Background: Relapsing polychondritis is a rare disorder characterised by recurrent inflammation of cartilaginous tissues. It usually presents with relapsing inflammation of the pinna of the ears, sparing the lobes. It can cause peri-orbital swelling and inflammation of the tracheobronchial tree. We present two patients with relapsing polychondritis who have presented with recurrent cellulitis as their presenting feature.

Methods: The first patient is a 69 year old female who initially presented in January 2016 with raised inflammatory markers (CRP 84) and right sided neck swelling. MRI revealed only soft tissue thickening in the left sternocleidomastoid muscle. Over the following months she had three episodes of cellulitis affecting different areas in the body (right cheek, left leg and left arm). In August 2016 she developed a left sided peri-orbital swelling leading to a four week admission to hospital. Extensive investigations, antibiotics and a decompression did not improve things until treatment with 40mg prednisolone led to rapid resolution. The steroids were gradually reduced. She was referred to rheumatology for an opinion and in December 2016 she developed erythema, pain and swelling of the pinna of both ears but sparing of the lobes. Alongside this she also had right sided peri-orbital swelling. This was associated with raised inflammatory markers (CRP 106). A diagnosis of relapsing polychondritis was made and there was rapid resolution of her symptoms with 40mg oral prednisolone daily. She had normalisation of her inflammatory markers. She was put on a reducing course of prednisolone and has been maintained on 10mg of prednisolone daily without any further episodes of cellulitis. Of note, she also has a macrocytic anaemia with an MCV of 110, with no cause found despite extensive investigation under haematology. This remains under review due to the association with myelodysplasia and relapsing polychondritis.

Results: The second patient is a 69 year old male who presented in a very similar way with significantly raised inflammatory markers (CRP 216) and relapsing cellulitis of his thigh. Antibiotics did not improve things but oral prednisolone at 30mg daily led to rapid resolution of the cellulitis. A biopsy showed no infective aetiology but chronic inflammation only. He has also had two episodes of peri-orbital cellulitis which have been treated with antibiotics without resolution but has had rapid improvement with steroids. He has yet to have ear involvement but is under follow up.

Conclusion: Recurrent cellulitis is a very rare presenting feature of relapsing polychondritis and a literature search has found only one other patient described presenting in this way. We would recommend that relapsing polychondritis remains on the list of differential diagnosis in patients who present with relapsing cellulitis and raised inflammatory markers that does not respond to antibiotics but has rapid resolution with steroids.

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