A 37-year-old African American female with a past medical history significant for stage 1 sarcoidosis presented to our facility with a chief complaint of shortness of breath.
Ten years prior, she presented with bilateral uveitis and lupus pernio (LP) on her right ear and was subsequently diagnosed with sarcoidosis.
She was successfully treated for these conditions and her sarcoidosis remained quiescent until three years ago, when, at an outside institution, she was discovered to have laryngeal involvement.
She was treated with prednisone 60 mg daily for several months and eventually tapered to 10 mg daily.
Her sarcoidosis remained well-controlled on this maintenance dose of prednisone until six months prior, at which time she self-discontinued her prednisone in favor of the homeopathic treatment Nopalea cactus juice, which unsubstantially claimed to have anti-inflammatory properties [4].
Subsequently, she developed dyspnea on exertion progressing to dyspnea at rest.
During this time her voice became increasingly hoarse and she experienced frequent episodes of difficulty swallowing.
In our emergency department, her physical examination was concerning for respiratory distress as she presented with inspiratory stridor and hoarseness.
She also had chronic-appearing, indurated lesions on her right ear.
Given that she had signs of upper airway disease for impending respiratory failure, an emergent bedside laryngoscopy was performed, revealing an obstructed airway with the epiglottis retroflexed over the glottis and significant edema in the arytenoids and aryepiglottic folds.
She was immediately treated with high-dose intravenous dexamethasone and taken emergently to the operating room (OR) to secure her airway for concern for complete upper airway obstruction, which was confirmed with direct visualization of her larynx in the OR.
She was intubated for a surgical airway, and after taking biopsies from the lingual surface of her epiglottis, a #4 cuffed Shiley™ tracheostomy was placed.
Her respiratory status immediately stabilized, was extubated, and transferred to our medical intensive care unit.
Her tracheostomy was exchanged to a #4 cuffless Shiley on postoperative day 5.
During this time she was transitioned from intravenous dexamethasone to prednisone 60 mg daily.
Biopsies ultimately revealed non-necrotizing epithelioid granulomas consistent with sarcoidosis (Figure 1).
She was prescribed this high-dose prednisone for three months, and after receiving education for self-tracheostomy care, she was discharged home.
At her subsequent one-month and three-month follow-up visits, she denied any further respiratory issues.
Repeat laryngoscopies showed significant improvement in the edema in the arytenoids and aryepiglottic folds, but the epiglottis continued to obscure the glottis despite therapy with high-dose prednisone.
Methotrexate was initiated while prednisone was tapered to 10 mg daily; however, this regimen failed and her prednisone dosage was increased to 20 mg daily to reduce edema.
Because she declined surgical treatment, she will continue with medical management with immunosuppressive therapy to facilitate eventual de-cannulation.