A 37-year-old woman was referred to the rheumatology clinic due to symptoms concerning for spondylitis. She had noted worsening low back pain about 18 months ago while pregnant with twins. At the time of evaluation in the clinic, she reported intermittent back pain episodes with right-sided groin pain that was exacerbated by working long hours and lifting heavy objects. She took nonsteroidal anti-inflammatory drugs for pain, which was beneficial. She denied difficulty with routine activities of daily living, morning stiffness, and nocturnal awakening due to low back pain. She had experienced no episodes of enthesitis, dactylitis, or inflammatory eye disease.

Years previously she had an episode of colitis with abdominal pain and rectal pressure. Computed tomography at that time was notable for colitis and abnormal sacroiliac joints with bilateral subchondral sclerosis (Figure 1). About 1 month later, she underwent a colonoscopy, which was unremarkable.

On physical examination at the rheumatology clinic, findings were notable for normal peripheral joints, normal range of motion in the spine, and no sacroiliac joint tenderness with a negative FABER (flexion, abduction, external rotation) stress test. There was no evidence of enthesitis, and her eye examination was normal.

Plain radiography showed dense bilateral subchondral sclerosis on the iliac sides of the mid portion of the sacroiliac joints (Figure 2). These radiography findings and the earlier computed tomography findings were consistent with osteitis condensans illii (OCI).

OCI is a benign, noninflammatory cause of axial low back pain first described in 1926 by Sicard et al.\textsuperscript{1} Its pathogenesis remains unclear. OCI has a predilection for...
multiparous females, mean age 35 at time of diagnosis, leading some to propose vascular compression and resulting ischemia related to the physiologic changes of pregnancy, or mechanical laxity and sacroiliac joint overload during pregnancy, as potential mechanisms of injury. Nevertheless, OCI does occur in nulliparous females and males.

Clues to the diagnosis
Patients with OCI complain of intermittent axial low back pain with occasional hip area pain. This pain can be worse during the third trimester of pregnancy or post pregnancy. OCI can be an incidental radiographic finding in an asymptomatic patient. Radiographic findings of OCI include bilateral triangular (or oval) subchondral sclerosis predominant on the iliac side and the absence of erosions and ankylosis (Figure 2). Computed tomography may also show sacral subchondral sclerosis.

The differential diagnosis
The differential diagnosis for OCI is sacroiliitis, which can be seen in other disease entities such as infection, ankylosing spondylitis, psoriatic arthritis, and osteoarthritis. In patients with chronic low back pain, particularly young patients, it is essential to look for features associated with spondyloarthritis, such as the following:
- Inflammatory back pain (age of onset < 40, insidious onset, improvement with exercise, no improvement with rest, and nocturnal awakening)
- Enthesitis (inflammation of insertion sites of tendons or ligaments into bone)
- Dactylitis (severe swelling of an entire finger or toe)
- Peripheral arthritis
- Extra-articular manifestations (eg, psoriasis, uveitis, inflammatory bowel disease)
- Family history of spondyloarthritis.

OCI and inflammatory sacroiliitis are differentiated based on radiography findings. Imaging in a patient with ankylosing spondylitis shows bilateral symmetric sacroiliitis characterized by a variable combination of erosions, subchondral sclerosis, and ankylosis (Figure 3). Unilateral involvement can be seen in infection, destructive neoplastic processes, and psoriatic and reactive arthritis. Computed tomography can provide better evaluation of sacroiliac joints but is not necessary for diagnosis.

Treatment
Management is usually conservative, consisting of physical therapy and analgesics. OCI is thought to resolve over years in most cases.

REFERENCES

Address: Aditi Patel, MD, Department of Rheumatologic and Immunologic Disease, A50, Cleveland Clinic, 9500 Euclid Avenue, Cleveland, OH 4195; patela7@ccf.org