Images In Medicine

Floppy Ear, Premature Myocardial Infarctions, and Severe Arthritis. Are They Related?

Peter Than and Rami Abumasmah, MD

A 53-year-old man awoke one morning to find his left ear swollen and extremely painful. He could not hear clearly. Notably, he had had a similar episode of rapid onset ear pain six weeks prior, when his ear looked and felt the same. For that episode, he was treated empirically for cellulitis with vancomycin with resolution of symptoms after 4 weeks. He has a history of two myocardial infarctions in his forties though he had no cardiovascular risk factors or family history of myocardial infarction.

Physical examination revealed an edematous, erythematous, tender left ear with effacement of the normal pinna architecture, destruction of the rigid cartilaginous structure, and sparing of the earlobe. There was a large nodule in the left elbow, multiple tender hyperpigmented cutaneous patches in the lower extremities and significant crepitus in the right knee. Laboratory examination revealed leukocytosis, elevated CRP, slightly elevated c3, normal serum uric acid, with no ANF, c-ANCA, p-ANCA, or c4. Echocardiography revealed a dilated aortic root.

He was diagnosed with relapsing polychondritis. Premature coronary artery disease is a documented manifestation of relapsing polychondritis and may, in our patient with a history of early onset cardiovascular events in the absence of known risk factors for MI, have led to early myocardial infarctions. Although relapsing polychondritis typically presents with non-erosive arthritis, our patient's atypical and severe presentation, requiring bilateral knee replacements before the age of 40, is noteworthy as we could not clearly attribute it to any other etiology.

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Disclosure of Financial Interests

The authors and their spouses/significant others have no financial interests to disclose.

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Figure A. Cartilage destruction leading to loss of supportive structure in the pinna.

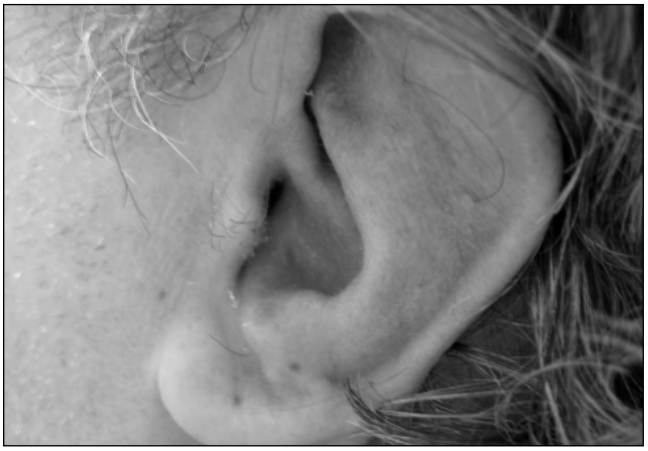

Figure B. Effacement and loss of the pinna architecture and edematous swelling of the external ear canal. The erythema had subsided as this photograph was taken three days after corticosteroid therapy had been initiated.

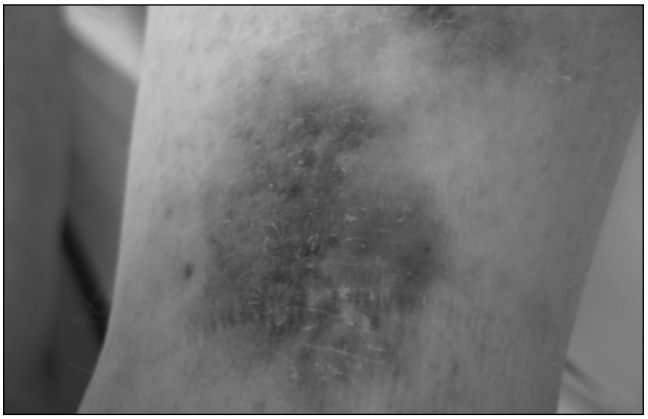

Figure C. Hyperpigmented cutaneous lesions on the extensor surfaces of the lower extremities.