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A CASE OF UVULAR ANGIOEDEMA

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ABSTRACT

Uvular oedema can be a serious sign of suffocation due to the obstruction of the airway path. There are various causative agents of oedematous uvula such as Idiopathic, hereditary angioedema, trauma, inhalation exposure, medication reactions. Snoring is a common predisposing factor to uvular oedema. Therefore, we should rule out the etiology and try to remove the stimuli as early as possible so that we can conserve the patient's life. In most cases of oedematous uvula, patients usually complain of difficulty swallowing and feel like something is stuck in their throat. In this article, we report a case of an asymptomatic oedematous uvula with increased its length.

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INTRODUCTION

A 21years old male patient came to Oral Medicine and Radiology department with the chief complaint of discomfort swelling uvula during swallowing and increased its length from 5days back (Fig. A) and was asymptomatic. He came to know his uvula is enlarged after he had seen in the mirror. There was history of breathing through mouth as he got sinusitis from 6years back. He didn't give any dental or allergic drug histories and affected family members. Extra orally, right submandibular lymph nodes was palpable. It was tender on palpation and firm in consistency. The shape was oval shaped and roughly (0.5*1) cm. And nasal blockage was present. Intraorally, uvula was oedematous (enlarged) and elongated which was hanging down over the posterior one-third of dorsum surface of tongue (slightly tilted on the right side). There was absence of pain and inflammation around the adjacent structures (Fig. B and C). Based on the patient's history and clinical findings, we preferred the diagnosis of Uvula angioedema. We just advised the patient to consume more water and gargled warm water with salt as he was not ready for further investigations. Drinking more water will help in lubricating the area and gargle warm water with salt aid in soothe.

We recalled him after 5 days though he came on third day. During inspection we found out that uvula was reduced their size and length compared with the oedematous one (Fig. D). Patient also revealed of consuming water more than 3 litres per day and gargled warm water with salt. On 10th day, it was going to be completely normal (Fig. E).

DISCUSSION

Uvula comes from the latin word for grape 'uva' and it is an accessory gland of speech (Welling, 2008). It is the soft palate that extends posteriorly into a thick pendant of mucous membrane. It is thin and non-keratinized. The mucosa is quite vascular (Sawyer *et al.*, 1997). Uvular angioedema is a lethal condition which can take patient's life due to the compromised airway (Rasmussen, 2014). Clinical feature includes; fullness of oropharynx, difficulty in breathing due to the obstruction in airway path and speaking as it affects the vocal cords (Patel, 2014). In 1882, Quincke defined the term "Isolated uvular angioedema" (Cevik, 2010) and also known as 'Quincke's disease' (Deutsch, 1991). It is a rare presentation of angioedema of upper airway (Huang, 2007). First of all we must to rule out the aetiology. Various causative agents of uvular angioedema are infections, hereditary, trauma, idiopathic, allergy, medications and drugs (Alcoceba *et al.*, 2010; Boyce, 2002). Uvular angioedema due to infection occur when the oedema is caused by infection and it is called as uvulitis.

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Fig. A. Extraoral picture of the patient



(B)

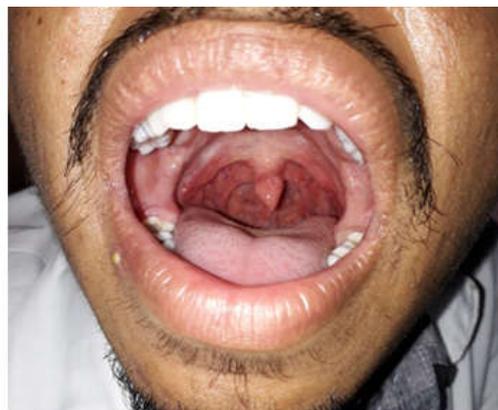


(C)

Fig: (B & C) Uvula presenting enlarged and elongated without any inflammation and pain



(D)



(E)

Fig. (D) shows reducing in size and length after 3 days; (E) almost normal after 10 days

It is commonly caused by Group A Streptococcal, haemophilus influenza type b, candida or anaerobic bacteria (Huang, 2007). It is uncommon and often associated with epiglottitis (Shomali, 2016), pharyngitis and tonsillitis (Rapkin, 1980). The choice of medicine is penicillin as penicillin respond immediately (Lathadevi *et al.*, 2005). Hereditary uvular angioedema (C1 esterase inhibitor deficiency); is a rare disorder of autosomal dominant inheritance (Farkas, 2010). The diagnosis is suggested by the family history, the time of the onset of symptoms (after puberty, during pregnancy or the use of oral contraceptives), clinical manifestations, triggering factors (estrogen contraceptives, pregnancy, estrogen hormone replacement therapy), the predominance of females among patients, and the favourable response to progesterone replacement (Bork *et al.*, 2009). Inhaled corticosteroid reduced airway inflammation and control of asthma symptoms (Farkas, 2010). Uvular angioedema caused due to trauma (oropharyngeal intubation, snoring) show uvular oedema and respond to treatment with C1-inhibitor concentrate partially. Idiopathic uvular angioedema is the most common type without any distinct etiological agent. Allergic reaction can caused uvular enlargement and its treatment includes; airway maintenance and in emergency situations, intravenous H1 and H2 histamine blockers, corticosteroids, infrequently, epinephrine may be required. It has good prognosis with low recurrence rate (Mohseni, 2008). Medications and drugs such as non-steroidal anti-inflammatory drugs(NSAIDs), ACE inhibitors, cannabis, glucosamine sulfate, ipratropium bromide) induced uvular angioedema (Patel, 2014). Bradykinin receptor antagonist or complement C1-inhibitor concentrate should be given for bradykinin-mediated angioedema rather than the histamine-pathway (Rasmussen, 2014). In this case we preferred the diagnosis of snoring induced traumatic uvular angioedema. Differential diagnosis can includes; uvulitis and non-resolving post-operative sore throat.

Conclusion

We need to monitor whether the airway is safe or not as the airway might be compromised due to the oedema. So, the clinicians should always keep in mind about the potential tendency of upper airway obstruction. In this case, we prevented airway obstruction through early diagnosis, useful patient information and timely recognition.

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