Clinical Case Presentation

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Mrs BH, 47 years old, was addressed from the ophtalmology department for etiological investigation of a **left anterior nodular scleritis.**

The history taking:

- **Sicca syndrome** with ocular and oral dryness
- **Inflammatory polyarthralgia** of the metacarpophalangeal and the proximal interphalangeal joints
- **Masses r**egarding proximal and distal interphalangeal joints of the indexes and the right big toe
- Dry **cough**
- **Nasal obstruction**

Physical examination:

❖**Afebrile**

❖Urine Dipstick Analysis_: No Hematuria, No Proteinuria

❖No palpated lymphadenopathy

❖Cardiopulmonary auscultation: Normal

❖Neurological examination: Normal

❖Dermatological Examination : No anomalies

❖Articular examination:

Painful active and passive mobilization of the proximal and the distal interphalangeal joints of the two indexes and the two big toes.

Phalangeal nodules of the two indexes and the two big toes.

Ulcers and suppuration regarding the left index and the left big toe.

Figure 1: Ulcers of the left big toe

Figure 2: Ulcers and nodules of the indexes

Specialized ophthalmologic examination:

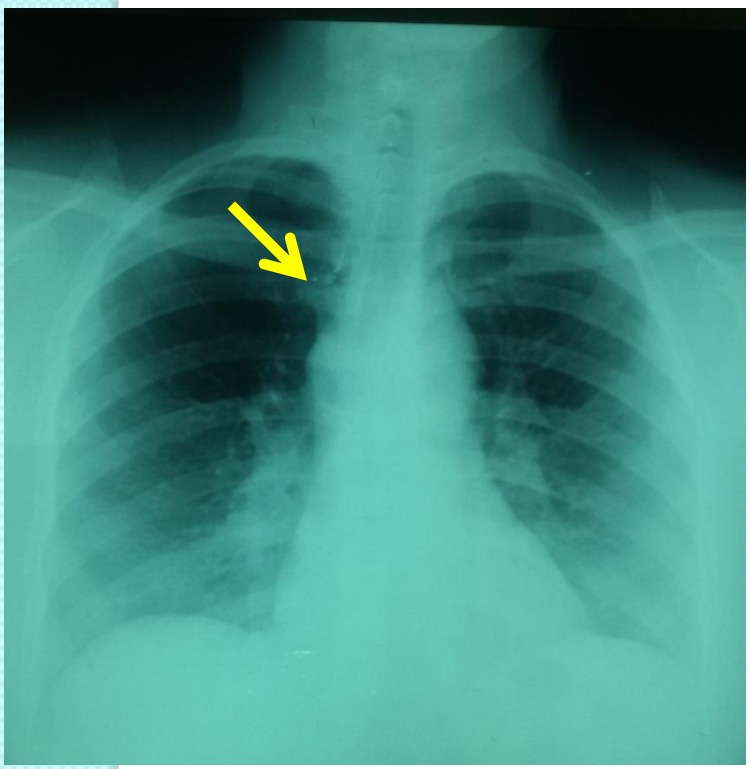
- Left anterior nodular scleritis
- Shirmer Test= Abnormal.

Lab Tests

- Blood Count: Hb = 14.4 g / dl; lymphocytes: 870 elements / mm3
- CRP = 10.7 mg / l (<5 mg/L)
- Creat = 8mg / L (9-13)
- Serum electrophoresis: hypergammaglobulinaemia at a level of 18.32g /l (6-12)
- Blood and urinary calcium and phosphate: normal

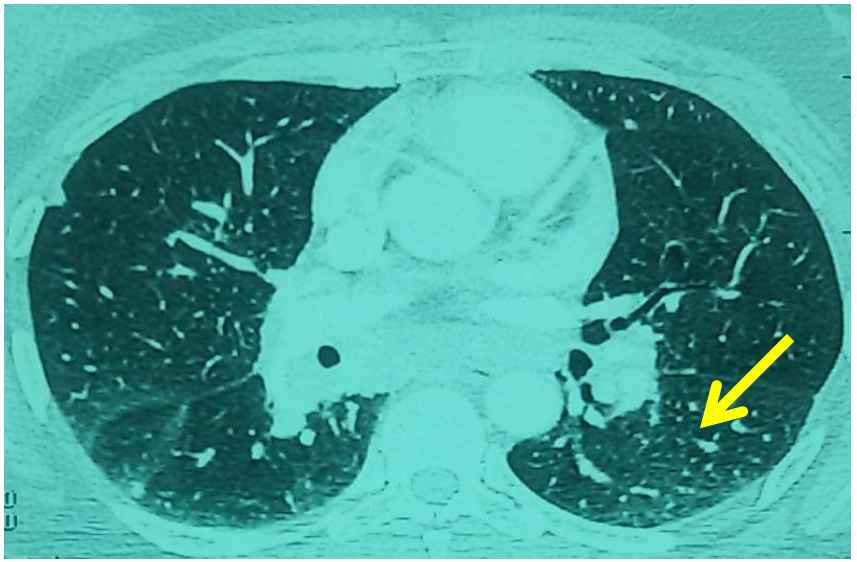
CHEST X RAY:

- Bilateral interstitial syndrome and mediastinal widening



Chest computed tomography:

- Granulomatous nodules in perilymphatic distribution
- Mediastinal adenopathies
- Parenchymal lung congestion

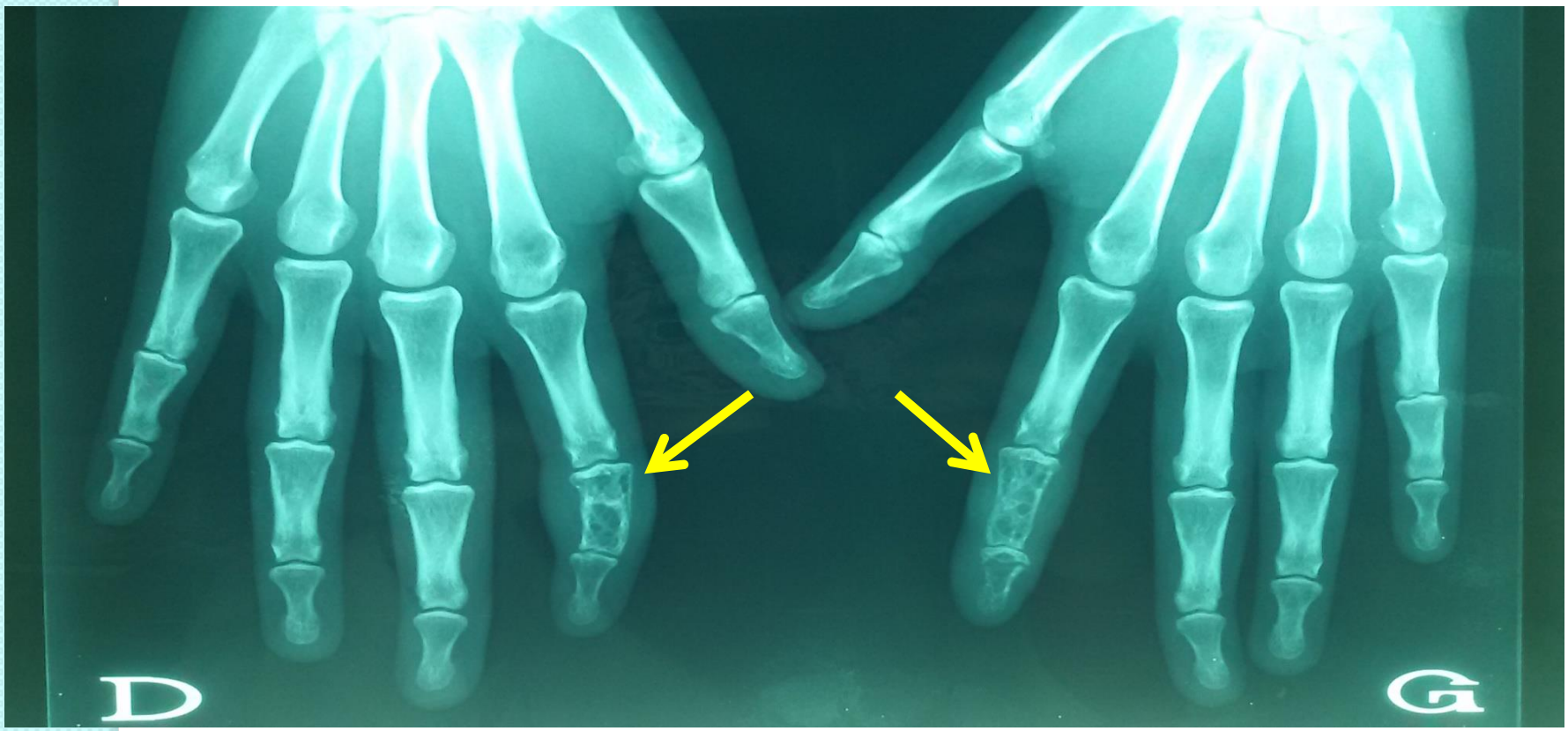


Hand and feet X-rays:

- Lytic bone lesions of the proximal and the second phalanx

  giving a **lacy appearance**

- Soft tissue swelling



OTORHINOLARYNGOLOGICAL EXAMINATION AND ENDOSCOPIES:

- **Rhinitis**
- No masses
- No tumors

HISTOLOGICAL STUDY:

- **Nasal biopsy: Granuloma** without necrosis neither vasculitis**.**
- **Labial salivary gland biopsy exhibits: granulomatous sialadenitis.**
- **Bone biopsy: Granuloma** without necrosis **neither neoplastic cells.**

To sum up:

Ocular involvement → Eye dryness and nodular scleritis

ORL involvement → Nasal obstruction, epistaxis and nasal granuloma

Oral dryness and labial granuloma

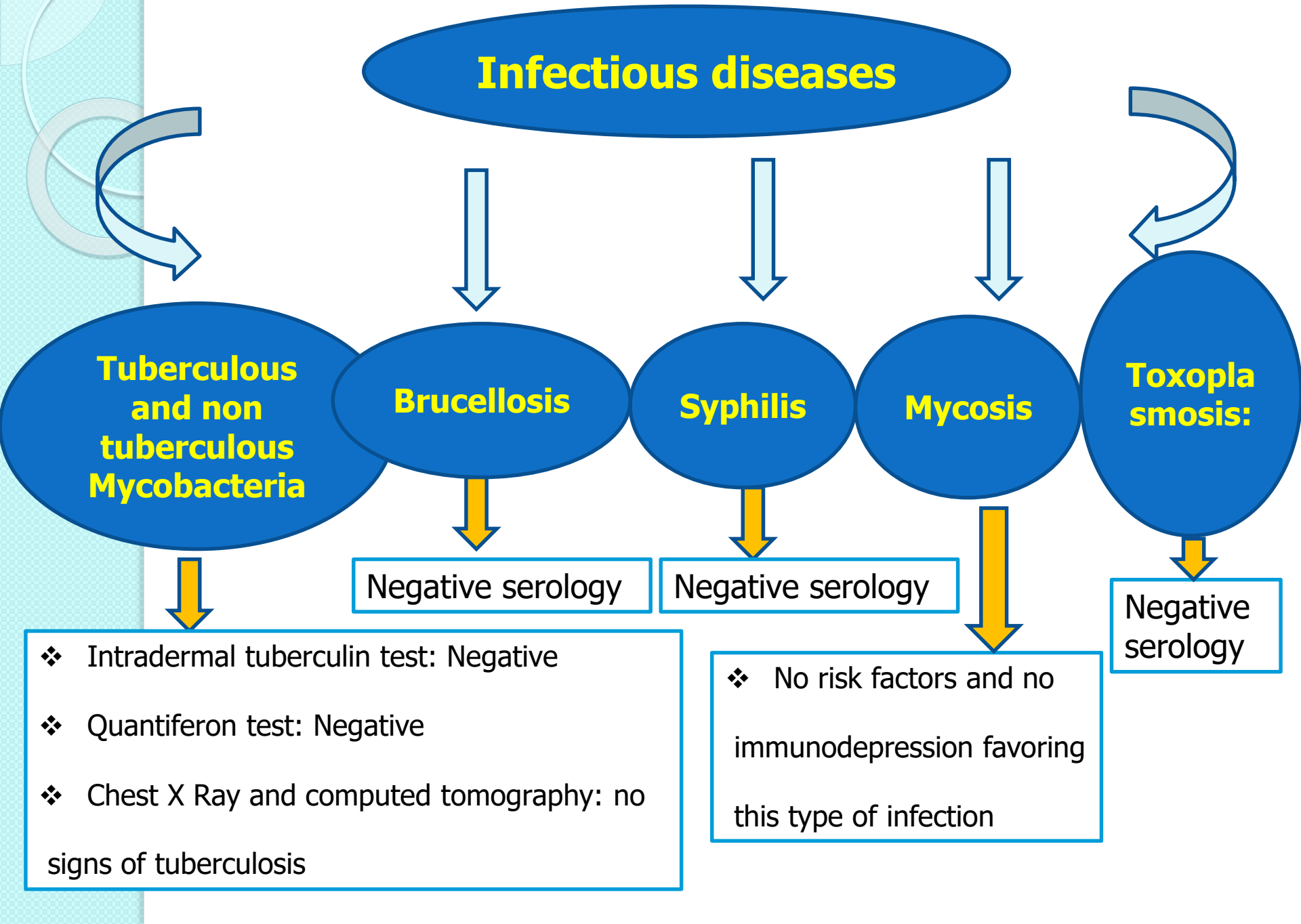
Osteolysis

Pulmonary involvement → Cough, dyspnea, interstitial syndrome and mediastinal adenopathies

Biology: →

- ❖Lymphopenia,
- ❖Polyclonal hypergammaglobulinemia

Diagnosis ?


Infectious diseases
Tuberculous and non tuberculous Mycobacteria
Brucellosis
Syphilis
Mycosis
Toxoplasmosis:
Negative serology
Negative serology
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❖ Intradermal tuberculin test: Negative
❖ Quantiferon test: Negative
❖ Chest X Ray and computed tomography: no signs of tuberculosis
❖ No risk factors and no immunodepression favoring this type of infection

Neoplasia

- No impairment of the general condition
- Normal blood count (no cytopenia, no hyperleucocytosis)
- Thoracoabdominopelviccomputed tomography: No abnormalities, no masses.

Inflammatory diseases

❖**HISTIOCYTOSIS:**

histological and immunophen esional bone tissue:

Negative staining of the lesional cells with **CD1a.**

❖**SARCOIDOSIS**

✓No cutaneous signs of vasculitis (Purpura, livedo…)

✓Histology: No eosinophilic infiltration neither vasculitis

✓Immunological tests: Antineutrophil cytoplasmic antibodies were negative

ARGUMENTS FOR SARCOIDOSIS

Clinic

✓ No

✓Th

evo

Radiological arguments:

Biological and immunological

Histological arguments:

✓Tuberculoid granuloma without necrosis in the bone tissue, the labial tissue and the nasal tissue

We retained the diagnosis of sarcoidosis

❖She was treated with **corticosteroids:** 1mg/kg/day and **Methotrexate:** 15mg/week.

❖Corticotherapy was preceded of **antibiotherapy**

❖The **evolution** was favorable with:

✓Decrease swellings

✓Purulent flow disappearance

✓Disappearance of inflammatory signs

✓Wound healing but persistent strain

It is currently nine months of decline.

TAKE HOME MESSAGES:

- Sarcoidosis bone involvement **is rare** and occurs in approximately 5% [illegible] of patients with sarcoidosis.
- Phalanges of the hands and feet are the most common sites of involvement.
- On radiographs, osseous sarcoid classically manifests as **lacelike lytic bone lesions** in the phalanges of the hands or feet.
- Sarcoid bone lesions are often multiple and lesions may have imaging features that may be identical to **osseous metastatic disease** and biopsy may be required for definitive differentiation.
- **The treatment** of bone sarcoidosis **is not coded** and based on the analgesics,steroidal and non-steroidal antiinflammatory and immunosuppressants if necessary.

THANK YOU!

FOR YOUR ATTENTION!