

# Not All De Quervains are De Quervains - A Rare Case Report

Hany Hameed<sup>1ID</sup>, Vivek Kumar Gupta<sup>1ID</sup>, Jeash Narayan Kanthalu Subramanian<sup>1ID</sup>,  
Nehasri Kuppa Srinivas Bapu<sup>1ID</sup>, Kanthalu Narayanan Subramanian<sup>1ID</sup>

## Learning Point of the Article:

Acute calcific tendinitis of the wrist, though extremely rare, can mimic De Quervain's Tenosynovitis and requires radiographic evaluation for accurate diagnosis and appropriate treatment.

## Abstract

**Introduction:** Introduction: Acute calcific tendinitis is a benign, painful condition commonly described in the shoulder and frequently seen in diabetic patients, especially females. It is usually self-limiting and relieved with nonsteroidal anti-inflammatory drugs (NSAIDs), rarely requiring surgery. Calcific tendinitis involving the wrist is less common and often underdiagnosed, leading to improper treatment. Calcific tendinitis of the first extensor compartment of the wrist has not been previously reported and may be mistaken for De Quervain's Tenosynovitis or cellulitis. This case report aims to highlight this rare presentation to avoid diagnostic errors.

**Case Report:** A 57-year-old diabetic female presented with a 2-week history of progressive severe pain over the dorsoradial aspect of the left wrist without trauma or fever. Initially diagnosed as De Quervain's Tenosynovitis with a positive Finkelstein test, she did not respond to NSAIDs and splinting. Radiographs revealed calcification at the base of the first metacarpal. Magnetic resonance imaging confirmed calcific tendinitis of the first extensor compartment. Surgical release revealed chalky white calcium phosphate deposits. Post-operatively, the patient had complete symptom resolution and regained full, pain-free wrist movement.

**Conclusion:** Although rare, acute calcific tendinitis of the wrist can mimic De Quervain's Tenosynovitis. Radiographic evaluation is essential when symptoms persist despite conservative treatment. Prompt diagnosis and surgical intervention can reduce morbidity and avoid prolonged unnecessary NSAID and antibiotic use.

**Keywords:** Calcific tendinitis, first extensor compartment, De Quervain's tenosynovitis, wrist pain.

## Introduction

Calcific tendinitis is characterized by calcium crystal deposition in or around tendons, typically near their insertion sites, causing acute severe pain and swelling. The shoulder, particularly the supraspinatus tendon, is the most commonly affected site [1]. Other locations, such as the hip and wrist are rarely involved. Within the wrist, the Flexor Carpi Ulnaris tendon is most

frequently affected [2]. Acute calcific tendinitis is often misdiagnosed as infection or inflammatory conditions, leading to inappropriate antibiotic use. Diabetes is a significant risk factor for this [3].

## Case Reports

A 53-year-old diabetic female presented with abrupt-onset,

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## Author's Photo Gallery



Dr. Hany Hameed



Dr. Vivek Kumar Gupta



Dr. Jeash Narayan  
Kanthalu Subramanian



Dr. Nehasri Kuppa Srinivas  
Bapu



Dr. Kanthalu Narayanan  
Subramanian

<sup>1</sup>Department of Orthopaedics, Vale Speciality Ortho Hospital, Madurai, Tamil Nadu, India.

### Address of Correspondence:

Dr. Hany Hameed,  
Department of Orthopaedics, Vale Speciality Ortho Hospital, Madurai, Tamil Nadu, India.  
E-mail: hanyhameed2005@yahoo.com

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**Figure 1:** Clinical image of the swelling showing inflammation of the dorsoradial aspect of the wrist.

throbbing pain over the left wrist lasting 2 weeks, exacerbated by movement. There was no history of trauma. Examination revealed erythema, edema, and severe tenderness over the first extensor compartment of the wrist with a positive Finkelstein test (Fig. 1).

Conservative treatment with nonsteroidal anti-inflammatory drugs (NSAIDs) failed to relieve symptoms for 1 week. Radiographs showed calcification proximal to the base of the first metacarpal. Laboratory tests indicated leukocytosis with neutrophilia, elevated C-reactive protein, and high HbA1C; uric acid was normal. Magnetic resonance imaging confirmed



**Figure 3:** Coronal view of the Magnetic resonance imaging image of the wrist showing involvement of the first extensor compartment.



**Figure 2:** Radiograph of the left wrist showing a calcific deposit proximal to the base of the first metacarpal.

calcific tendinitis in the first extensor compartment (Fig. 2, 3, 4).

Due to failed conservative management, surgical decompression was performed. A curvilinear incision was made over the first extensor compartment, and subcutaneous tissue was dissected to identify the compartment. Thick chalky white calcium deposit was found on releasing of the compartment. A thorough wash was given and all tendons were separately isolated (Figs. 5 and 6).

Post-operatively, the patient was immobilized with a thumb spica splint, administered NSAIDs, and underwent strict glycemic control. Gradual thumb ranges of motion exercises were initiated. At 1-week follow-up, inflammation resolved with significant pain relief, and by 2 weeks, the patient resumed

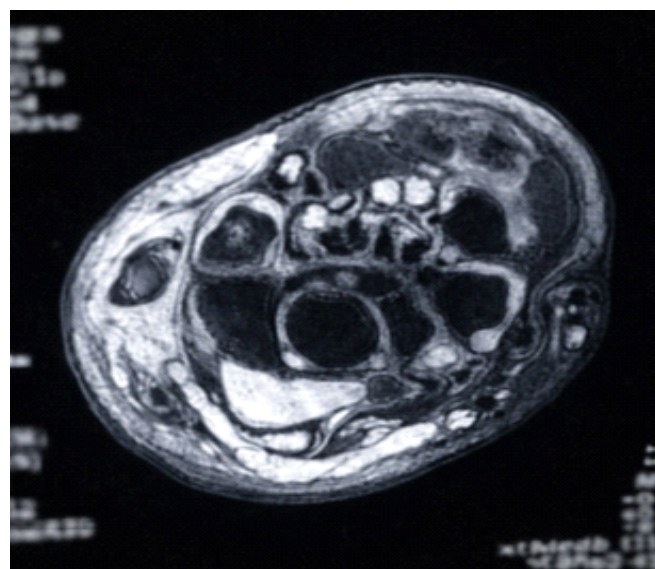


**Figure 4:** Axial slice of the Magnetic resonance imaging image of the wrist showing involvement of the first extensor compartment.



**Figure 5:** Intraoperative image showing chalky white calcium deposit on opening of the 1st compartment.

normal activities without pain. At 3 months follow-up patient is fully asymptomatic.

### Discussion

Acute calcific tendinitis of the wrist is exceedingly rare. A systematic review by Draghi et al. identified only 13 hand and 7 wrist cases among 184 extra-shoulder calcific tendinitis cases [4]. It predominantly affects females aged 30–60 years. The Flexor Carpi Ulnaris tendon is most commonly involved, usually near its insertion at the pisiform bone. The etiology is not fully understood but may involve tendon degeneration, reactive calcification with fibrocartilaginous metaplasia, tissue hypoxia, mechanical strain, and failed healing [5]. Uthoff's model describes stages from pre-calcific fibrocartilaginous metaplasia through calcific phases to tendon remodeling [6].

Clinically, patients present with acute localized pain, erythema, swelling, and tenderness, often mimicking infection [7]. Fever is usually absent or low-grade, and inflammatory markers may be normal or mildly elevated. A history of significant trauma is present in only a minority of patients, although repetitive wrist activities – such as racket sports or manual work demanding repeated flexion – may contribute, and the dominant hand is more frequently affected [8].

Plain radiographs are the initial modality of choice and typically show calcifications measuring 2–10 mm, with fluffy, ill-defined,



**Figure 6:** Image showing completely free extensor tendon after clearing all deposits.

inhomogeneous deposits in acute stages and denser, homogeneous foci in chronic stages. Ultrasonography further aids evaluation by precisely localizing calcifications, characterizing their consistency, and assessing vascularity and activity with Doppler; it also facilitates interventional procedures, such as ultrasound-guided barbotage [9].

Treatment lacks consensus, but most cases resolve with conservative management and strict diabetes control. Those cases that are refractory to conservative management have been treated by a myriad of different methods, including open resection, arthroscopic resection, steroid injection, ultrasound-guided needle lavage (barbotage), extracorporeal shockwave therapy, and platelet-rich plasma injection [10]. Refractory cases benefit from surgical or other interventional treatments. Surgical debridement provides early and definitive relief when conservative measures fail. There are no reports of recurrence at the same site after surgical debridement.

### Conclusion

Acute calcific tendinitis of the first extensor compartment of the wrist is a rare entity that can mimic De Quervain's Tenosynovitis. Radiographic evaluation is essential when patients do not respond to conservative treatment. Surgical intervention offers prompt symptom resolution and prevents prolonged morbidity.

## Clinical Message

In cases of persistent wrist pain resembling De Quervain's Tenosynovitis, especially in diabetic patients, clinicians should consider acute calcific tendinitis and perform appropriate imaging. Early diagnosis and timely surgical management can significantly improve outcomes.

**Declaration of patient consent:** The authors certify that they have obtained all appropriate patient consent forms. In the form, the patient has given the consent for his/ her images and other clinical information to be reported in the journal. The patient understands that his/ her names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

**Conflict of interest:** Nil **Source of support:** None

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