PHILADEPHIA RHEUMATISM SOCIETY
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Case #2: A 74 year old woman with a necrotic tongue

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Discussant: Dr. Antoine Sreih, *University of Pennsylvania*

History of present illness: A 74 year old Caucasian woman presented to the emergency room with two weeks of tongue swelling. She had three courses of antibiotics in the two weeks prior to admission without any improvement in the swelling. She complained of difficulty swallowing as well as difficulty speaking. In the emergency room, her tongue was described as "violacous and protruding from her mouth." She was sent to the ICU where she was treated for angioedema attributed to the lisinopril she was on. She was given short-term intravenous steroids with some improvement. Later she was transferred to a regular medical floor; however, her tongue continued to worsen. It became necrotic and began to slough off.

Past Medical History: Hypertension, hypothyroidism, osteoporosis, osteoarthritis, depression, COPD, carotid stenosis, h/o uterine cancer (s/p TAH), h/o basal cell cancer

Social history: quit tobacco use one month prior to hospitalization, no current drug or Etoh use aware of, currently caregiver for husband who is on home hospice

Family history: no autoimmune disease

Medications (outpatient): lisinopril, lipitor, evista, subutex, wellbutrin, lexapro

Allergies: talwin, codeine

Review of Systems: Difficult because of compromised speech. However reports weight loss for months. She also has dysphagia. She denies any fever, chills or congestion. She denies arthralgias, sinus congestion/discharge.

Physical Exam:
Temp 99.5 BP=166/77 HR=75 RR=14
General: Frail woman looking older than stated age
HEENT: anicteric sclera, neck supple mucus membranes dry with poor dentition , violacous area over the left lower lip, whitish/enlarged tongue;
Heart: RRR; no M/R/G
Lungs: rhonchi/wheezes on the right
Abdomen: soft/nontender
Extremities: no synovitis; no edema

Labs:
WBC=13.2 (80 N, 11 L, 9 M cells), Hgb=12.7, Hct=37.1, Plt=590
C-reactive protein=11.7 mg/dl (normal is up to 0.9)
ESR=78 mm/hr
Acetylcholine receptor ab= <0.30 nmol/L (normal)
Aldolase=7.4 U/L

Vitamin D 25OH=7
TSH=1.91 T4=10.9
Na=132 gluc=98 K=4.6, Ch=94, CO2=26, BUN=15, Cr=0.9, Ca=9.6
AST=30, ALT=22, Alk Phos=125 , total bili=0.2 , bili direct=<0.1
Amy=81, lipase=161
Uric acid=2.9 mg/dl
Total protein=7.6 , albumin=2.2, globulin=5.4
CK-MB=15.4, myoglobin=187 ng/ml
Urinalysis: no glucose moderate blood, 30 protein,2-5 WBC/hpf, 5-10 RBC/hpf

Imaging studies:
CXR: no active lung disease
CT head/neck: no evidence of an abscess, soft tissues and airway are normal; no acute intracranial changes, mild sinusitis, a few small round lucencies in skull posteriorly are nonspecific and without significant changes.
CT chest: no infiltrate or mass; 4 mm nodule in right apex, no adenopathy and no pleural effusions
MRI brain: no acute infarcts or major venous sinus thrombosis

Hospital Course:
Her tongue continued to worsen and a diagnostic procedure was performed.