

A.I.M series

گنجینه برتر داخله

مجموعه پرسش ها و
پاسخ های تشریحی
تفکیک شده

آزمون مورد و ارتقا

رومانولوژی

از سال ۱۳۹۹ تا ۱۴۰۴
بر اساس

۲۰۲۵
هاریسون

گردآوری و تالیف

دکتر سید مجتبی نكوفدم

متخصص بیماری های داخلی

استادیار دانشگاه علوم پزشکی شهید بهشتی

رتبه یک مورد تخصصی ۱۳۹۴

دکتر سها یکتا

رتبه ۵ درصد برتر مورد تخصصی بیماری های داخلی

عضو هیئت علمی دانشگاه علوم پزشکی گیلان

کتاب پیش رو که به همت انتشارات وزین آرتین طب و مساعی جمعی از پزشکان جوان و علاقه مند، به رشته‌ی تالیف درآمده است، حقیقتاً گنجینه‌ای ارزشمند از سوالات مورد و ارتقای سالیان گذشته است که بر اساس منبع جدید امتحانات داخلی یعنی هریسون 2025 بازنویسی و تشریح شده است. تا جاییکه این حقیر مطلع هستم، در میان مکتوبات و مطبوعات پزشکی، کتابی با این رویکرد که سوالات هر درس را به طور مجزا و اختصاصی جمع‌آوری نموده و به تفصیل پاسخ هر سوال را بر اساس آن فصل استخراج نموده باشد در طی این سال‌ها کم‌سابقه و حتی بی‌سابقه بوده است و این به یقین راه را برای دستیاران عزیزی که اغلب برای آمادگی آزمون مورد اقدام به مطالعه‌ی درس به درس کتاب می‌نمایند هموار تر و آسان‌تر خواهد نمود. امید که این وجیزه گامی هرچند کوچک در راه تسهیل مسیر دشوار طبابت و مطالعه‌ی آن جهت همکاران محترم دانشجو و دستیار بر داشته باشد.

اما نه طبیب آدمی کش
تا معنی آن تمام دانی

می‌باشد طبیب عیسوی هُش
می‌کوش به هر ورق که خوانی

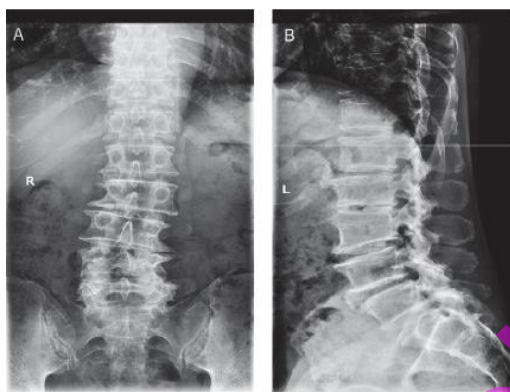
معلم کوچک طب داخلی
سید مجتبی نکو قدم

Contents

7.....	Low Back Pain :18	فصل
13.....	Neck Pain :19	فصل
15.....	Urticaria, Angioedema, and Allergic Rhinitis :363	فصل
16.....	Systemic Lupus Erythematosus :368	فصل
31.....	Antiphospholipid Syndrome :369	فصل
38.....	Rheumatoid Arthritis :370	فصل
51.....	Acute Rheumatic Fever :371	فصل
55.....	Systemic Sclerosis (Scleroderma) and Related Disorders :372	فصل
69.....	Sjögren's Disease :373	فصل
77.....	Spondyloarthritis :374	فصل
95.....	The Vasculitis Syndromes :375	فصل
109.....	Behçet Syndrome :376	فصل
115.....	Inflammatory Myopathies :377	فصل
125.....	Relapsing Polychondritis :378	فصل
127.....	Sarcoidosis :379	فصل
139.....	IgG4-Related Disease :380	فصل
	Familial Mediterranean Fever and Other Hereditary Autoinflammatory Diseases :381	فصل
145.....		
147.....	Musculoskeletal Disorders Approach to Articular and :382	فصل
152.....	Osteoarthritis :383	فصل
162.....	Gout and Other Crystal-Associated Arthropathies :384	فصل
174.....	Fibromyalgia :385	فصل
	Arthritis Associated with Systemic Disease, and Other Arthritides :386	فصل
178.....		
188.....	Periarticular Disorders of the Extremities :387	فصل

فصل 18: Low Back Pain

1- آقای 67 ساله به علت کمردرد مکانیکال که از یک سال قبل شروع شده مراجعه کرده است. در معاینه بیمار حرکات ستون فقرات محدود بوده اما تندرست موضعی ندارد. رادیوگرافی بیمار را مشاهده می‌کنید:



محتمل‌ترین تشخیص کدام است؟ (ارتقا 1401)

الف) DISH

ب) Spinal Spondylosis

ج) Ochronosis

د) Ankylosing Spondylitis

پاسخ: ب

نگارنده: این سوال براساس چاپ قبلی هاریسون طراحی شده که در فصل اسپوندیلوآرتروپاتی و کمردرد به اصطلاحاتی از جمله اسپوندیلوزیس پرداخته بود که در هاریسون 2025 حذف شده است و صرفاً به‌طور خلاصه به آن اشاره شده است. در این قسمت به بررسی گزینه‌ها جهت رسیدن پاسخ صحیح می‌پردازیم.

DISH یک وضعیت غیرالتهابی و دژنراتیو است که با استخوان‌سازی جدید در لیگامان طولی قدامی و خلفی در حداقل چهار جسم مهره‌ای و نیز استئوفیت‌های حجیم flowing به طور تیپیک در سمت راست ستون فقرات همراه است که در تصویر داده شده این نمای کلسیفیکاسیون در لیگامان‌ها دیده نمی‌شود (رد گزینه الف). بیماری AS اغلب با درد کمر، هیپ و باتک تظاهر می‌کند که این علائم قبل از سنین 40-45 سالگی شروع می‌شود و برخلاف بیمار مورد سوال ماهیت التهابی دارد. در تصویربرداری شواهد ساکروایلئیت، Romanus lesion، مربعی شدن تنه مهره، سین دیسموفیت، bamboo spine و انکیلوزیس و Andersson lesion دیده می‌شود. دقت شود که سین دیسموفیت‌های تیپیک AS به صورت عمودی قرار می‌گیرند برخلاف استئوآرتрит که استئوفیت‌ها افقی هستند. (رد گزینه د). Ochronosis می‌تواند یک فنوتیپ شبیه به AS ایجاد کند (رد گزینه ج) که البته این عنوان از متن مباحث روماتولوژی هاریسون 2025 حذف شده است. با توجه به سن بالای بیمار و ماهیت مکانیکال کمردرد مزمن و هم‌چنین شواهد رادیوگرافیک مبنی بر کاهش فضای مفصلی، وجود استئوفیت و اسکروز endplate، تشخیص محتمل یک بیماری دژنراتیو مفصلی از قبیل اسپوندیلوزیس می‌تواند باشد که در جدول 18-1 به آن اشاره شده است. مطالعه دقیق جداول زیر که از مطالب جدید هاریسون 2025 می‌باشد توصیه می‌گردد.

TABLE 18-2 Summary of Common Physical Exam Maneuvers for the Low Back		
TEST	DESCRIPTION	COMMENTS
Lumbar Radiculopathy		
Straight leg raising (SLR)	The patient is in a supine position. The examiner passively flexes the leg of the affected side at the hip, reproducing radicular pain.	SLR has greatest sensitivity (80%) for impingement of the L5 or S1 nerve roots; sensitivity markedly decreases for nerve roots cephalad to L4. Unreliable for eliciting radicular symptoms from spinal stenosis.
Crossed SLR	The patient is in a supine position. The examiner passively flexes the leg of the nonaffected (contralateral) side at the hip, reproducing radicular pain in the affected leg.	High specificity (>85%) but low sensitivity.
Femoral stretch	The patient is in a prone position. The examiner passively extends the leg of the affected side at the hip, reproducing radicular pain in the thigh.	Modest sensitivity (50%) for L2–L4 nerve root impingement.
Sacroiliac (SI) Joint Provocation		
Compression	The patient is in a lateral decubitus position with the affected side up, with hips and knees flexed; the examiner exerts downward pressure on the superior border of the iliac crest.	There are no physical examination maneuvers that reliably distinguish between intraarticular and extraarticular pathologies, but most tests have been studied based on blocks diagnosing intraarticular pathology.
Thigh thrust (posterior shear test [POSH]; femoral shear test)	The patient extends their unaffected leg while in a supine position. On the affected side, the examiner flexes the patient's hip to 90° and simultaneously flexes the ipsilateral knee while applying downward pressure along the longitudinal axis of the femur.	Estimated sensitivities and specificities for individual tests vary greatly. The thigh thrust, FABER, and pelvic torsion tests have relatively greater sensitivities (up to 50–80%), whereas the compression and distraction tests have relatively greater specificities (up to 70–80%).
Distraction (gapping test)	The patient is in a supine position. On the affected side, the examiner applies downward (dorsolateral) pressure on the ipsilateral anterior superior iliac spine (ASIS).	A battery of ≥3 tests is generally accepted as having the greatest overall sensitivity (potentially ≥90%) and specificity (potentially ≥80%).
Flexion, abduction, and external rotation (FABER; Patrick's test)	The patient is in a supine position. On the affected side, the examiner flexes the patient's hip and knee and positions the foot under the contralateral knee (abduction). While stabilizing the contralateral ASIS with one hand, the examiner uses their other hand to apply downward pressure on the knee of the affected side (external rotation).	
Pelvic torsion (Gaenslen's test)	The patient is in a supine position, usually on the edge of an examining table. The examiner hyperextends the leg of the affected side while maximally flexing the hip and knee of the unaffected side against the patient's abdomen.	
SI Joint Mobility/Alignment		
Standing hip flexion test (SHFT; Gillet's test; Stork test)	The patient stands upright with both feet on level ground. The patient is instructed to lift one leg by flexing their hip and knee toward the chest. The examiner stands behind the patient and observes the spine and pelvis. The test is repeated in the other leg for comparison.	During hip flexion, the ipsilateral ASIS should rise slightly while the posterior superior iliac spine (PSIS) drops slightly. If these motions are paradoxical (i.e., PSIS rises with hip flexion) or asymmetrical, this suggests SI joint mobility dysfunction.
Deep Gluteal Syndrome/Piriformis Syndrome		
Freiberg's sign	The patient is in a supine position. The examiner passively extends, adducts, and internally rotates the thigh and calf ("log roll") on the affected side.	Assesses potential impingement of the sciatic nerve by nonspine structures (e.g., piriformis muscle, gluteal muscles) by stretching the piriformis and associated (e.g., gemelli) muscles, which can produce symptoms similar to those of lumbar radiculopathy.
Flexion, adduction, and internal rotation (FADIR; FAIR test)	The patient is in a supine position. On the affected side, the examiner flexes the patient's hip and knee, and while maximally adducting the thigh, internally rotates the hip.	
Pace test	In a sitting position, the patient is asked to abduct and externally rotate their hip, eliciting pain.	There are variants in which the patient lies supine with the hips and knees flexed.
Beatty test	The patient is positioned in a lateral decubitus position with the affected side up. Elevating the affected leg elicits pain in the buttocks.	Unlike the FAIR test and Freiberg's sign, this test causes contraction of the piriformis muscle and thus may not reliably elicit sciatic nerve entrapment symptoms.
Spondyloarthritis/Ankylosing Spondylitis		
Schober test	The patient stands upright, and horizontal lines are drawn across L5 and 10 cm superior to L5. The patient is asked to bend forward and touch their toes. If the distance between the drawn lines increases <5 cm, this indicates decreased range of motion and is a positive result.	Numerous modifications exist regarding the location of the drawn lines. Nonspecific for inflammatory spinal arthritis (i.e., other conditions such as discogenic pain associated with decreased forward flexion can lead to a positive result).
Nonorganic Signs/Functional Disorders		
(Neurologic and/or psychiatric consultations potentially indicated prior to interventional procedures)		
Hoover's sign	The patient is in a supine position. The examiner asks the patient to flex the leg of the affected side at the hip, against resistance. If an organic source of neuropathy or paresis is present, with normal effort, the unaffected leg will involuntarily push downward on the examination table.	A discordant response might suggest malingering or the presence of a functional neurologic disorder (e.g., conversion disorder).
Tripod sign	With the patient in a seated position, elevating the affected leg may result in pain in the leg and back.	Leaning back and resting both hands on the table should reduce the pain. Failure to do this may suggest nonorganic pathology or malingering.
Waddell signs	Five categories of signs: (1) nonanatomic distribution of tenderness; (2) pain from sham stimulation (i.e., lumbar pain from gentle downward force on the shoulders); (3) distraction (i.e., positive SLR test in supine position but not while sitting, or while preoccupied); (4) regional disturbances (i.e., motor or sensory findings that do not correlate with areas of pathology); and (5) overreaction (i.e., disproportionate physical or emotional responses on exam).	A greater number of positive signs is associated with a greater risk of treatment failure.

ETIOLOGY	RISK FACTORS	TYPICAL ONSET	CLINICAL PRESENTATION	PHYSICAL EXAM	DIAGNOSTIC TESTS	TREATMENTS*
Mechanical Pain						
Myofascial pain	Srenuous activities, sedentary lifestyle, abrupt movements (sneezing)	Usually insidious (chronic) but sometimes acute (muscle tear or spasm)	Axial pain, occasionally referred into thigh, mid-back, or groin. Often superimposed with other etiologies.	Tenderness, occasionally trigger points. Midline tenderness in between spinous processes may indicate ligamentous injury.	Occasionally ultrasound or electromyography	<i>Pharmacologic:</i> NSAIDs; nonbenzodiazepine muscle relaxants; antidepressants (e.g., duloxetine, tricyclic compounds); topical analgesics (e.g., diclofenac, lidocaine in those with irritable nociceptors or allodynia) <i>Interventional:</i> trigger point injections
Intervertebral disks	Advanced age (although patients younger than those with facet joint pain), acute (torsional event) or repetitive trauma, genetic predisposition	Insidious, occasionally abrupt (e.g., annular tear)	Axial pain, may radiate into extremities, more likely to be bilateral than SI or facet joint pain, worse with sitting	Midline tenderness, reduced range of motion (especially forward flexion)	Discography (high false-positive rate), bony vibration test; MRI generally nonspecific but high-intensity zone correlates with discography results	<i>Pharmacologic:</i> NSAIDs; antidepressants (e.g., duloxetine) <i>Interventional:</i> biacuplasty or IDET can be considered, but evidence for long-term benefit is mixed and disk puncture may increase risk of future disk degeneration; the benefit for intradiscal corticosteroid injections or ESI unclear
Vertebral	Advanced age/osteoporosis, trauma	Abrupt (trauma) or insidious	Axial pain that may radiate into upper leg, worsened with activities	Midline tenderness	MRI to identify endplate abnormalities and acute, plain films for acute fractures. Bony vibration test sometimes used.	<i>Pharmacologic:</i> NSAIDs; antidepressants (e.g., duloxetine); topical analgesics (e.g., diclofenac, lidocaine) only if superimposed soft tissue pain. Judicious use of opioids can be considered for severe pain secondary to acute fracture(s). <i>Interventional:</i> In acute vertebral compression fracture(s) (<6 weeks) with severe pain or disability, percutaneous vertebral augmentation (vertebroplasty or kyphoplasty) can be considered. The benefit for vertebral augmentation in chronic fractures is mixed. In patients with chronic axial pain with Modic type 1 or type 2 vertebral endplate/bone marrow changes on MRI and in whom other lumbar structures are less likely to be the predominant source of pain, basivertebral nerve RFA can be considered.
Facet joints	Increases with age, repetitive strain, genetic predisposition	Insidious	Axial pain may radiate into upper and occasionally lower legs. About half are bilateral.	Paraspinal tenderness, improved with sitting	CT or MRI generally reveals degeneration. Diagnostic medial branch or intraarticular injections.	<i>Pharmacologic:</i> NSAIDs; antidepressants (e.g., duloxetine) <i>Interventional:</i> RFA of the relevant medial branch nerves when preceded by a positive diagnostic block (e.g., >50% reduction in pain)
SI joint	Bimodal prevalence (younger individuals with unilateral extraarticular pathology often secondary to trauma, older people with bilateral intraarticular pathology). True and apparent leg length discrepancies, hip pathology, inflammatory arthritis (intraarticular), and lumbar spine surgery are predisposing factors.	Abrupt for extraarticular, insidious for intraarticular.	Unilateral (younger individuals, post-trauma) or bilateral (older individuals, intraarticular). About half of cases radiate into leg, sometimes below knee.	Tenderness below L5; positive provocative tests. Most painful area located near posterior superior iliac spine.	Advanced imaging (especially CT) may indicate intraarticular pathology. Battery of provocative tests correlate well with diagnostic injections.	<i>Pharmacologic:</i> NSAIDs; antidepressants (e.g., duloxetine); topical analgesics (e.g., diclofenac, lidocaine) only if superimposed soft tissue pain <i>Interventional:</i> Intra- and/or extra-articular SI joint injection; RFA of the sacral lateral branch nerves for extraarticular pathology; minimally invasive fusion of the SI joint in refractory cases involving joint degeneration or instability

(Continued)

TABLE 18-3 Clinical Evaluation, Diagnosis, and Treatment of Low Back Pain Etiologies (Continued)						
ETIOLOGY	RISK FACTORS	TYPICAL ONSET	CLINICAL PRESENTATION	PHYSICAL EXAM	DIAGNOSTIC TESTS	TREATMENTS*
Predominantly Radicular Pain						
Herniated disk	Peak prevalence 30–50 years, preexisting disk degeneration, trauma, genetic predisposition, lifestyle (heavy lifting, smoking), obesity	Often abrupt, may be insidious	May be unilateral or bilateral (large, central herniation) pain radiating into leg in dermatomal distribution	Most patients also have back pain. Sensory loss and neurologic weakness common; may be associated with diminished reflexes. Straight leg raising test usually positive for lower lumbar levels.	MRI or CT scan, myelography when contraindicated. Electrodiagnostic tests or selective nerve root blocks may be confirmatory.	<i>Pharmacologic:</i> NSAIDs; nonbenzodiazepine muscle relaxants; antidepressants (e.g., duloxetine). Gabapentinoids are commonly used (gabapentin, pregabalin), but systematic reviews and meta-analyses suggest minimal benefit when balanced against potential harms (e.g., dizziness, somnolence, gait disturbance). <i>Interventional:</i> ESIs, which are likely most effective in the acute phase of radicular pain secondary to disk herniation. ESIs might confer a weak but potentially meaningful surgery-sparing effect.
Spinal stenosis	Advanced age, concomitant spinal pathology (disk degeneration, spondylolisthesis, facet hypertrophy)	Usually insidious	Usually unilateral for lateral recess or foraminal stenosis; central stenosis may be unilateral or bilateral. Wide-based gait, often affects multiple dermatomes. Pain often improves with sitting. Although the severity of pain and disability may wax and wane, the causes of spinal stenosis (e.g., spondylolisthesis, degenerative changes/osteophyte formation) often progress with age.	Sensory and motor deficits: SLR test usually negative. Improved walking ability when bending forward.	MRI or CT scan	<i>Pharmacologic:</i> NSAIDs; nonbenzodiazepine muscle relaxants; antidepressants (e.g., duloxetine). Gabapentinoids are commonly used (gabapentin, pregabalin), but systematic reviews and meta-analyses suggest minimal benefit when balanced against potential harms, especially in the elderly (e.g., dizziness, somnolence, gait disturbance). <i>Interventional:</i> ESIs commonly used and may confer short-term and sometimes intermediate-term benefit, but evidence for long-term benefit is mixed given the progressive pathology.
Neuropathy	Underlying neuropathic pain condition (e.g., herpes zoster, diabetic amyotrophy)	Generally insidious, acute for herpes zoster	Lumbosacral dermatomes less common with herpes zoster than thoracic dermatomes. Unilateral (herpes zoster), occasionally bilateral (advanced neuropathies). Advanced neuropathies usually multidermatomal.	Sensory and motor loss, diminished reflexes	Workup for underlying cause; advanced imaging may rule out disk pathology	<i>Pharmacologic:</i> gabapentinoids (gabapentin, pregabalin), antidepressants (e.g., SNRIs, TCAs), topical local anesthetics (e.g., lidocaine patches or creams), topical capsaicin. Other anticonvulsants (e.g., oxcarbazepine, lamotrigine) are occasionally used, but minimal evidence is available. <i>Interventional:</i> peripheral nerve blocks might confer analgesia, but evidence for long-term benefit is minimal or negative for certain conditions (e.g., PHN).
Nociplastic Pain						
Nonspecific back pain	Central sensitization, more common in females, peak age 20s to 50s, genetic predisposition	Usually insidious, but >20% report a physical or psychological inciting event	Bilateral, often involves other spinal regions, frequently radiates into legs. Most patients have other nociplastic and nocioplastic pain conditions. High co-prevalence rate of mood disorders and sleep dysfunction.	Marked diffuse tenderness, provocative tests often positive but nonspecific, neurologic exam nonfocal	Based on clinical presentation. Patients often score in “neuropathic” range on validated instruments (painDETECT); central sensitization inventory and conditioned pain modulation may confirm central sensitization.	<i>Pharmacologic:</i> NSAIDs; nonbenzodiazepine muscle relaxants; antidepressants (e.g., duloxetine); gabapentinoids (gabapentin, pregabalin); over-the-counter topical analgesics (e.g., diclofenac, lidocaine, menthol). Nonpharmacologic therapies (e.g., physical therapy, targeted exercise) should be prioritized.

Mixed Pain Phenotypes

Most neuropathic conditions have concomitant mechanical pain (e.g., spinal stenosis may be from facet hypertrophy or degenerated/herniated disks, which in themselves can cause mechanical pain); herpes zoster can cause cutaneous inflammatory pain.

Postlaminectomy syndrome	Younger age, female sex, opioid use, greater presurgical disease burden, more concurrent pain conditions (e.g., baseline central sensitization)	Poor patient selection (e.g., irrelevant surgical levels), pseudoarthroses, and retained fragments may result in no benefit. Epidural scar tissue, arachnoiditis, and muscle wasting may present with worsening pain weeks or months after surgery. Adjacent segment disease can take >1 year to manifest.	Often involves axial and radicular pain in a multidermatomal fashion	Sensory loss and weakness common. Neurologic signs may be in multiple dermatomes. Muscle wasting and/or loss or lordosis may be appreciated. Superficial tenderness is common in individuals with nociceptive pain.	MRI with gadolinium, or even myelography. Diagnostic blocks (e.g., discography, facet blocks) are associated with a high false-positive rate.	Pharmacologic: NSAIDs; nonbenzodiazepine muscle relaxants; antidepressants; gabapentinoids (depending on whether neuropathic or nociceptive symptoms predominate) Interventional: Epidural lysis of adhesions can be considered in individuals with epidural scar tissue. SCS can be considered in refractory cases, especially those in whom neuropathic symptoms predominate.
--------------------------	---	--	--	---	---	--

*Nonpharmacologic treatments such as physical therapy, along with the management of concomitant mood disorders and maladaptive coping mechanisms (e.g., via pain psychology or CBT), should be considered for all patients with chronic pain.

Abbreviations: CBT, cognitive-based therapy; CT, computed tomography; ESI, epidural steroid injection; IDET, intradiscal electrothermal therapy; MRI, magnetic resonance imaging; NSAID, nonsteroidal anti-inflammatory drug; PHN, postherpetic neuralgia; RFA, radiofrequency ablation; SCS, spinal cord stimulation; SI, sacroiliac; SLR, straight leg raise; SNRI, serotonin-norepinephrine reuptake inhibitor; TCA, tricyclic antidepressant.

CLINICAL CHARACTERISTIC	NOCEPITIVE PAIN	NEUROPATHIC PAIN	NOCIPLASTIC PAIN
Etiology	Cumulative stress	Usually preceded by spine degeneration; herniated disk may sometimes occur after inciting event	Usually insidious, but sometimes occurs after physically or psychologically traumatic event
Onset	Insidious	Usually insidious	Usually insidious
Examples/causes	Degenerative spondylosis, myofascial pain	Herniated disk, spinal stenosis	Nonspecific back pain; may present as mechanical or radicular pain
Descriptors	Aching, deep, throbbing	Sharp, shooting, lancinating	Usually similar to neuropathic descriptors, but may include nociceptive ones as well
Sensory deficits	Uncommon	Common	Occur sometimes, but often outside of any dermatomal distribution
Motor deficits	May be pain-induced	Frequent	Pain-induced weakness, fatigue common
Hypersensitivity	Occasionally, with myofascial pain	Common	Extremely common
Pain pattern	May be referred into leg (usually proximally) in nondermatomal distribution	Reflects dermatomal pattern	Diffuse, often outside of any anatomic pain patterns
Precipitating/relieving factors	Worse with activities that stress structure	More unpredictable; spinal stenosis may be alleviated by forward flexion	Unpredictable, typically worse with stress
Autonomic signs	Uncommon	Present in up to 25% of patients	Sympathetic nervous system hyperactivity and postural orthostatic tachycardia syndrome (POTS) very common
Accompanying symptoms	Co-existing psychopathology common, and increased rate of neck pain	Higher levels of psychological stress and quality of life decrements than in nociceptive pain	Very high levels of psychological distress and sleep abnormalities; generally co-prevalent with other nociplastic conditions
Diagnosis	Imaging correlated with history and physical exam and diagnostic blocks	History and neurologic exam, instruments such as s-LANSS and painDETECT ^a	History (e.g., multiple concomitant nociplastic and nonnociplastic conditions), physical exam (e.g., diffuse tenderness), instruments (central sensitization inventory), and psychophysical tests (conditioned pain modulation)

^aS-LANSS (self-report version of the Leeds Assessment of Neuropathic Symptoms and Signs) and painDETECT are patient-reported questionnaires used to distinguish neuropathic from nonneuropathic pain. Developed before the term *nociplastic pain* was proposed, individuals scoring in the predominantly or likely "neuropathic pain" range in the absence of identifiable nerve damage are often presumed to have nociplastic pain.

Demographics	
Age <18 years	Congenital defect, tumor, spondylolysis, or spondylolisthesis
Age >50 years	Tumor, fracture, vascular abnormality (aortic aneurysm)
Social and Treatment Related	
Intravenous drug use	Infection
Anticoagulant use	Hematoma
Recent procedure	Hematoma (complication after spine procedure) or infection
Immunocompromised state	Infection
Trauma	Fracture, hematoma
History of cancer	Tumor
Symptoms	
Fever, night sweats, chills	Infection, tumor
Weight loss	Tumor, infection
Saddle anesthesia	Cauda equina syndrome
Urinary or rectal incontinence, sexual dysfunction	Cauda equina syndrome
Rapidly progressive or severe neurologic symptoms	Cauda equina syndrome
Pain not relieved by rest or at night	Tumor, infection
Physical Exam Signs	
Saddle anesthesia	Cauda equina syndrome
Decreased rectal tone	Cauda equina syndrome

فصل 19: Neck Pain

1. آقای 60 ساله به دلیل درد گردن هنگام کار، از چند ماه قبل مراجعه کرده است. انتشار درد به شانه و بازوها و پس سر ندارد. درد فک هنگام جویدن غذا احساس نمی‌کند و خشکی صبحگاهی ندارد حرکات گردن محدودیت ندارد. درد در انتهای فلکشن و اکستنشن گردن تشدید می‌شود. معاینه نبض اندامهای فوقانی و سمع کاروتیدها و حرکات شانه‌ها و معاینه عصبی طبیعی است. معاینه عمومی بیمار نیز نکته‌ای ندارد. برای بیمار آزمایشی درخواست نشده است. تصویر رادیوگرافی بیمار را ملاحظه می‌نمائید. محتمل‌ترین تشخیص بیمار کدام است؟ (بورد 1399)



الف) Cervical spondylosis

ب) Diffuse idiopathic skeletal hyperostosis

ج) ankylosing spondylitis

د) Metabolic bone diseases

پاسخ: الف

نگارنده: در هاریسون 2025 به مباحث مربوط به کمردرد و درد گردن در دو فصل جداگانه پرداخته شده است و مطالب مربوطه نیز با تغییراتی همراه بوده است که توصیه می‌شود به دقت مطالعه شود. در چاپ جدید هاریسون توضیحات مربوط به اسپوندیلوزیس در این فصل حذف شده و صرفاً به طور خلاصه به آن اشاره شده است. لذا جهت پاسخ به این سوال به بررسی گزینه‌ها می‌پردازیم.

هایپرستوز اسکلتی ایدیوپاتیک منتشر (DISH) یک وضعیت غیرالتهابی و دژنراتیو است که با استخوانسازی جدید در لیگامان طولی قدامی و خلفی در حداقل چهار جسم مهره‌ای و نیز استئوفیت‌های حجیم flowing به طور تیپیک در سمت راست ستون فقرات همراه است که در گرافی داده شده دیده نمی‌شوند (رد گزینه ب).

اسپوندیلیت انکیلوزان اغلب با درد التهابی کمر، هیپ و باتک تظاهر می‌کند و به ندرت ممکن است با درد گردن یا توراسیک تظاهر کند یافته‌های تصویربرداری شامل شواهد ساکروایلئیت، Romanus lesion، مربعی شدن تنه مهره، سین دیسموفیت، bamboo spine و انکیلوزیس Andersson lesion می‌باشد که در این بیمار دیده نمی‌شود (رد گزینه ج).

از علل متابولیک درد گردن می‌توان به بیماری پاژه اشاره کرد که این بیماری نواحی توراکولومبار را بیشتر از ناحیه گردن درگیر می‌کند ولی با این حال می‌تواند از علل درد گردن باشد که با استراحت بدتر شود. از سایر علل متابولیک، استئوپروز، که معمولاً در زمینه هایپرپاراتیروئیدیسم و مصرف کورتون ایجاد می‌شود و استئومالاسی ناشی از متابولیسم ابنورمال ویتامین دی را نام برد که باعث شکستگی پاتولوژیک استخوان می‌شوند. اگرچه این اختلالات معمولاً مهره‌های لومبار و توراسیک تحتانی را درگیر می‌کنند اما در صورت