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Oral lesion in Rheumatoid Arthritis

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SUMMARY

Rheumatoid arthritis is one of the main types of connective tissue disease. Although rare, oral mucosal pathology is known to be part of the disease presentation. Anti-rheumatic drugs used in managing the disease are also known to cause oral ulcers. Furthermore, the immunosuppressive state of the disease also exposes the patient to opportunistic infection and malignancy; which may present as oral lesion. We report a case of a patient with underlying rheumatoid arthritis presented with chronic oral ulcer.A 63 years old lady, presented with a painful tip of tongue ulcer for one month. She denied any history of trauma or frequent biting. She did not smoke or drank alcohol. She has an underlying rheumatoid arthritis, and currently is on weekly oral methotrexate and daily oral folic acid. Intraoral examination showed 0.5cm superficial ulcer at the tip of the tongue, with a whitish bed and induration area surrounding it. Otherwise, no discharge or bleeding seen. No obvious sharp tooth edges seen. Other ENT examinations were unremarkable. Biopsy of the tip of ulcer was reported as consistent with ulcer, no evidence of malignancy and GMS staining for fungal was negative. She was treated with 2 weeks of oral antibiotics, unfortunately the treatment failed. Discussions and referrals were made to the rheumatologist and dentist. The oral methotrexate was temporarily withheld and the patient was advised on compliance to folic acid. She was also arranged for scaling over teeth with sharp edges near the ulcer by the dental team.Subsequently, the case was discussed with the infectious disease team in view of no improvement of symptoms by the third week of watchful follow up. A trial of oral antifungal was commenced. At review after 6 weeks post antifungal treatment, the patient's symptoms subsided and the ulceration resolved entirely. Chronic oral ulcer presented in rheumatoid arthritis patients remains a diagnostic challenge and warranted multidisciplinary management.

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Kissing in the retropharynx

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SUMMARY

Aberrancy of the carotid arteries in the neck has interchangeable terms and may present as submucosal masses in posterior pharyngeal wall . Although most of the time are asymptomatic, certain extreme aberrant was associated with increase risk of dissection, stroke and injury during surgery. We report a case of patient presented with 'kissing carotid artery'. A 62years old lady, presented with foreign body sensation over throat for1 week associated with halitosis. She denied any odynophagia, dysphagia or fever. No history foreign body ingestion, change in voice or stridor. On examination noted patient was alert and not septic looking. Neck and oral cavity examination was normal. Flexible nasopharynxlaryngoscopy revealed bilateral paramedian pulsatile mass over posterior pharyngeal wall, starting at the level of base of tongue till tip of arytenoids, it was not compromising the airway and pulsation was synchronized with the radial pulse. Otherwise, the overlying mucosa was normal, no other mass was seen and vocal cord was mobile. Initial lateral neck xray did not showed any widening of preveterbral space. We proceed with CT neck and angiogram which showed abnormal course of bilateral carotid artery. In the imaging, the proximal portion of both common carotid arteries runs within the carotid space up to C5 vertebral level. At the level of C3/C4, the common carotid arteries course in the retropharyngeal space and abuts the oropharyngeal wall. Here,significant medialization of the left posterolateral pharyngeal wall was seen. The distance between both arteries are 0.4 cm in between, giving the appearance of kissing carotid. Superiorly, both left internal carotid and external carotid artery to run along the normal course of vascular anatomy. On the right side, the proximal segment right internal carotid artery appears to run along the midline of C2/C3 vertebra, for a length of 2cm. Then, superiorly, both right internal carotid artery and external carotid artery appear to run along the normal course of the vascular anatomy.No aneurysmal dilatation, intimal flap or arteriovenous malformation of this vessel.CT result was informed, and reassurance given to the patient. She was then followed up yearly.In conclusion, one must know anatomical variantcarotid artery in the neck before embarking on any procedure or surgical intervention as catastrophic complication may arise.