisional diagnosis of tubercular arthritis or osteomyelitis, and had been prescribed or had completed a course of ATT for a variable length of time before referral and were identified to have intra- or juxta-articular osteoid osteoma. We reviewed the literature on typical and atypical clinical and radiological presentations of osteoid osteoma depending upon their location and present the features on MRI that should alert the radiologists toward a correct diagnosis.

Cases

The first patient (patient 1) was a 14-year-old male who presented with a history of night pain in the left hip. He was diagnosed as tubercular osteomyelitis on the basis of MRI findings and had taken a 6 weeks course of ATT before referral to our hospital. The MRI of the patient [Figure 1] showed bone marrow edema in the proximal femur...
on the left side with thickening of the medial femoral cortex. Although no definite nidus could be appreciated, patient history, failure to respond to therapy, and cortical thickening raised the suspicion of an osteoid osteoma. The patient underwent a computed tomogram (CT) [Figure 2] of his left hip joint, which revealed a 6 × 8 × 14 mm nidus with central calcification and associated cortical sclerosis and periostitis. The patient underwent CT-guided biopsy and radiofrequency ablation. The biopsy confirmed osteoid osteoma and the patient has been symptom-free at the recent follow-up after 10 months.

The second case (patient 2) was a 21-year-old male patient who suffered from upper back pain and presented to our hospital with a diagnosis of Pott’s spine, and had no response from 8 months of ATT. Examination showed tenderness at T8-T9 level with a C-reactive protein (CRP) of 5.0 mg/l and erythrocyte sedimentation rate (ESR) of 4 mm/h. MRI examination [Figure 3] revealed extensive bone marrow edema in the left T9 transverse process, pedicle, posterior aspect of left T9 vertebral body, and left 9th costotransverse joint. Patient was sent for a CT of thoracic spine [Figure 4], which showed sclerosis and expansion of left T9 transverse process with an intraosseous nidus, highly suggestive of an osteoid osteoma. The patient underwent open surgical excision and biopsy that confirmed the diagnosis of an osteoid osteoma.

The third case (patient 3) was a 14-year-old male who presented with upper back pain persistent throughout the day and was referred to our hospital for a biopsy of an abnormal area of bone marrow edema within T3 lamina, with a diagnosis of TB of spine. The patient had received treatment with ATT for over a week. Review of the external MR images [Figure 5] showed a small nidus that could be appreciated within the lamina of T3 vertebra, along with bony expansion surrounding the bone marrow edema and high signal within the soft tissues around erector spinae muscles. A thin section CT of the dorsal spine [Figure 6] was performed and it revealed a 6-mm intraosseous nidus, with a 2-mm central area of calcification, within the lamina of T3 with bone expansion and surrounding sclerosis. Patient underwent laminectomy in another hospital and the histopathology report confirmed the diagnosis of an osteoid osteoma.

The fourth case (patient 4) was a 24-year-old male who presented with neck pain for the last 2-3 years and an external MRI (not available), which raised the suspicion of tubercular infection with non-specific marrow edema within lamina of C6 and mild syringomyelia. Patient was referred to our hospital for a second opinion, before starting ATT. A repeat MRI was performed as the previous images were not available, and it showed [Figure 7] periarticular bone marrow edema around right C6-C7 facet joint with surrounding soft tissue high signal. On careful review, a subtle 3 mm nidus with a tiny central signal void was suspected in the right C6 inferior articular process. A further CT scan [Figure 8] confirmed the presence of a small subarticular nidus within the right C6 inferior articular process with minimal surrounding sclerosis, consistent with an osteoid osteoma. The patient has opted for non-operative management and is currently on non-steroidal anti-inflammatory drugs (NSAIDs).

The fifth case (patient 5) was a 15-year-old male with right hip pain for 2 months, responding to NSAIDs. He had undergone MRI outside our hospital, which reported the diagnosis as tubercular arthritis. The patient had been...
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Figure 3: A 21-year-old male with a left D9 transverse process osteoid osteoma - patient 2 (A-C). (A) Coronal, (B) sagittal and (C) axial T2 fat-saturated images show bone marrow edema in the left D9 transverse process and costotransverse joint (white arrow). On careful review, an oval hypointense intracranial lesion (broken white arrow) was identified, which raised the suspicion of an osteoid osteoma nidus.

Figure 4: A 21-year-old male with a left D9 transverse process osteoid osteoma - patient 2 (A-C). (A) Coronal, (B) sagittal and (C) axial thin section CT images show sclerosis and expansion of left D9 transverse process (black arrow in C), pedicle, and the posterior aspect of adjacent vertebrae with a subarticular osteoid osteoma nidus (white arrow) near the costotransverse joint (black arrow in A). The nidus shows heterogeneous areas of calcification with a thin rim of surrounding halo.
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Taking ATT for 15-20 days before referral. On review of external MRI [Figure 9], an osteoid osteoma was suspected and a CT [Figure 10A and B] was performed, which showed a 6 × 6 × 12 mm juxtacortical nidus in the right femoral neck with associated sclerosis and mild joint effusion. A CT-guided radiofrequency ablation (RFA) [Figure 10C] was performed and the patient remained symptom-free at 20 months follow-up.

The final case (patient 6) was a 20-year-old male who presented with a history of pain in the right elbow with reduced joint movements for 3-4 months. Pain was present...
only at night and was relieved with NSAIDs. Outside MRI suggested an infective lesion, possibly tubercular, within the proximal ulna. The patient presented to our hospital for a biopsy before starting ATT. Review of the external MR images [Figure 11] revealed bone marrow edema within proximal ulna with surrounding soft tissue high signal and joint effusion; however, there remained a suspicion of an osteoid osteoma due to the clinical history. A CT [Figure 12A and B] was performed and it showed a subarticular nidus in the inferior portion of radial notch of ulna, with an eccentric area of calcification and surrounding reactive sclerosis, suggestive of an osteoid osteoma. A CT-guided RFA [Figure 12C] was carried out and the patient has been symptom-free 12 months after the procedure.

Discussion

Osteoid osteoma is a benign osteogenic tumor, usually < 1 cm in size, that accounts for approximately 13.5% of benign
The amount of reactive bone may vary from minimal, particularly with intramedullary and intra-articular lesions, to extensive sclerosis. Standard radiographs only provide subtle findings in the intra-articular lesion due to the absence of any perilesional sclerosis or periosteal reaction. Radiographic changes in joint TB are absent or non-specific in the early stages of the disease and, hence, are not of much use in differentiating these two pathologies.

MRI remains the modality of choice for bone tumor exploration. Some believe that MRI has limited value for diagnosis of osteoid osteoma, which may have been due to the relatively low-resolution MRI techniques employed in these studies. Typically, osteoid osteoma shows low signal intensity on T1- and T2-weighted images with bone marrow edema around the nidus and high contrast enhancement after gadolinium administration. The increased signal intensity of the lesion on T2-weighted or enhanced T1-weighted images has been pathologically correlated with the degree of vascularity of the fibrovascular nidal stroma and the amount of osteoid substance within the nidal. Calcified osteoid within the nidal is typically represented as a central area of signal void. Intra-articular lesions may demonstrate synovial thickening apparent on MRI, with the diagnosis confirmed after gadolinium injection. However, precise localization of the nidal may not be easy. The nidal may not be visualized in 35% of the cases because of the associated surrounding perilesional edema and in 50% of the cases, atypical presentation of the nidal may lead to misdiagnosis. Osteoid osteoma may be mistaken for inflammatory or infectious arthritis, aseptic osteonecrosis of the femoral head, fatigue fracture, radicular syndrome, pigmented villonodular synovitis, or even tubercular arthritis. Five out of six cases presented in our series had intra- or juxta-articular osteoid osteoma, which explains the cause of confusion.

CT remains the examination of choice when using high-resolution contiguous millimetric thin slices, thus providing accurate data regarding the size and location of the lesion. The typical appearance of an intra-articular osteoid osteoma on CT images is that of a round or oval low-attenuation nidal surrounded by varying degrees of sclerosis. Calcification within the nidal is variable, occurring in 50% of cases reported by Kransdorf et al. Patterns of calcification include “punctate, amorphous, or ring-like, due to dense central mineralization.” The density of the tumor increases with age, and thereby provides an indication of the lesion’s maturity. The vascular groove sign, defined as serpigenous or linear grooves extending from the periosteal surface of the cortical bone down to the nidal, is a moderately sensitive but highly specific sign of osteoid osteoma that helps in differentiation and improves confidence in atypical indeterminate cases. These radiating grooves represent prominent enlarged feeding
arterioles that have become encased by the hyperostotic reaction incited by the osteoid osteoma nidus. Additional CT findings include “changes often seen on both sides of the joint,” described as osteophyte formation at the joint margins, muscle wasting, a localized soft tissue mass, and reduced bone density.

TB can occur almost at any site within the body and has three different patterns of involvement in the spine, depending upon the stage of the disease: Osteitis, osteitis with an abscess, and osteitis with or without an abscess plus discitis. Abscess formation and collection of granulation tissue adjacent to the vertebral body is highly suggestive of spinal TB. The involvement of posterior spinal element is generally not a characteristic feature of spinal TB. Joint TB is monoarticular with the initial presentation involving soft tissue swelling and joint effusion. Later, a classic triad of radiological findings, known as the Phemister triad, is seen, which includes juxta-articular osteopenia, joint space narrowing, and erosions. If a sclerotic rim is present around the nidus that is sub-periosteal or subchondral in location and lacks central calcification, differentiation from tuberculous osteomyelitis or a small Brodie’s abscess can be difficult. MRI features of a Brodie’s abscess, i.e. high signal intensity on fat-suppressed T2W images, lack of central contrast enhancement, and target appearance with “penumbra sign,” are characteristic. A biopsy is always recommended and it may be considered obligatory in every case presenting as osteitis or osteitis with periarticular soft tissue edema (before abscess formation) in countries where TB is not common. However, since TB is quite common in India, ATT is sometimes started without a biopsy in patients presenting with marrow edema and surrounding soft tissue high signal on MRI and suspected to be suffering from bone or joint TB.

The cases presented above were diagnosed as tubercular arthritis or osteomyelitis and came to our institute for a second opinion. It is important to understand that the nidus can be less conspicuous and is not consistently visualized on MRI than with CT. MRI is more sensitive than CT in detecting bone marrow and soft tissue changes adjacent to the nidus, and should be interpreted with caution in order to avoid erroneous diagnosis. Diagnosis only on the basis of MR images may be very difficult, since they may demonstrate a more aggressive appearance than that suggested by a plain radiograph and CT imaging. Both volume averaging and decreased MR spatial resolution may make the nidus less conspicuous. Therefore, it is important that state-of-the-art MRI techniques with fast-spin echo, 512-image-matrix acquisition are obtained. CT is more accurate than MRI in demonstration of the nidus, and is the diagnostic modality of choice for osteoid osteoma. Thin-section CT (1 mm slices) reconstructed in bone algorithm with multi-planar reformat is optimal and should be obtained whenever osteoid osteoma is suspected.

Bone marrow edema in posterior elements of spine, with surrounding soft tissue edema should be interpreted with caution. All the cases of spinal osteoid osteoma involved only posterior elements, which is not typical in TB. TB of the posterior elements is usually associated with bone destruction, more marked adjacent soft tissue changes, and abscesses formation. Table 1 lists the findings on MRI one should specifically take note of to alert one to the possibility of an osteoid osteoma over TB.

**Conclusion**

We believe that both high-resolution CT and state-of-the-art high-spatial resolution MRI have the capability to significantly improve the detection of nidus for diagnosis of osteoid osteoma, if we remain aware of their relative common occurrence at juxta- or intra-articular sites, along with being familiar with their specific MRI findings. We would like to emphasize that when a diagnosis of tubercular arthritis or osteomyelitis is being considered on the basis of juxta-articular soft tissue and bone marrow changes or while reviewing external MRI, it is important that (1) images are interpreted with caution, making sure not to miss an inconspicuous nidus; (2) we make sure that state-of-the-art MRI techniques have been used; and (3) a low threshold is kept for performing high-resolution CT imaging, which is the modality of choice for detection of osteoid osteoma lesion.

**References**

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