

Glottic *Staphylococcus aureus* in a patient with systemic lupus erythematosus: Videolaryngostroboscopic characteristics

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SUMMARY

Chronic laryngitis in systemic lupus erythematosus (SLE) patients may be caused by opportunistic organisms. Here a case of SLE who presented with bilateral whitish lesions on the true vocal folds for one month, is presented. The chronological images of videolaryngostroboscopy images were shown. The videolaryngostroboscopy evaluation showed severe asymmetry, reduced amplitude, and aperiodic mucosal wave bilaterally. The duration of closure of a glottal cycle was 'always open'. The lack of improvement of the videolaryngostroboscopy findings after two weeks of initial treatment with antifungal led to the decision to perform biopsy for histopathological examination, and culture and sensitivity, which showed *Staphylococcus aureus*. Results: Cloxacillin was prescribed. The duration of 6 weeks of cloxacillin was guided by the serial evaluation with videolaryngostroboscopy until the normal mucosal wave of the true vocal folds was visualised. Conclusion: The case depicted the importance of videolaryngostroboscopy in leading to the diagnosis and optimum treatment for glottic *Staphylococcus aureus*.

Facial nerve palsy following bee sting. A case report

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SUMMARY

One of the most common insects poisoning is bee sting. It can produce local symptoms such as pain, redness, and fever following a local pain. Rarely, anaphylaxis, myocardial infarction, organ failure, epilepsy and other neurological diseases have been reported. Lower motor neuron facial nerve palsy is one of the common diseases of the Otorhinolaryngology clinic. Although it is usually idiopathic, trauma and tumors are the two most common causes. Usually it is diagnosed clinically and the grade of palsy is based on House Brackmann Classification. We present a case of left facial nerve palsy due to bee sting. A 21-year-old male patient was referred to our clinic for persistent incomplete eye closure for two weeks duration. Upon further history, he complained that prior to the left sided facial weakness he was stung by a bee the night before on his left toe and developed the facial weakness when he woke up in the morning. He did not get immediate treatment. Clinically he had Grade III left lower motor neuron facial nerve palsy. Other ear, nose and throat examinations were unremarkable. He was treated with oral steroid and eye care. One week upon follow up, his facial weakness was completely resolved.