Chief Complaint

“I cannot close my left eye”
HPI

• A 59 year old African American woman with PMHx of HTN, GERD, depression who was in her USOH until 4-5 months ago, when she started to have subjective fevers and night sweats.

• Patient also complained of difficulty swallowing, especially solid food which was followed by a weight loss of about 30lbs over the next 3-4 months.
HPI...

• A week prior to presentation, the patient developed productive cough with blood tinged sputum.

• The patient then developed sore throat which was followed by one day history of left sided facial droop, facial swelling and inability to close her left eye.

• Patient c/o chronic weakness in her left hand for the past several weeks, denied weakness in any other parts of her body.

• She also denied any vision changes, headache, tingling or numbness.
ROS

• Patient admitted to:
  – Dyspnea on exertion
  – Pleuritic chest pain

• Patient denied:
  – Palpitation
  – Pedal edema
  – Rashes
  – No known tuberculosis exposure
  – Never lived in shelters
  – Never been incarcerated
  – No sick contacts
  – No recent travel history
Past History

• PMHx:
  – HTN diagnosed 1 ½ years ago
  – GERD diagnosed for 2 years ago
  – Depression diagnosed for 1 year ago
  – Of note she also was treated for left sided pneumonia a month ago
Past History

• Allergies:
  – No known drug or food allergies

• Surgical history:
  – Right breast fibroid removal 10 years back.

• FMHx:
  – Mother died of esophageal cancer at 80 years of age
  – Sister died of esophageal cancer at 56 years of age.
  – Brother had Bell’s palsy
Past History

• Meds:
  – HCTZ 25 mg PO daily
  – Citalopram 20 mg PO daily
  – Esomeprazole 40 mg PO daily
Past History

• Social History:
  – Lives in Port Sulphur and works for Counsil of aging.
  – Social drinker (3-4 drinks a year)
  – Denies smoking and illicit drug use.
Physical Exam


• Gen: AAO x 3, NAD
• HEENT: PERRL, EOMI, unable to close left eye and has left facial droop, 2 cm firm, tender mobile mass in front of left tragus, no erythema/warmth or fluctuance noted.
• Neck: No carotid bruit, 3 cm left anterior and 2 cm right anterior cervical lymphadenopathy: smooth surface, firm, NT, mobile, non-fluctuant.
Physical Exam

- CVS: RRR, no murmurs or rubs heard, JVP at 6 cm H2O
- Resp.: CTA (B)
- Abd: ND, positive BS, soft, NT
- Ext: 2+ distal pulses, no cyanosis, clubbing or edema
- Rectal: Normal tone, FOBT negative
Physical Exam

- **Neuro: Cranial Nerves**
  - **CN2:** Visual acuity 20/40 right eye, 20/100 left eye, normal field of vision bilaterally, she can appreciate colors
  - **CN7:** Cannot raise eyebrows or frown on left side, unable to close her left eye, loss of left nasolabial fold, unable to blow air into left cheeks.
  - Otherwise **CN 3,4,5,6,8,9,10,11,12:** Tested and within normal limits
Physical Exam

• Neuro:
  – Motor: 5/5 in upper and bilateral lower extremities
  – Sensations: Intact for fine and crude touch, position sense intact
  – DTR: 2+
  – Coordination: Finger nose test and rapid pronation and supination intact
  – Gait: Normal
Laboratory Data

- WBC: 6.3
- Hgb: 12.2
- Hct: 36
- Plts: 243
- MCV: 95
- RDW: 15
- Segs: 51%
- Bands: 0%
- Lymphs: 27%
- Monos: 13%
- Eos: 8%
Laboratory Data

- Na 136
- K 3.6
- Cl 103
- Bicarb 26
- BUN 13
- Creat 0.7
- Glucose 86

- Ca 9.7
- Mg: 1.5
Laboratory Data

- TProt 8.2
- TBil 0.7
- Alb 3.7
- AST 30
- ALT 19
- Alk Phos 45
- PT 14
- INR 1.2
- PTT 26
Laboratory Data

- **U/A**
  - Color: Pale yellow
  - SG: 1.006
  - pH: 6.0
  - Prot: None
  - Blood: 50
  - Urobili: (-)
  - Ictotest: (-)

- **WBC**: 0-2
- **Bacteria**: few
- **Sq epi**: 1-2
Admit CT head
MRI/MRA
Admit CXR
Admit EKG
Hospital course

• Patient was initially admitted to Neurology service to rule out CVA.
• CT head- Area of left parietal hypoattenuation, however the MRI/MRA of the brain did not show any evidence of an acute CVA.
• Consequently a working diagnosis of Bell’s palsy was made.
Hospital course…

• The patient was further evaluated for the etiology of:
  – Left sided facial palsy
  – Odynophagia
  – Left sided facial swelling
  – Lymphadenopathy, subjective fevers, weight loss
Hospital course.....

• Facial palsy- patient was started on Methylprednisone dose pack with marked symptomatic improvement by day #3 with ability to close her left eye.
• She had evidence of left optic neuropathy on ophthalmosscopic examination.
• Artificial tears and eye patch were used to prevent exposure keratopathy.
Hospital course....

• Evaluation of odynophagia:
  – GI performed an EGD which showed evidence of pharyngitis and mild non erosive gastritis. Recommended further evaluation by ENT for pharyngitis and odynophagia.
Hospital course....

Left sided facial swelling -

- ENT evaluated the patient, the left sided facial swelling was attributed to inflammation of the parotid gland (parotitis)
- Pharyngitis and subsequently odynophagia were also considered to be secondary to decreased lubrication due inflammation of the parotid and the submandibular salivary gland.
Hospital Course

• Lymphadenopathy, weight loss, fevers:
  – Further imaging studies (CT chest and neck) were concerning for an infectious vs neoplastic process.
  – Infectious causes were negative
    • ‘T’ spot test - negative
    • tissue and blood cultures – (negative)
  – FNA with cytology was done to rule out malignancy.
CT of the soft tissue neck
CT of Chest
PATHOLOGY
Left preauricular node, FNA

- Scant cellularity with rare naked granulomas and rare multinucleated giant cells.
- Consistent with granulomatous lymphadenitis.
• Presumptive diagnosis of Sarcoidosis was made.
• Rheumatology consulted for further recommendations
Hospital Course

• Rheumatology evaluated the patient, recommended some additional tests and treatment with high dose prednisone (60mg).
Additional Laboratory Data

- ANA: Negative
- ACE level: **132** (Normal range: 12-68)
- CRP: **1.42**
- ESR: **41**
- HIV: Negative
- C-ANCA, P-ANCA: Negative
- Ig A: **409** (75-374)
- Ig G: **1953** (680-1530)
- Ig M: 74 (47-188)
Follow up

• Patient was discharged home on high dose prednisone (60mg) until her next follow up appoint with Rheumatology in a week.

• She was able to close her eyes completely, odynophagia and her left sided facial weakness completely resolved during subsequent clinical visits.
DIAGNOSIS

UVEOPAROTITIS SECONDARY TO SARCOIDOSIS.
THANK YOU