References


Polycythaemia rubra vera presenting with severe glossitis

Sir,

Polycythaemia rubra vera (PRV) can present in various ways including acute bleeding or thrombotic episodes, cerebral circulatory disturbances, gout and pruritus. We report an unusual case of PRV in whom the main presenting complaint was severe glossitis.

An 84 year old woman was admitted to hospital with a 3 month history of severe soreness of the tongue with associated loss of taste, prominent dysphagia for solids and weight loss of 12 kg. There was a past history of ischaemic heart disease and hypertension, and a mild stroke with very good recovery 6 years prior to the present admission. At the time of her stroke, routine tests including a full blood count were normal. She had no history of abdominal or respiratory disease, was a non-smoker and did not drink alcohol. Her only regular medication prior to admission was multimatin tablets for a few weeks, but the glossitis had not improved.

On examination there was facial plethora, a smooth atrophic, ‘beefy’ red tongue and moderate splenomegaly. Investigations revealed: haemoglobin 17.8 g%, white cell count 42.2 x 10^9/l, platelet count 195 x 10^9/l; differential white cell count-neutrophils 58%, lymphocytes 17%, basophils 10%, myelocytes 10%, myeloblasts 2%; MCV 73 fl, MCH 24 pg, MCHC 33 g/dl. Blood film showed a leukoerythroblastic picture and the ESR was 1 mm in the first hour. Serum electrolytes, renal, liver, calcium and thyroid function tests, as well as serum folate and ferritin levels were normal. Chest X-ray and arterial blood gases were also normal. Serum B12 was > 1,000 ng/l (normal 200–900) and leucocyte alkaline phosphatase score 182 (normal 35–100). Bone marrow trephine examination revealed panhyperplasia with the presence of moderate myelofibrosis, and no evidence of iron deficiency or metastatic disease. An abdominal ultrasound confirmed moderate splenomegaly and showed no abnormality of other abdominal visceras. A barium meal and a gastroscopy were normal. On the basis of these findings, a diagnosis of PRV with secondary myelofibrosis was made and busulphan 4 mg daily was commenced. By the end of 4 weeks’ therapy the glossitis and dysphagia resolved, her weight steadily increased, and the full blood count normalized.

Glossitis could occur in PRV as a result of severe iron deficiency due to repeated bleeding or venesections with no iron replacement. However, in our patient the existence of glossitis without iron or vitamin deficiency, and its fast resolution with chemotherapy given for the