Relapsing Polychondritis

Sir,

Relapsing polychondritis (RP) is an autoimmune disorder of unknown etiology, primarily affecting the cartilaginous structures of the body, such as the ears, nose, laryngotracheal tree, and joints. It also involves the noncartilaginous proteoglycan-rich structures, including the eye, heart, blood vessels, and inner ear. This relatively rare disease is episodic and progressive, with a heterogeneous phenotype. The common presenting features include auricular chondritis, seronegative arthritis, nasal chondritis, ocular inflammation, and laryngotracheal symptoms.\(^{[1]}\)

A 70-year-old male presented with a history of pain and swelling of the right ear lobe for a week’s duration. The symptoms preceded a transient fleeting type of joint pain involving both small and large joints for the past 6 months, which was temporarily relieved with nonsteroidal anti-inflammatory drugs (NSAIDS). Symptoms worsened when he had a postcataract iridocyclitis, which was steroid responsive. He had one episode of vertigo, which was extensively evaluated by a neurologist, who diagnosed the patient with labyrinthitis and provided with appropriate treatment. Over the past 5 years, he had been evaluated by ENT surgeons for repeated throat clearing and discomfort, which was treated as gastroesophageal reflux disease with proton pump inhibitors. An upper gastrointestinal endoscopy revealed no abnormalities. The patient is a known hypertensive and diabetic, for which he has been receiving treatment for the past 15 years.

On physical examination, he was noted to have a swollen exquisitely tender erythematous upper cartilaginous part of the right pinna with sparing of the ear lobule [Figure 1] with no tracheal tenderness. No joint swelling or redness of eyes was noted. Initial laboratory data were remarkable revealing a sedimentation rate of 36 mm/hr, C-reactive protein of 40, and hemoglobin of 10.4 g/dL. Antineutrophil cytoplasmic antibodies, antinuclear antibodies, rheumatoid factor, and creatinine were all unremarkable. Clinical diagnosis of relapsing polychondritis was made based on McAdams criteria.\(^{[2]}\) He was started on oral prednisolone, colchicine, and methotrexate. On a 2-month follow-up visit, steroids were tapered, and remission was sustained with methotrexate.

Figure 1: Typical violaceous hue, involving the cartilaginous part of pinna with classical sparing of ear lobule: Hallmark of relapsing polychondritis.

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Unusual Case of a 13-Year-Old Male with Blount’s Disease Who was Unable to Walk: A Prevention Lesson

Sir,

Blount’s disease, with or without complications, is not usually encountered in primary care centers. It is important to diagnose this disease in infants as early as possible to administer treatment, thereby allowing the infant to grow normally and avoid serious complications as the infant grows.

However, some primary care physicians might not have received sufficient training to be able to detect this disease in infants. Therefore, it is important to educate all family physicians about Blount’s disease so it can be detected and referred to a pediatric orthopedic surgeon for early treatment.

In addition, the family physician should undertake the responsibility of following the child and family throughout the period of treatment to take care of all psychological, physical, and social aspects of the disease. This case has been chosen to increase the awareness of all primary care physicians about Blount’s disease and its complications.

A 13-year-old Saudi male came to Primary Care Clinic in a Tertiary University Hospital, in Riyadh, Saudi Arabia. The patient arrived in a wheelchair with his mother; he was obese and looked worried and depressed. The patient was unable to walk and it was difficult for him to stand without support to be weighed. The patient’s weight was 117 kilos, height 151 cm, and body mass index 51.3%.

The child was born with no obvious abnormalities but...