An attempt to evaluate the criteria for diagnosing nonspecific inflammatory diseases observed on ancient skeletons

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Abstract

The study presents the criteria for diagnosing nonspecific inflammatory diseases observed on ancient bones. It is very important to remember about two forms of ostitis - acute and chronic, and about diseases causing similar changes, e.g. tuberculosis, lues, brucelosis, cysts, osteoid-osteoma.


Inflammatory diseases belong to the oldest ones, as the traces of inflammatory processes were found on the plants from the Carboniferous period. Changes such as necrosis and fistulas were noticed on bones of fossil animals from different periods [MOODIE 1967] as well as on bones of pre-human beings, e.g. the man from Rhodesia [HRDLIČKA 1930]. There are many descriptions of osteomyelitis in man dating back to the period from pre-historic times to present. We would like to mention here some of the authors writing about ostitis, to show how common the disease has been - it has been found all over the world: WOOD-JONES [1910], HOOTON [1935], HRDLIČKA [1930], FRANKENBERGER [1935], CRESMAN, LARSELL [1945], JELINEK [1963], ROCHLIN [1965], MILES [1966], RONEY JR. [1966], ERY [1967–1968, 1970, 1981], STLOUKAL, VYHNANEK [1976], STEINBOCK [1976], THURZO [1969], MALLENGNI, FORNACIARI [1980], GLADYKOWSKA-RZECZYCKA [1980, 1981, 1984, 1989, 1993], ORTNER, PUTSCHAR [1981], HANAKOVA [1983], CAPASSO [1985], CZARNETZKY [1985], WINKLER [1988–1989], BLAJOEROVA [1975], JAKAB [1997], LALLO, BLANK [1977], ČWIRKO-GODYCKI, SWEDBORG [1978], DERMUS [1978], MARCSIK, OLÁH [1991], KRAMAR et al. [1990], TAKAO [1991].

The above-mentioned authors described few cases of ostitis usually found in large skeletal series. In Poland 12 skeletons among 1192 ones had changes characteristic for ostitis.

Differentiation of macro- and microscopic picture of ostitis makes it difficult to diagnose, especially in paleopathology. Therefore, it is important to give basic information about that disease, its
forms and differential diagnosis.

Bacteria causing ostitis may originate from a urinary infection, bacterial endocarditis, a soft tissue infection and other.

Depending on the spreading route ostitis may be divided into:

1. hematogenous or primary ostitis;
2. secondary ostitis (posttraumatic ostitis and ostitis from a contiguous infection).

In secondary ostitis the source of the infection is known, whereas in the primary one it is usually unapparent and infection spreads by the circulatory system.

The most common clinical and pathological classification of ostitis is that based on time of duration and clinical manifestation (acute, subacute and chronic ostitis) is. There are also other classifications of the hematogenous ostitis, for example those considering etiology or age [TRUETA 1959].

Ostitis is most often caused by Staphylococcus aureus (61%), and streptococci (9%) according to DICHT et al. [1975], and affects mostly such bones as: the femur and tibia (80%) according to ORTNER and PUTSCHAR [1981], humerus (10%) according to BOREJKO AND DZIAK [1988]. Ostitis may afflict all bones, but is rarely seen in the ribs, clavicle and vertebrae [WALDVOGEL, VASEX 1980, DONOVAN, SMAM 1982]. Ostitis of vertebrae may cause a hump. In 9% of ostitis cases more than two bones are affected [DICHT et al. 1975]. Pathologic findings during the acute phase include inflammation, and bone necrosis. In the subacute phase a new bone formation may occur around necrosis and formation of fistulas. The chronic phase may manifest itself as smouldering infection in postinflammatory sites and infection may recur after months or years of quiescence [COHEN 1990, TUMEH 1987].

In the acute phase of ostitis bacteria reach the bone and cause inflammation: vascular congestion and purulent exudate. Because of the bone rigidity, increased intramedullary pressure develops, compressing the blood supply and causing ischemia and necrosis. The pus spreads via the Volkmann canals to reach periosteum, beneath which abscesses may form. The supplicative and ischemic injuries may cause fragmentation of bones into devitalized segments called sequestra. After 4–6 weeks the new bone formation and proliferation begin. Osteogenesis from the periosteum may surround the inflammation to form the bone envelope or involucrum. After many years, distension, diffuse sclerosis of the bone and sequestra in different phase of sequestration may occur [ŁAKOMSKI 1976, ŻAK 1983].

Brodie’s abscess and ostitis chronica scleroticans typus Garré are considered as chronic osteomyelitis [MALAWSKI 1976].

Brodie’s abscess is usually located in the tibia, rarely in the femur. It is placed intramedullary, close to epiphysis. It is usually a single cyst, cherry-size, and no periosteum changes are observed.

Garré’s sclerosing ostitis affects mainly children and young adults and is located in the proximal part of tibia. This form of ostitis is characterized by regular fusiform distension and thickening of the proximal part of the bone without leading to suppuration, sequestration and fistulization. The radiological picture shows pronounced sclerosis and distention of the affected bone and no medullary cavity [COLLERT, ISACSON 1980].
The bone changes observed in active osteomyelitis (with sequestrum and fistulas) are very characteristic and do not cause problems with diagnosis. However, the bone changes at the beginning of ostitis are not typical thus creating many diagnosing troubles [Murczyński 1952]. The bone changes in the chronic form of ostitis may resemble the bone changes caused by tuberculosis, brucellosis or syphilis. Brodie’s abscess may cause confusion with cyst or osteoid-osteoma (Tab. 1).

Tuberculosis — in comparison to ostitis — is an infectious disease, in which usually more than one bone is affected and most often the process is located in vertebrae and joints. Tuberculosis does not affect medullary cavity. Because tuberculosis affects the spongy part of the bone it may cause great destruction, sometimes changing the bone’s shape. Ostitis usually affects shafts of long bones and abscessus very rarely penetrates to the joint. In tuberculosis neither periostitis nor destruction of the bone is found. Tuberculous sequestra are more round — shaped, smaller and with smoother surfaces than sequestra in ostitis. Tuberculous sequestra are located in the spongy bone, whereas ostitis’ ones are found mainly in the compact bone.

As regards tertiary syphilis, it usually affects many bones at the same time; very often the skull is affected, whereas in ostitis the skull is very rarely affected and in that case the process is limited to the maxilla and the jaw. The lesions caused by syphilis are wide-spread and found in the spongy and compact bone, where many osteolitic foci occur. The medullary cavity also may be affected by the syphilitic process. There is irregular shape of the bone with periostitis, sequestra are not found or are found very rarely. If they are present – they are very small, disc-shaped and located in spongy bone. No fistulas are present.

Brucellosis is a disease which is transmitted to humans from domestic animals. Human infection results from ingestion of affected animal tissue or milk products. Many bones may be affected, but most commonly the vertebrae, jaw, and ribs. The lesions with osteolitic foci are found in the spongy bone. The medullary cavity is not affected. No sequestra and fistulas are found.

Benign cysts may imitate Brodie’s abscess. They may be single or rarely several in the bone. They are larger in comparison to Brodie’s abscess. They may be found in spongy as well as in compact bone, whereas Brodie’s abscess is located in spongy bone alone. They may cause deformation of the medullary cavity or of the shaft of the bone. There is no sclerotic capsule in the X-ray picture, which differs benign cysts from Brodie’s abscess. Fistulas and sequestra have been never found.

Osteoid-osteoma is very similar to Brodie’s abscess as well as to ostitis scleroticans. It is a benign carcinoma, most often located in the compact bone of the tibia or in the femur. This lesion is usually single, small (ca. 1 cm in diameter), oval-shaped, composed of osteolitic focus and sclerotic capsule. It is similar to ostitis scleroticans or when only osteolitic focus is present, it resembles Brodie’s abscess. The medullary cavity is not involved, but localized thickening shaft of the bone may be found.

Two typical lesions for osteomyelitis are shown on fig. 1 and 2.
Table 1. Differentiation

<table>
<thead>
<tr>
<th>Features</th>
<th>Ostitis acute</th>
<th>Ostitis chronic</th>
<th>Ostitis Garré abscess</th>
<th>Tuberculosis</th>
<th>Syphilis III</th>
<th>Brucellosis</th>
<th>Osteoid - osteoma</th>
<th>Benign bone cysts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Sex</td>
<td>0 - 20</td>
<td>6 - 30</td>
<td>6 - 30</td>
<td>0 - senilis</td>
<td>0 - senilis</td>
<td>0 - senilis</td>
<td>10 - adults</td>
<td>0 - adults</td>
</tr>
<tr>
<td></td>
<td>M : W = 3 : 1</td>
<td>1</td>
<td>PERIODS IN WEEKS</td>
<td></td>
<td></td>
<td></td>
<td>various</td>
<td>various</td>
</tr>
<tr>
<td></td>
<td>1-2</td>
<td>4-5</td>
<td>&gt;6</td>
<td></td>
<td></td>
<td></td>
<td>various</td>
<td>various</td>
</tr>
<tr>
<td>Number of bones</td>
<td>1 (80%)</td>
<td>1 (80%)</td>
<td>1 (80%)</td>
<td>1 (80%)</td>
<td>1 (80%)</td>
<td>1 (80%)</td>
<td>1 (80%)</td>
<td>1 (80%)</td>
</tr>
<tr>
<td>Localization</td>
<td>metaphysis</td>
<td>diaphysis</td>
<td>diaphysis</td>
<td>diaphysis</td>
<td>diaphysis</td>
<td>diaphysis</td>
<td>diaphysis</td>
<td>diaphysis</td>
</tr>
<tr>
<td>Size</td>
<td>limited</td>
<td>extensive</td>
<td>extensive</td>
<td>extensive</td>
<td>2/3 metaphysis</td>
<td>small</td>
<td>limited</td>
<td>extensive</td>
</tr>
<tr>
<td>Changed bone tissue</td>
<td>spongy</td>
<td>compact</td>
<td>all</td>
<td>all</td>
<td>all</td>
<td>spongy</td>
<td>spongy</td>
<td>both</td>
</tr>
<tr>
<td>Structure</td>
<td>changed</td>
<td>changed</td>
<td>changed</td>
<td>changed</td>
<td>changed</td>
<td>changed</td>
<td>destroyed</td>
<td>osteolitic foci</td>
</tr>
<tr>
<td>Medullary cavity</td>
<td>changed</td>
<td>changed</td>
<td>narrow</td>
<td>narrow</td>
<td>lack</td>
<td>normal</td>
<td>normal</td>
<td>lack</td>
</tr>
<tr>
<td>Shape of the bone</td>
<td>distension of metaph.</td>
<td>irregular</td>
<td>irregular</td>
<td>irregular</td>
<td>fusi - form</td>
<td>local thick.</td>
<td>destruc. thick.</td>
<td>lesion irreg thick</td>
</tr>
<tr>
<td>Periosteum (changes)</td>
<td>discreet</td>
<td>extensive involucrum</td>
<td>extensive involucrum</td>
<td>untypical</td>
<td>rough</td>
<td>local</td>
<td>rather normal</td>
<td>extensive or local thick</td>
</tr>
<tr>
<td>Sequestrum</td>
<td>very rare</td>
<td>big, irreg. well defined</td>
<td>well defined or latent</td>
<td>latent or active</td>
<td>small, many well defined</td>
<td>lack</td>
<td>small, smooth bad defined</td>
<td>lack or small, resorb</td>
</tr>
<tr>
<td>Fistulas</td>
<td>lack</td>
<td>one or many</td>
<td>many or traces</td>
<td>remains</td>
<td>lack</td>
<td>lack</td>
<td>present</td>
<td>lack</td>
</tr>
<tr>
<td>Regeneration</td>
<td>small</td>
<td>great</td>
<td>intensive</td>
<td>great</td>
<td>great</td>
<td>great</td>
<td>small</td>
<td>varying</td>
</tr>
<tr>
<td>Cavity of the abscess/ sequestrum</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>surrounded by sclerotic layer</td>
<td>surrounded by sclerotic layer</td>
<td>surrounded by sclerotic layer</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Gibbus</td>
<td>lack</td>
<td>lack</td>
<td>rare</td>
<td>lack</td>
<td>lack</td>
<td>lack</td>
<td>present</td>
<td>rare</td>
</tr>
<tr>
<td>Calcification</td>
<td>discreet</td>
<td>good</td>
<td>extensive</td>
<td>extensive</td>
<td>extensive</td>
<td>extensive</td>
<td>low</td>
<td>local</td>
</tr>
</tbody>
</table>

[106]
An attempt to evaluate the criteria for diagnosing nonspecific inflammatory diseases

References

BLAJEROVA M., 1875, Kostrove pozastatky ze slovenského pohrebište v Radomýšli, Crania Bohemic, Praha, 5, 314
BOREJKO M., A. DZIAK, 1988, Badanie radiologiczne w ortopedii, Warszawa
CAPASSO L., 1985, L’Origine delle Mallatie, Marino Solfanelli, Chieti
COLLERT S., J. ISAACSON, 1982, Chronic sclerosing osteomyelitis (Garré), Clinical Orthopedics, 164, 136–140
CZARNETZKY A., CH. UHLING, W. ROTRAUT, 1985, Menschen des frühen Mittelalters, im Spiegel
der Anthropologie und Medizin, München
CZARNETZKY A., CH. UHLING, W. ROTRAUT, 1985, Menschen des frühen Mittelalters, im Spiegel
der Anthropologie und Medizin, München
DERUMS W.J., 1978, Changes in skeletal bones in residents of the Baltic area studied on paleoanthropological material (in Russian), Archiv Patologii, 2, 65–69
DONOVAN R., K. SMAM, 1982, Unusual sites of acute osteomyelitis in childhood, Clinical Radiology, 33, 222–230
ÉRY K., 1967–1968, Reconstruction of the tenth century population of Sarbogarad on the basis of archaeological and anthropological data, Alba Regia, 8–9, 93–147
ÉRY K., 1970, Anthropological studies on a tenth

Fig. 1. Tibia of a *maturus* man, with characteristic changes of ostitis chronica scleroticans Garrei (Czersk, Warsaw province)

Fig. 2. Bones of an *adultus* man with well marked traces of healed ostitis (Czersk, district Warsaw)
An attempt to evaluate the criteria for diagnosing nonspecific inflammatory diseases

the past decade, The New England Journal of Medicine, 303, 360–370
WOOD-JONES F., 1910, General pathology (inclu-
ding diseases of the teeth), [in:] G. Elliot-Smith and F. Wood-Jones (eds.), The archaeo-

Streszczenie

Przedstawiono krótki rys historyczny chorób zapalnych nieswoistych znanych z piśmiennictwa, genezę, postacie, fazy, przebieg, obraz makroskopowy i radiologiczny oraz różnicowanie z innymi chorobami pozostawiającymi na kościach podobny obraz.