

Síndrome de Fabella

Fabella syndrome

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Palavras-chave: Ossos Sesamoides; Síndrome.

Keywords: Sesamoid Bones; Syndrome

To the Editor,

I recently observed a man in the Physical and Rehabilitation Medicine consultation, referenced by his assistant orthopaedist with the diagnoses of patellar tendinopathy and external hyperpressure syndrome of the patella, that had a knees magnetic resonance imaging (MRI) which identified the “presence of a sesamoid bone adjacent to the posterior portion of the external femoral condyles in relation to the normal variant”. This mere radiological finding gave rise to the opportunity to inform or remind colleagues that the presence of the fabella may be the source of pain in the posterior aspect of the knee.

The fabella is a sesamoid bone located in the lateral head of gastrocnemius muscle behind the femur lateral condyle.¹⁻⁵

It is an anatomic variant present in 10%-30% subjects from Western countries, typically bilateral (Fig. 1), but increased incidence is reported in Asian population and young active athletes.²⁻⁴ The length may vary between 4 and 22 mm with a diameter of about 10 mm; the largest fabella described in the literature measured 30×16×8 mm.⁶

Fabella syndrome, a rare cause of knee pain, is often misdiagnosed as other common causes of knee pain; such misdiagnosis may delay treatment or result in unnecessary arthroscopic procedures.² For this reason, fabella syndrome must be included in chronic posterolateral knee pain differential diagnosis as Baker’s cyst, meniscal tear, intra-articular loose body, osteochondral fragment, osteoarthritis, foreign body, lateral ligamentous instability, proximal tibiofibular joint hypomobility, fabella fracture and lumbosacral radiculopathy.^{1-3,5}

Patients usually present one or more position- or activity-related posterolateral mechanical knee pain during end-range knee flexion or extension, cross-legged sitting and

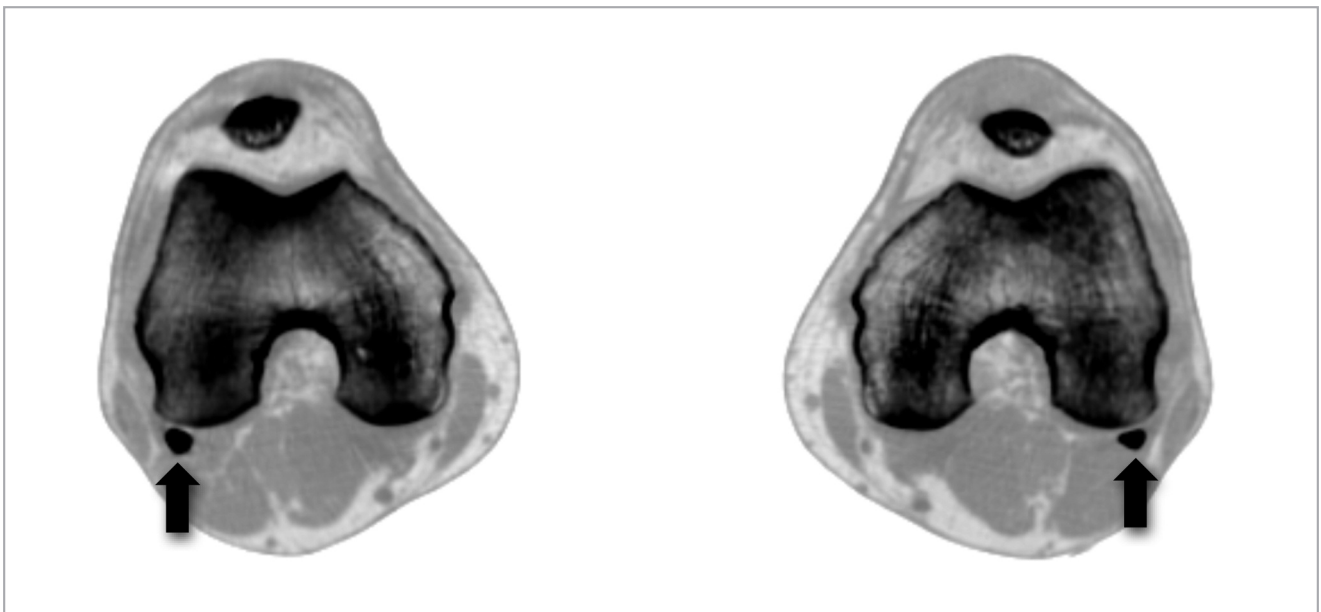


Figure 1 - Bilateral fabella in relation with lateral femoral condyle (black arrows).

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various sporting attempts.^{2,3,5} Some patients may present signs and symptoms of fibular nerve palsy as sudden onset, paresthesia, steppage gait and foot drop.^{1,5}

On physical examination specific pain should be reproduced by pressing the fabella against the femur lateral condyle.^{1,3} Knee lateral radiographs, ultrasound and MRI imaging reveal suggestive anatomy alterations and ultrasonography allows fabella assessment and local anaesthetic injection for diagnostic purpose.^{2,3}

Conservative treatments, including local steroid injection, immobilization with splint and cast, temporary activity restriction, physical modalities (for example, radial extracorporeal shock wave therapy if the cause of the fabella syndrome is thought to be the enthesopathy of fabella complex), manual therapy and analgesics, can be effective in fabella syndrome.^{2,5} Otherwise, fabellectomy, open or

arthroscopic, and proper rehabilitation should be considered as definitive treatment.^{1,4}

Provencher MT and colleagues describe a rehabilitation program proposal following an open fabella excision that includes flexion and extension exercises initiated immediately postoperatively to avoid loss of motion (no restrictions on range of motion), and ankle pumps, straight leg raises, and quadriceps exercises initiated immediately after surgery as tolerated with gradually frequency increase to 3 to 5 times daily.¹ A brace is not routinely used and patients are allowed to bear weight as tolerated with the aid of crutches until they can ambulate without a limp (crutches are probably necessary during the first 2 weeks, but its use is a patient choice).¹ Return to competitive activities is normally allowed after approximately 3-4 months of rehabilitation program.¹

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