Abstract

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Co-existing sarcoidosis and systemic lupus erythematosus: a case report

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Background: Sarcoidosis is a multi-systemic disease of unknown etiology characterized by the formation of granulomas in various organs. It affects predominantly women with a bimodal age distribution: 25-29 years and 65-69 years. The most affected organs are the mediastinal lymphatic system, lungs, skin, and eyes. Patients with sarcoidosis may develop rheumatologic complications, but the coexistence of sarcoidosis and systemic lupus erythematous (SLE) in the same patient has uncommonly been reported. We present a case of sarcoidosis with concomitant SLE.

Case Report: A 35-year-old woman with history of axillary adenopathy was admitted to the emergency department for haemolytic anemia with positive Coombs test, thrombocytopenia, and fever. Her lab tests showed elevated inflammatory indices, high LDH, low C3 and low C4, positivity of ANA and anti-dsDNA antibodies, tumor markers negative and viral panel negative, except HBsAb, HbcAb and HBeAg that were positive with HBV-DNA negative. Total body CT with contrast showed multiple supra and sub-diaphragmatic lymphadenopathies and splenomegaly. Osteomedullary biopsy excluded lymph proliferative disease. Severe haematological manifestations necessitated immunosuppressive treatment. Therefore, she was unsuccessfully treated with a high dose of glucocorticoids and with IV immunoglobulin therapy. Then, for concomitant diagnosis of SLE, she started hydroxychloroquine at a dosage of 200 mg/bid in addition to oral glucocorticoids (prednisone at a dosage 0.5mg/kg) with partial remission. In addition, during hospitalization, the patient underwent mediastinal lymphadenectomy with histological evidence of non-caseating granuloma compatible with sarcoidosis, excluding tuberculosis and malignancy disease. Diagnosis of stage II pulmonary sarcoidosis was confirmed to FDG/PET-TC. Pulmonary function tests carried out (Spirometry and Diffusing capacity of the lung for carbon monoxide- DLCO) showed disventilatory syndrome of type mild obstructive (FEV1: 76%) with a low DLCO value (72%). Oral corticosteroid therapy and hydroxychloroquine were continued for six months with an adequate clinical and radiological response and an improvement in pulmonary function tests (FEV1 97%, DLCO 80%). She started a multidisciplinary appropriate follow-up for monitoring of disease progression and corticosteroid-related adverse effects.

Conclusion: Sarcoidosis may have several clinical manifestations, including rheumatologic manifestations. Our study describes the diagnosis of SLE in the context of unrecognized sarcoidosis and reinforces the need of a multidisciplinary approach for patients with sarcoidosis to improve the management and treatment of the disease.