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Case Report

Ear, Nose and Throat Section

Unusual Clinical Presentation of Dermatomyositis in a Young Male: A Case Report

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ABSTRACT

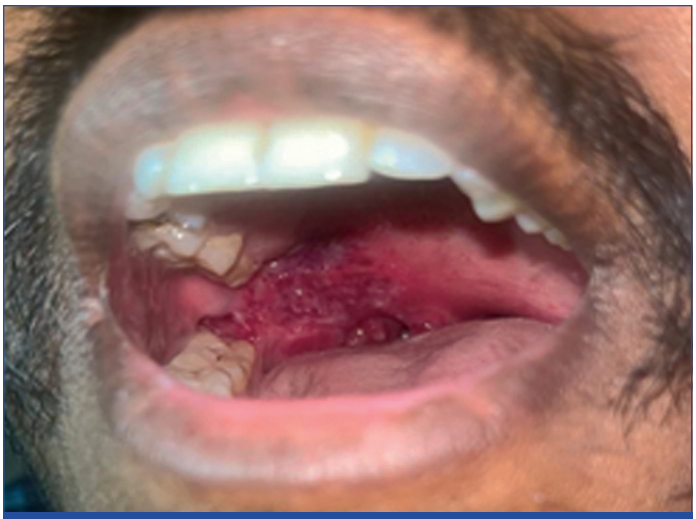
Dermatomyositis (DM) is a rare idiopathic inflammatory myopathy characterised by distinctive dermatological manifestations and systemic involvement. This present case report involved a 25-year-old male was presented with throat pain, progressive dysphagia, and oral ulcers following a recent tooth extraction. Examination revealed ulceroproliferative lesions in the retromolar trigone that were prone to bleeding. This case emphasised an unusual presentation of DM with oropharyngeal ulcerations and leukocytoclastic vasculitis. Prompt recognition, comprehensive evaluation, and multidisciplinary management are essential for improving patient outcomes in atypical cases.

Keywords: Classic dermatomyositis, Clinically amyopathic, Idiopathic, Myositis, Polymyositis, Ulceroproliferative

CASE REPORT

A 25-year-old male presented with complaints of oral ulcers for 14 days, which began after a tooth extraction, i.e., the left lower second molar, performed approximately 15-20 days ago. He also had throat pain with progressive odynophagia and dysphagia for the past 12 days, more for solids than liquids. The patient reported swelling of the lower limbs for one day and an unintentional weight loss of 6 kg over the preceding 20 days. There was a history of allergy to an unidentified drug, with no similar history in the family. No history of fever, foreign body sensation in the throat, dyspnoea, hematemesis, or haemoptysis was noted.

The clinical examination revealed a normal oral cavity, but oropharyngeal inspection demonstrated ulceroproliferative growths bilaterally in the retromolar trigone. A similar lesion, measuring 2×1 cm, was observed on the right retromolar trigone, also covered with slough. Lesions were tender and bled on palpation [Table/Fig-1]. The posterior pillars and posterior pharyngeal wall were not visualised. Examination of the neck revealed no palpable lymphadenopathy. Nasal examination showed a Deviated Nasal Septum (DNS) to the left, a left-sided septal spur, and bilateral inferior turbinate hypertrophy. Otoscopic examination revealed bilateral pars tensa grade 1 retraction.



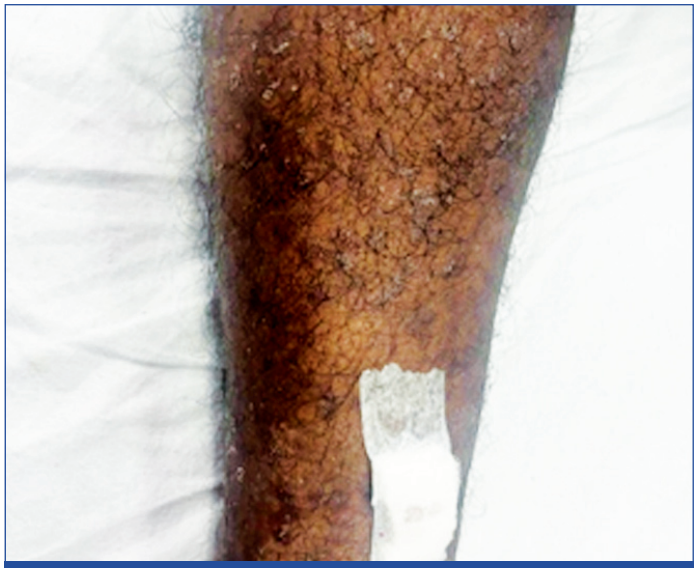
[Table/Fig-1]: Detailed pretreatment clinical image showing lesion over the right tonsillar fossa.

A throat swab was obtained on an outpatient basis, and the patient was admitted for further evaluation. Routine investigations, including Complete Blood Count (CBC), Liver and Kidney Function Tests (LFT, KFT), Glycated Hemoglobin A1c (HbA1c), Human Immunodeficiency Virus (HIV) screening, and Electrocardiography (ECG), were carried out, all of which were within normal limits. Furthermore, the patient was started on oral prednisolone (Wysolone) 10 mg for five days for the post-tooth-extraction ulcer, as he had already taken a course of antibiotics with no improvement and continued to have odynophagia and dysphagia. The throat swab culture yielded Methicillin-Sensitive *Staphylococcus Aureus* (MSSA), prompting the initiation of intravenous clindamycin therapy (2 mL twice daily for 7 days). A biopsy of the oropharyngeal lesions was subsequently performed, which showed mild focal dysplasia with a possible suggestion of actinomycosis. Based on this, oral fluconazole 250 mg once daily was added for 21 days.

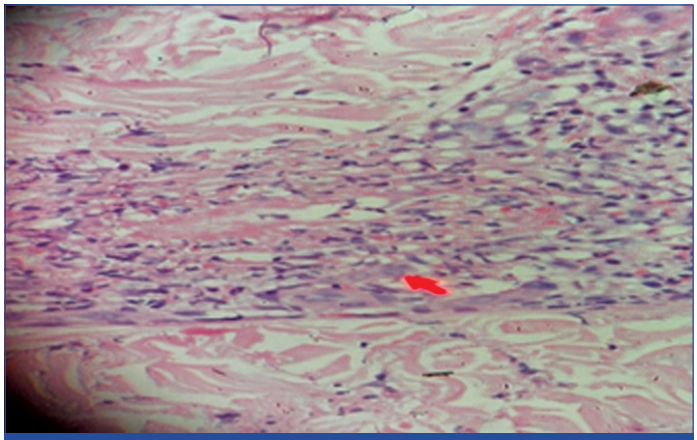
During the hospital stay, the patient developed irregularly shaped, erythematous, circular, and purpuric cutaneous lesions on the lower limbs. Treatment was started with intravenous clindamycin and ceftriaxone, oral fluconazole, and topical lotions. A punch biopsy was performed to aid in diagnosis [Table/Fig-2]. Histopathological examination revealed leukocytoclastic vasculitis, characterised by transmural necrotic infiltrates within the vessel walls, extravasation of red blood cells, karyorrhectic debris, and fibrinoid necrosis [Table/Fig-3]. Periodic acid-Schiff (PAS) staining further confirmed fibrinoid necrosis within the vessel walls [Table/Fig-4]. An autoimmune panel demonstrated weakly positive Anti-Nuclear Antibody (ANA) and anti-Jo 1 antibodies, raising initial suspicion for an underlying connective tissue disease. However, further laboratory investigations were negative, and the findings were deemed clinically insignificant. In light of these findings, the patient was referred to a Rheumatologist for further evaluation and remains under ongoing management and assessment. At the 2-week follow-up, a notable regression of the lesions was observed [Table/Fig-5].

DISCUSSION

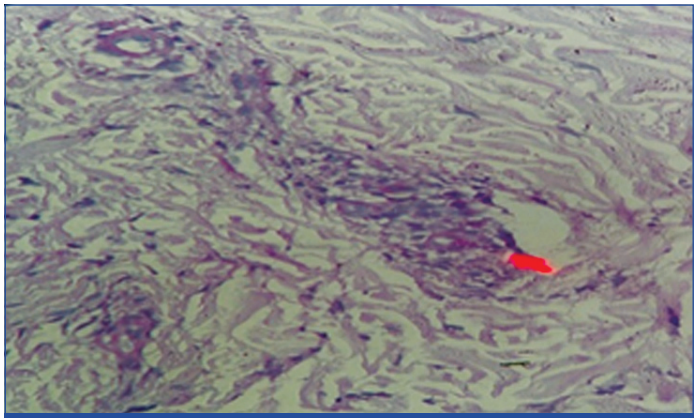
The DM is an idiopathic inflammatory myopathy characterised by hallmark cutaneous manifestations and systemic involvement. It is frequently associated with malignancies and autoimmune conditions. The presentation in our case, characterised by oropharyngeal ulcerations, progressive dysphagia, and leukocytoclastic vasculitis,



[Table/Fig-2]: Post procedural image showing the dressing site, following punch biopsy taken from the lower limb for histopathological examination.



[Table/Fig-3]: Transmural necrotic inflammation of vessels with extravasation of RBCs, karyorrhetic debris, and fibrinoid necrosis (H&E -400x). [Red arrow].



[Table/Fig-4]: Microscopic examination shows fibrinoid necrosis of a small vessel wall highlighted by Periodic Acid-Schiff (PAS) stain, indicative of vasculitic changes commonly associated with DM under 40x.

is a rare manifestation of DM. While classic DM primarily presents with heliotrope rash, Gottron's papules, and proximal muscle weakness, the presence of severe oropharyngeal involvement in the form of ulceroproliferative lesions is uncommon and warrants further discussion [1,2].

According to the literature, previous case reports have described oropharyngeal involvement in DM; however, they predominantly manifest as dysphagia due to pharyngeal and esophageal muscle involvement rather than ulceroproliferative lesions [3]. A study by Langdon PC et al., (2012) documented a case of DM with severe dysphagia but attributed it to pharyngeal muscle weakness rather than mucosal ulcerations [4]. Similarly, a case

[Table/Fig-5]: The post-treatment image (at 2-week follow-up) shows a notable regression of the lesion, and replacement by healthy granulation tissue with evidence of mucosal healing.

presentation by Elmdaah A et al., (2019) reported pharyngeal dysphagia in DM patients but did not observe ulcerative lesions [5], whereas a recent study in 2024 reported that the incidence of dysphagia was 18.8%, with predominantly pharyngeal-phase impairments [6].

To the best of our knowledge, the present case is unique in that the patient developed painful ulcerative lesions in the oropharynx, resembling infectious or neoplastic conditions. Histopathological findings demonstrated mild focal dysplasia with a possible actinomycosis component, necessitating broad-spectrum antimicrobial therapy. While infections can exacerbate DM, the presence of leukocytoclastic vasculitis in our patient further complicates the clinical picture. Vasculitis is a well-documented but infrequent manifestation in DM, typically involving small vessels and presenting with cutaneous lesions. The presence of leukocytoclastic vasculitis over the lower limbs in our patient adds to the rarity of the case, as only a handful of studies, such as the report by Xu H et al. (2024), have described vasculitic lesions in DM [7].

The diagnostic approach in our case involved a combination of clinical, histopathological, and immunological assessments. Positive antinuclear and anti-Jo 1 antibodies supported an underlying connective tissue disorder, although their weak positivity raised challenges in definitive classification. Early recognition of these atypical features is crucial to prevent delayed diagnosis and complications.

CONCLUSION(S)

This case underscores the necessity of considering DM in patients presenting with atypical oropharyngeal ulcerations, vasculitic lesions, and systemic symptoms. Timely intervention with immunosuppressive therapy can mitigate disease progression and improve prognosis.

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