



Figure. (A) T1-weighted image shows increased signal intensity in multiple areas, indicating hemorrhage within vastus medialis and rectus femoris (arrows). Streaky areas of low signal within subcutaneous tissue represent edema. (B) T2-weighted image with areas of hyperintensity in several muscle groups indicating edema. (C) Post-gadolinium fat-saturated T1-weighted image shows enhancement of muscle tissue with focal areas of hypoperfusion (arrow). The T1 (A) and T2 (B) images are typical of diabetic muscle infarction.¹ The finding of hypoperfusion, not previously emphasized in diabetic muscle infarction, is supportive of a role for ischemia in the pathophysiology.

MRI in diabetic muscle infarction

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A 45-year-old man, with a 20-year history of type 1 diabetes mellitus, dilated cardiomyopathy, and hemodialysis-dependent, end-stage renal disease, developed severe right medial thigh pain, swelling, erythema, and an antalgic gait 2 weeks before admission. A diabetic muscle infarction

diagnosis was made based on clinical findings and a MRI scan (figure). Symptoms gradually resolved with analgesics. The patient returned 2 months later with recurrent thigh pain and swelling (this time on the left). His symptoms again resolved with analgesics. Local erythema, swelling, and exquisite tenderness of involved thigh muscles serve to distinguish diabetic muscle infarction from diabetic amyotrophy, where asymmetric proximal lower extremity weakness, muscle wasting, pain, and weight loss are typical.

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