

EP-187

성인 피부근염 환자에서 다발성 석회침착증에 대한 단계적 수술적 절제를 통한 기능 회복: 증례보고

(Stepwise Surgical Excision of Multifocal Calcinosis Cutis Restores Function in Adult Dermatomyositis: A case report)



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**Purpose:** Calcinosis cutis associated with dermatomyositis can cause significant pain, neurologic symptoms, and joint restriction. Surgical excision is considered for refractory symptomatic lesions; however, experience with staged procedures in multifocal adult disease is limited. This study aimed to evaluate the clinical effectiveness of staged selective excision in a patient with multifocal calcinosis cutis causing neurologic compromise and functional limitation.

**Methods:** A woman in her sixties with dermatomyositis presented with painful calcified masses in the left buttock, both axillae, and left upper arm. Imaging confirmed multifocal dystrophic calcifications. Surgical excision was performed in stages according to symptom severity: first the buttock lesion due to sciatic-type radiating pain, followed by the right axillary lesion for shoulder motion restriction, and subsequently the left axillary and upper-arm lesions. Clinical outcomes, functional improvement, and recurrence were evaluated during follow-up.

**Results:** Excision of the buttock lesion resulted in immediate resolution of radiating pain. Subsequent axillary excisions led to improvement in shoulder abduction and functional mobility. Histopathology confirmed dystrophic calcification in all specimens. No recurrence or major complications were observed during 30 months of follow-up.

**Conclusion:** Conclusion: Staged, selective excision provided substantial symptomatic relief and functional improvement in a patient with multifocal calcinosis cutis associated with dermatomyositis. An individualized, symptom-based surgical approach may represent an effective treatment strategy, particularly in cases where lesions result in neurologic compromise or mechanical restriction of movement.

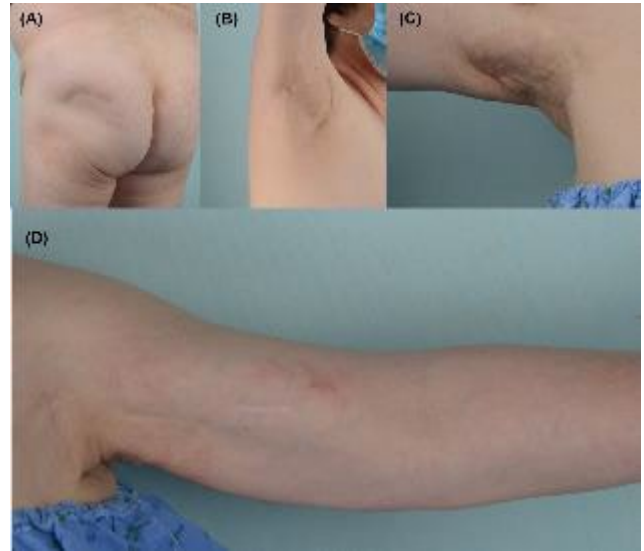


Fig. 1. Examination revealed an 8-cm firm, irregular mass in the left buttock producing sciatic-type radiating pain (Fig. 1A). Large palpable calcifications were present in both axillae (Fig. 1B, C), and a smaller lesion was noted in the left upper arm (Fig. 1D)

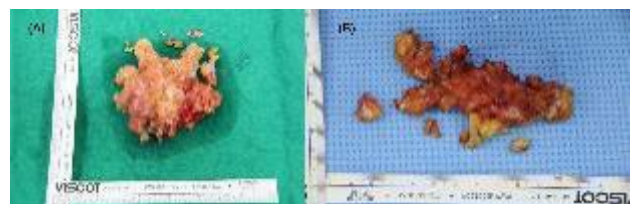


Fig. 2. Multiple firm, lobulated calcified nodules were removed en bloc (Fig. 2A), and radiating pain resolved immediately. Persistent restriction of right shoulder motion prompted excision of the right axillary lesion four months later (Fig. 2B).