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CE - MEDICAL ILLUSTRATION

Sarcoidosis with complications

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A 40-year-old man of Pakistani origin presented with a 2-week history of fever (39.5 °C), malaise and arthralgias. He had been living in Spain for 16 years, and he had not travelled to a foreign country in the prior 4 years. Three days before, conjunctival erythema and multiple painful and violaceous-erythematous nodules (red arrows in Panel B) appeared in both pretibial regions, preventing him from walking because of pain. Physical examination showed bilateral metacarpophalangeal, wrist, knee and ankle arthritis. Ophthalmologic examination showed bilateral anterior scleritis, with preserved visual acuity and without signs of uveitis (Panel A). A chest X-ray study demonstrated bilateral hilar and mediastinal adenopathies (blue arrows in Panel C). He was admitted to the internal medicine ward. Serum angiotensin conversor enzyme levels were normal. Human immunodeficiency virus serologies, Mantoux test, three sputum cultures with Ziehl–Neelsen staining and a bronchoalveolar lavage (BAL) ruled out infectious disease. The CD4/CD8 ratio in the BAL was 2:1. A transbronchial biopsy of an adenopathy showed non-necrotizing granulomas, without microbiological findings. The patient was diagnosed as a case of sarcoidosis, with the clinical presentation of a Löfgren's syndrome. Lung alterations corresponded to a stage II pulmonary sarcoidosis. The patient was treated with dexamethasone eye drops and oral dexketoprofen. Scleritis, temperature, joint swelling and arthralgias disappeared, and he was discharged home. Two weeks later, he again developed fever and mild dyspnoea. Lung functional tests were normal, with the exception of a slightly lowered carbon monoxide lung diffusion (71 %), which was normalized after volume correction. After ruling out etiologies different from sarcoidosis, oral prednisone 20 mg/day was administered for a 4-week course as indicated in refractory disease, with total disappearance of symptomology. Adenopathies and parenchymal lung alterations remained stable. Currently, he has completed the treatment, and remains asymptomatic.

We have presented a case of sarcoidosis with a typical Löfgren's syndrome, consisting of hilar adenopathies, erythema nodosum and polyarthralgia or polyarthritis. This syndrome is found more frequently in women, and the course is usually benign often with [1] spontaneous remission. Anterior scleritis is an unusual ophthalmologic finding in sarcoidosis, and it has been related with Löfgren's syndrome in a few cases [2]. Sporadic case reports [3] describe a good response to corticosteroids, but in this case, the scleritis responded well to non-steroidal anti-inflamatory medication. The treatment of sarcoidosis with corticosteroids is not recommended [4] for stage II pulmonary sarcoidosis because 50 % of the untreated patients heal spontaneously. Nevertheless, symptomatic

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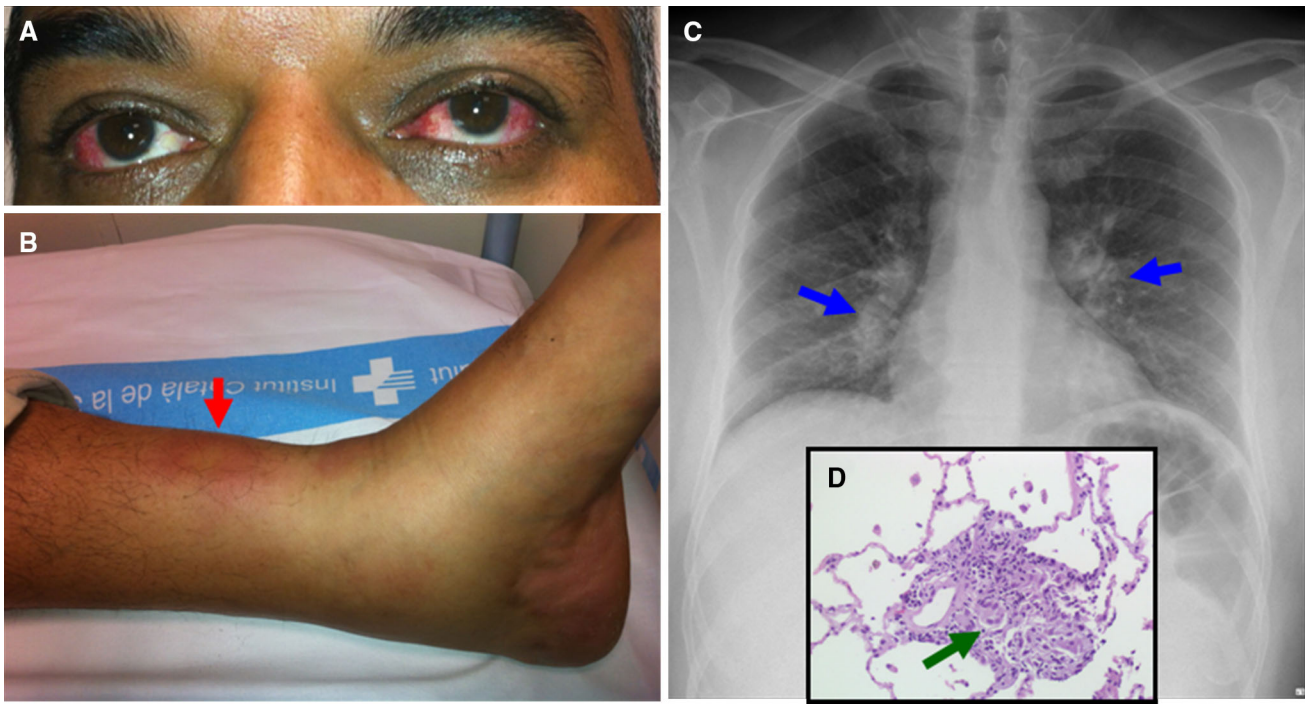

stage III, all stage IV pulmonary sarcoidosis, and patients with lower grades of pulmonary sarcoidosis but with severe extrapulmonary sarcoidosis or with incapacitating disease, should be treated with 20–40 mg/day of oral prednisone for a month. A 3–6 months slow prednisone tapering down is started thereafter. Unfortunately, some patients may still have relapses, and develop steroid-dependent sarcoidosis.

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