

Retropharyngeal Edema – A Case Report.

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Abstract:

Infections of the deep neck space involving retropharyngeal and prevertebral spaces can result in significant morbidity and mortality. A high index of suspicion is needed when we encounter a patient who presents with neck swelling and obstructive symptoms such as dysphagia and odynophagia. Proper history from the patient is crucial to narrow down possible diagnoses that are exceedingly uncommon. Other underlying medical illnesses and systemic conditions must be considered to exclude another possibility especially when the patient is afebrile.

Introduction :

Focal segmental glomerular sclerosis is one of the most common causes of primary glomerulopathy in adults. It is one of the most common causes of nephrotic syndromes. Focal segmental glomerular sclerosis occurs due to genetics, infection, and the usage of nephrotoxic drugs. The most common clinical manifestation is generalized edema, hypertension, malaise, limb swelling, and facial puffiness. Diagnosis of focal segmental glomerular sclerosis is achieved only by histopathology findings. When a patient presents with afebrile neck swelling with obstructive symptoms, a complete examination with investigation must be done to assist in the diagnosis. One of the common presentations is edema and it can occur in deep neck spaces. Early detection can lead to unwanted surgical intervention.

Case Report :

A 44-year-old Malay female presented with dysphagia, odynophagia, and anterior neck swelling for the past 3 days. She has been having bilateral lower limb swelling and facial puffiness for the past 1 month, and it is not worsening. She does not have a fever, oral intake is still acceptable, and there is no evidence of upper airway compromise. The main concern was her anterior neck swelling. She does not have any ear or nose-related complaints. She is a newly diagnosed focal segmental glomerulosclerosis confirmed with renal biopsy. She was on oral steroids for her kidney conditions and was advised to 1 liter per day fluid restriction. On examination, there was fullness over the anterior neck, which was soft on palpation, size 4cmx4cm, no skin changes, and not tender on palpation. Flexible nasopharyngolaryngo-scope revealed normal findings. Given neck swelling, an X-ray was ordered and noted loss of lordosis and prevertebral thickening. Because of X-ray findings, the patient was subjected to Computed Tomography Neck which shows minimal fluid and effusion at retropharyngeal space, both carotid space and middle mediastinum as well as bilateral pleural effusion secondary to nephrotic syndrome, diffuse fat stranding of the upper thorax and neck region likely edema secondary to nephrotic syndrome. Laboratory investigations showed marked hypoalbuminemia and heavy proteinuria consistent with a diagnosis of Nephrotic Syndrome. The patient was then referred to the nephrology team for further assessment. She was admitted and started on

diuretics and strict restrictions to prevent fluid overload. The anterior neck swelling subsided after 1 week, and she was discharged well after 10 days.

Image a: anterior neck fullness



Image 1b : X-ray showing loss of lordosis and prevertebral thickening.



Discussion :

History taking is crucial when dealing with a patient who presents with afebrile neck swelling. Apart from typical infection, edema is a differential. Thus, underlying medical or systemic illness and the current ongoing treatment for this condition must be known to aid with the diagnosis. Apart from clinical examination, imaging can aid with the diagnosis. Choosing the suitable imaging modality is important as well.

Conclusion :

Retropharyngeal edema is not a scenario we encounter in our clinical practice commonly. Detailed examination and history taking, proper imaging can aid with the diagnosis. Early diagnosis can help with proper management and reduce morbidity and mortality.

Reference :

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