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Relapsing Polychondritis

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A 42-year-old non smoker woman admitted to hospital for a worsening dyspnea, a dry cough without fever or chills. Two years earlier, she was diagnosed as bronchial asthma and required multiple emergency visits. Her physical examination revealed an inspiratory stridor with wheezing on auscultation. Her nose and ears were inflamed with tenderness on palpation without any deformation. The spirometry test demonstrated an obstructive pattern not reversible after bronchodilator administration and a plateau in expiratory flow. Flexible bronchoscopy revealed a 2 cm tracheomalacia feature. The lumen of this part of the trachea is narrowed with the absence of cartilage and collapsed during expiration (Figure 1). Tracheal biopsies confirmed the absence of cartilage. Blood laboratory test were normal. Autoantibody for rheumatoid arthritis, granulomatosis with polyangeitis and other auto immune diseases were negative. The diagnostic of relapsing polychondritis was based on clinical, pathological findings. The patient respiratory status improved after immunosuppressive and corticosteroids. Relapsing polychondritis involving airways might be misdiagnosed as bronchial asthma due to stridor and transient corticosteroid-related improvement. Early diagnosis is necessary to prevent irreversible airway stenosis.



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