

ENT MANIFESTATIONS OF AUTOIMMUNE RHEUMATISM DISEASE

Imad Sadeq Mohammed Jawad¹, Ahmed Thabit Numan², Ayad Salih Al-Zubaidy³

1 Ministry of Health, Baghdad, Iraq.

2 Ministry of Health - Baghdad Medical office - Al-Karkh, Abu Ghraib General Hospital, Baghdad, Iraq.

3 Ministry of Health - Baghdad Medical office - Al-Karkh, Al Karama Educational Hospital, Baghdad, Iraq.

1- INTRODUCTION

Ear-nose-throat (ENT) manifestations of rheumatologic disorders represent a diagnostic challenge for the rheumatologist, the otorhinolaryngology, and the general practitioner. Not uncommonly ENT symptoms represent the initial sign of an otherwise asymptomatic or even undiagnosed autoimmune disorder which often calls for prompt and aggressive immunosuppressive treatment. Moreover, ENT symptoms may be overlooked by the patient or the internist who are usually preoccupied with the main manifestations of the disease. Herein we review the most frequent ENT manifestations of connective tissue disorders with emphasis on what we consider to be helpful diagnostic clues that could facilitate early diagnosis and treatment.

2- HEARING-AUDIO VESTIBULAR DISTURBANCES

Immune-mediated inner ear disease (IMIED) Sometimes there are reports of ear damage Complicate various processes Rheumatism. Immune Mediated inner ear disease (IMIED) Immune-mediated sensory neuron Hearing loss and other performance Such as dizziness, tinnitus and occasionally, the feeling of full auricle Improve clinical disease. Patients can complain

Hearing loss or decline Sound discrimination. Usually IIMED Subtly or over time Of course, it goes from a few days For a few months. It can help clinicians Differentiate IMEED and Nell Rael syndrome Follow longer time. In addition, IMEED is at least suitable for Bilateral (although both sides Can be asymmetrically distributed, even Asynchronous with interval Complement between the two sides

In rare cases, up to one year), Is a useful diagnostic tool for distinguishing Between IMEED and acoustics Neuroma. However, MRI examination Usually for exclusion Diagnosis of cerebellopontine angle lesions usually a vestibular adenoma Especially at the beginning No signs of bilateral participation Clinically obvious. Symptom fluctuation Mode of several periods Also described for a few months. One kind a subset of patients with disease-limited Serum antibody in the inner ear Resistant to 68 KD inner ear antigen (1). Unilateral and bilateral sensory nerves Hearing loss (SNHL) Influence medium high Frequency has been reported SLE patients and have enough Evidence supporting strong connections Between SNHL and existence High titer anti-cardiolipin antibodies. Subclinical SNHL In more than 22% of patients Some researchers work with SLE. Acute Hearing impairment Primary ant phospholipid Syndrome (APS). Bibliographic scarcity Potential evidence

SNHL and Acute aortic regurgitation, a rare manifestation SLE. No correlation between Disease status or presence Type and appearance of antibodies Confirmation of SNHL. In On the other hand, the use of non-steroidal anti-inflammatory drugs And antimalarial drugs, a common clinical The practice of SLE patients may represent Because both are confusing The class of drugs has been Associated with SNHL (2-5). SNHL Medium and high frequency Clinical findings of pharyngeal pat The tube is already in Patients with systemic sclerosis (SSc). Mixed hearing loss has been The reporting frequency is much lower (6). SNHL during Jorgen's syndrome Partially attributed to (SS) High titer anti-cardiolipin Antibody (7). Myeloperoxidase (MPO) related Vacuities has been involved Pathogenesis of hearing loss in patients Nodular polyarthritis (PN) and Multiple vacuities (MP) under the microscope.

3- CRICOARYTENOID ARTHRITIS AND SUBGLOTTIC STENOSIS

Ring joints may be potential Affected by various processes Inflammatory joint disease. Rheumatoid Concurrent arthritis (RA) Ring arthritis cases account for 30%. Sore throat, hoarseness and inhalation Wheezing is the most common clinical which performed. Airway obstruction Need for immediate tracheotomy It has been described (46). Laryngoscopy Redness and edema, reduced Unilateral or bilateral vocal cord movement Sound adduction, closing is not complete After diopter (Conducive to aspiration) and cartilage Asymmetry. Occasionally Glottis stenosis may be narrow Also noticed. Corrosion Ring joint and its surroundings Can prove soft tissue swelling High resolution (HR) CT scan. Throat blocked upper airway Very little participation, but well documented Complications of SLE Usually happen with other people Symptoms and signs Active disease. Double umbilical cord fixation Can be noticed. Interestingly, SLE Ring ico joint arthritis reaction Steroid treatment Usually not enough to provide cycloecosane Arthritis of RA. Ankylosing spondylitis (AS) can It also affects the joints of the ring. Review the performance of rheumatism / E.D. Papadimitraki et al. On one side,

the sound on both sides is small Wire fixing and maintenance The position of the rope is seemingly Late performance of uncontrolled disease Gouty laryngeal arthritis Deafness, sound disorder and difficulty swallowing Can accompany multiple joints Participate or behave as gout Performance. Throat headache Soft tissue or vocal cord Very few reports of similar symptoms. Circumferential degenerative ulcer Articular osteoarthritis (OA) can also happen. These structures Change comparable to OA Limbs, may damage joints Cartilage movement (so Sound quality is degraded, sound is reduced activity). In one study, 50% Laryngeal joints of patients over 40 years old Age indicates this degradation Change. Acute laryngitis, gastroesophageal reflux Chronic drip after disease Smoking, drinking and chronic sounds Strain (all potential chronic causes Laryngitis), spastic dystonia, hypothyroidism, Vocal cord polyps and Nodules, throat (after thyroidectomy) Or other reasons Conversion barrier and throat Cancer represents some reason Hoarseness and sound disorder Must be excluded. Serious Small glottis (SGS) causes serious Acute dyspnea, requiring tracheotomy Already described in the patient With WG. In this group of patients Usually occurs independently of the disease Activity and treatment type Seems to be systemic slow Immunosuppressive therapy.

4- OROPHARYNGEAL DYSPHAGIA

Dermatomyositis (DM) patients Or polymyositis (PM), cr pharyngeal Loss of achalasia caused by pharyngeal injury Muscle activity can cause oropharynx Dysphagia is difficult More than swallowed liquid Solid, dysarthria and sound disorders. The Ring rear muscle Only muscles keep the vocal cords Admittance, so when damaged, The vocal cords are gathered together. So if After the ring, the aryl muscle is Airway obstruction occurs when it is involved. Or pharyngeal dysphagia may be further Concurrently Esophageal contents enter the respiratory tract Reduce the diameter and increase the stiffness And soft pa, thinning of

the throat And oral mucosa Systemic or pharyngeal dysphagia Sclerosis (SSc) . Film degree exam Is the most useful diagnostic tool For assessing oropharynx hard to swallow. Primary Sjogren's syndrome Description will affect The upper third of the esophagus (eg Proved by pressur measurement studies) Induced esophageal throat symptoms Reflux and dysphagia.

5- FACIAL NERVE

Appearance Many complex processes of connecting words Organize the disease. SS and sarcoidosis rheumatism Most frequently associated Face Active other performances In most cases, this is a disease. In Sarcoidosis The facial paralysis can be unilateral or Bilateral (simultaneous or sequential) And relapse (73). Other Causes of acute facial paralysis Including Bell's [may be due to Herpes simplex virus (HSV)], chickenpox - Herpes zoster infection (Ramsay-Hunt syndrome) Green Barry syndrome Lyme disease, acute or chronic otitis media Middle layer and cholesteatoma ear. Note Regular or permanent assessment Facial nerve paralysis, may be Showing tumor symptoms Parotid and humeral malignant transformation Middle ear ganglionoma, Cholesteatoma or other tumor The lesion involves the facial nerve.

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