

Michael Mohseni, MD
Mark D. Lopez, MD

From the Department of Emergency Medicine, Medical College of Georgia, Augusta, GA.

0196-0644/\$-see front matter
Copyright © 2008 by the American College of Emergency Physicians.
doi:10.1016/j.annemergmed.2007.05.017



Figure. Oropharyngeal examination of a 44-year-old patient presenting with chief complaint of sore throat. (Patient consent obtained before photography.) Used with permission of Mark D. Lopez, MD, Department of Emergency Medicine, Medical College of Georgia, Augusta, GA.

[Ann Emerg Med. 2008;51:8.]

A 44-year-old white man presented after transfer from an outside emergency department (ED) with 6 hours of sore throat. He awoke the morning of his presentation with the sensation of something “stuck” in the back of his throat. Patient had a medical history of hypertension that was not currently treated with medications. Physical examination was significant for a muffled voice and occasional gagging as a result of a swollen, edematous structure in the posterior oropharynx. Patient had no fever, drooling, pain with tongue elevation, or lymphadenopathy. The initial oral examination is shown in the [Figure](#).

*For the diagnosis and teaching points, see page 12.
To view the entire collection of Images in Emergency Medicine, visit www.annemergmed.com*

Address for correspondence: Jesse M. Pines, MD, MBA, 3400 Spruce Street, Ground Ravdin, Philadelphia, PA 19104; 215-662-4050, fax 215-662-3953; E-mail pinesjes@uphs.upenn.edu.

REFERENCES

1. Derlet RW, Richards JR. Overcrowding in the nation's emergency departments. *Ann Emerg Med.* 2000;35:63-68.
2. Institute of Medicine. Hospital-based emergency care: at the breaking point. Available at: <http://www.iom.edu>. Accessed January 5, 2007.
3. General Accounting Office. Hospital emergency departments: crowded conditions vary among hospitals and communities. Available at: <http://www.gao.gov>. Accessed January 6, 2007.
4. Emergency Nurses Association. Emergency Nurses Association position statement: crowding in the emergency department. *J Emerg Nurs.* 2006;32:42-47.
5. Pines JM, Hollander JE, Localio AR, et al. The association between emergency department crowding and hospital performance on antibiotic timing for pneumonia and percutaneous intervention for myocardial infarction. *Acad Emerg Med.* 2006;13:873-878.
6. Greene J. Emergency department flow and the boarded patient: how to get admitted patients upstairs. *Ann Emerg Med.* 2007; 49:68-70.
7. Jenson K. Perspectives: adopt a boarder. Available at: <http://www.urgentmatters.com>. Accessed January 11, 2007.
8. American College of Emergency Physicians. New York emergency physician recognized for excellence in health policy. Available at: <http://www.acep.org/webportal/Newsroom/NR/general/2005/101105.htm>. Accessed January 10, 2007.
9. American College of Emergency Physicians. Boarding of admitted and intensive care patients in the emergency department. Available at: <http://www.acep.org/webportal/PracticeResources/PolicyStatements/div/brdingadmittedintenscarepts.htm>. Accessed January 28, 2007.
10. Liu SW, Thomas SH, Gordon JA, et al. Frequency of adverse events and errors among patients boarding in the emergency department. *Acad Emerg Med.* 2005;12(suppl 1):49-50.

IMAGES IN EMERGENCY MEDICINE

(continued from p. 8)

DIAGNOSIS:

Uvular angioedema (Quincke's disease). The figure demonstrates isolated angioedema of the uvula. Patient had no history of similar episodes and no family history of angioedema. Further questioning revealed that the patient had been treated recently and was receiving amoxicillin for a tooth infection. No leukocytosis (WBC 4.1×10^3) or fever was present.

The patient was admitted to the otolaryngologic service and treated with diphenhydramine, famotidine, and dexamethasone. He was also treated empirically with antibiotics (clindamycin). A bedside nasopharyngeal scope revealed a normal epiglottis and vocal cords, with significant uvular edema. Patient's hospital course was uncomplicated, and he was discharged 36 hours later.

Quincke first characterized angioedema in the medical literature in 1882.¹ Since that time, isolated angioedema of the uvula has been termed Quincke's disease. Several causes of uvular swelling have been described, including hereditary angioedema, trauma, inhalation exposure, medication reactions, and infectious causes. Isolated uvular angioedema is usually caused by a type I hypersensitivity reaction.² This should be differentiated from uvulitis, which is infectious and frequently has concomitant epiglottitis.³

Maintaining the airway is the primary management strategy in Quincke's disease. Treatment in the ED consists of intravenous H₁ and H₂ histamine blockers, corticosteroids, and infrequently epinephrine. More invasive (surgical) techniques such as needle decompression and uvulectomy should be performed with the involvement of otolaryngology consultants.⁴

REFERENCES

1. Quincke H. Uber akutes umschreibnes Hautodem. *Monatschr Prakt Dermatol.* 1882;1:129-131.
2. Huang CJ. Isolated uvular angioedema in a teenage boy. *Internet J Emerg Med.* 2007;3. Accessed May 20, 2007.
3. Lathadevi HT, Karadi RN, Thobbi RV, et al. Isolated uvulitis: an uncommon but not rare clinical entity. *Indian J Otolaryngol Head Neck Surg.* 2005;57:139-140.
4. Kuo DC, Barish RA. Isolated uvular angioedema associated with ace inhibitor use. *J Emerg Med.* 1995;13:327-330.