

Recurrent sarcoidosis

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Although the clinical course of sarcoidosis is often prolonged and sometimes relentless, remission when it occurs is generally permanent. We describe here a patient who experienced two attacks of bilateral hilar lymphadenopathy (BHL), the first accompanied by lung infiltration and the second by erythema nodosum, separated by a nine-year interval in which he was clinically and radiologically free from disease. A survey of the literature suggests that recurrent sarcoidosis is extremely rare.

Case report

A 46-year-old white man had several normal routine chest radiographs between 1953 and 1968 while in the RAF. In 1969 a miniature radiograph revealed bilateral hilar lymphadenopathy with diffuse nodular shadowing throughout both lungs and these findings were subsequently confirmed at a chest clinic. At this time he was asymptomatic and there were no abnormal physical signs. He was followed up without treatment for several months and the chest radiograph returned to normal. A chest film taken in 1976, two years before his second presentation, was again entirely normal.

In 1978 the patient was admitted to hospital with a two-week history of widespread joint pain, night sweats, anorexia, and an unproductive cough. He smoked 20 cigarettes daily and worked as a stores foreman. On examination he was sweating but afebrile. Several raised, deep red plaques were noted in an old scar on the right knee. There was no peripheral lymphadenopathy and the joints did not appear actively inflamed. There were inconspicuous scattered crackles in the lungs.

The chest film showed gross mediastinal lymphadenopathy without lung infiltration. Apart from an ESR of 58 mm/hr, routine haematology and biochemistry were normal. The Mantoux test (10 TU) was negative. Histology of a skin lesion from the right knee showed the presence of giant cell granulomata with minimal necrosis but without caseation.

Within a week of presentation the constitutional and joint symptoms had resolved without treatment.

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Classical erythema nodosum then developed over both shins and persisted for a further two weeks. The mediastinal lymphadenopathy subsided slowly during four months of follow-up.

Discussion

Although the initial diagnosis of sarcoid lacked histological evidence, the radiological features, absence of clinical signs, and spontaneous resolution make any alternative diagnosis improbable. On presentation nine years later, the association of febrile arthralgia, bilateral hilar lymphadenopathy, erythema nodosum, and cutaneous granulomas placed the diagnosis beyond doubt. The appearance of sarcoid granulomas in pre-existing scars is a curious phenomenon which has been attributed to the presence of implanted silica or other particulate material.¹

Recurrence of sarcoidosis after complete resolution appears to be extremely rare. Lim² described a woman who suffered repeated episodes of BHL with pulmonary infiltration over a period of several years after successful treatment of pulmonary tuberculosis. Scadding³ has reported two cases. The first was a man who had three separate episodes of BHL in eight years, associated with pulmonary infiltration and erythema nodosum. The second was a woman with recurrent erythema nodosum and slight BHL.

Such reports may be scarce because sarcoidosis is frequently asymptomatic. We were particularly fortunate in being able to review chest films spanning a 25-year period. However, routine chest radiography has been common for many years and the natural history of the condition has been studied in detail. It is more likely that recurrence is an extremely rare event for reasons which must have some bearing on the pathogenesis of the disease.

References

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- 3 Scadding JG. *Sarcoidosis*. London: Eyre and Spottiswoode, 1967.