Pleural sarcoidosis: a rare presentation

E Loughney, B G Higgins

Abstract
Sarcoidosis is a chronic disorder of unknown aetiology which causes tissue injury and granuloma formation in many organs. Although over 80% of cases have intrathoracic disease at presentation, pleural sarcoidosis remains an unusual manifestation. A case of sarcoidosis presenting with a discrete pleural mass is reported.

(Torax 1997;52:200–201)

Keywords: sarcoidosis, pleural disease, mass lesion.

Sarcoidosis is a granulomatous disorder which may affect many organs throughout the body and therefore presents with a variety of symptoms and signs. Although pulmonary involvement is common, pleural disease is rare. We describe a case of sarcoidosis in which a discrete pleural mass was the presenting abnormality which predated the progression to parenchymal lung disease.

Case report
A 29 year old woman was admitted to hospital with sudden onset left sided pleuritic chest pain and two episodes of sputum streaked with haemoptysis. She gave a three week history of mild dyspnoea, malaise, and dry cough. Her current medications included norethisterone for irregular menstrual bleeding, and paroxetine, thioridazine, lithium carbonate, and procyclidine for bipolar psychosis. She smoked 10 cigarettes per day and consumed 15 units of alcohol per week.

On examination she was apyrexial and had no palpable lymphadenopathy or salivary gland enlargement. There was no evidence of joint disease, finger clubbing, skin rash, or eye disease. Respiratory examination revealed an area of dullness to percussion and reduced breath sounds posteriorly in the left mid zone. Cardiovascular, abdominal, and neurological examinations were normal. The chest radiograph showed a single, smooth, rounded homogeneous mass lesion in the left upper zone. There was mediastinal adenopathy but no evidence of hilar lymphadenopathy or parenchymal disease (fig 1). A ventilation perfusion scan showed a single matched defect at the area of radiological abnormality with a low probability of pulmonary embolus. Full blood count revealed a haemoglobin concentration of 11.9 g/dl, white blood cell count of 7.4 × 10^9 g/dl (granulocytes 75.9%, lymphocytes 19.4%, monocytes 4.7%), and a platelet count of 202 × 10^9 g/dl. Serum electrolytes, including total calcium concentration, and liver function tests were normal. Serum angiotensin converting enzyme (ACE) activity was 26 IU/l (range 21–54). Sputum was negative for acid fast bacilli (AFB), fungi, and other organisms. An intradermal tuberculin test (100 000 units/ml multiple puncture test) was grade 1. Arterial blood gas tensions on admission were normal (pH 7.41, PaO_2 4.1 kPa, PaCO_2 13.7 kPa). Pulmonary function tests showed forced expiratory volume in one second (FEV1) 3.45 l (predicted 3.10 l), vital capacity (VC) 4.20 l (predicted 3.60 l), total lung capacity (TLC) 6.85 l (predicted 4.95 l), residual volume (RV) 2.65 l (predicted 1.45 l), carbon monoxide transfer factor (TLCO) 6.23 mmol/min/kPa (predicted 8.42), and transfer coefficient (Kco) of 1.38 mmol/min/kPa/l (predicted 1.79). A computed tomographic (CT) scan of the thorax revealed a pleural based mass in the left mid zone with no involvement of bone but an associated lymphadenopathy affecting the superior mediastinal, hilar, and subcarinal stations.

Biopsy specimens were obtained from the pleural mass and mediastinal nodes. Histological examination of the nodes revealed multiple non-caseating granulomas composed of epithelioid cells and multineucleated Langhans giant cells with surrounding irregular lymphocytic infiltration. The pleural mass was composed of fibrous tissue housing non-caseating granulomas. At both sites the appearances were consistent with a diagnosis of sarcoidosis.

Symptoms settled with conservative treatment and the patient remained asymptomatic for 12 months. She then developed increasing breathlessness with an associated change in pulmonary function (FEV1 2.85 l, VC 3.55 l, TLC 4.04 mmol/min/kPa, Kco 1.03 mmol/min/kPa/l). Diffuse nodular shadowing developed throughout both lung fields on the chest radiograph. Prednisolone was started at a dose of 30 mg/day, leading to improvement in pulmonary function (FEV1 3.25 l, VC 5.20 mmol/min/kPa, TLCO 5.20 mmol/min/kPa and Kco 1.30 mmol/min/kPa/l) and partial regression of the nodular shadowing after several weeks of treatment. There was a steady decline in the size of the pleural mass over the following nine months with continued clinical improvement.

Figure 1 Chest radiograph showing pleural mass at presentation.
Sarcoidosis and primary biliary cirrhosis with co-existing myositis

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Abstract
In a small number of cases the co-existence of primary biliary cirrhosis and sarcoidosis is assumed from clinical serological and histological findings. A case of sarcoidosis is reported in which the M2 antibody, a highly specific marker for primary biliary cirrhosis, was detected. The patient also developed a severe myositis and a possible overlap syndrome is discussed. (Thorax 1997;52:201–202)

Keywords: sarcoidosis, primary biliary cirrhosis, overlap syndrome.

Hepatic granulomas in sarcoidosis are rarely of clinical significance, but occasionally a cholestatic picture occurs which has marked similarities to primary biliary cirrhosis. In a few reported cases there is evidence to suggest the co-existence of these two disorders, prompting suggestions of an overlap syndrome. We present a case of sarcoidosis with granulomatous hepatitis and immunological features of primary biliary cirrhosis in which a florid polymyositis developed. This feature has not been noted in previous cases of overlap.

The cause of breathlessness in our patient remains unknown. However, thoracic lymphadenopathy and concomitant compression of the pulmonary arterial circulation was thought to have led to breathlessness in two previously reported cases of sarcoidosis. Interestingly, in each of these cases the subject was female and was receiving oral progestogen therapy as in our case; treatment with prednisolone reportedly led to the amelioration of breathlessness on each occasion.

1 Batra P. Role of high-resolution CT in the diagnosis and evaluation of primary sarcoidosis. Sarcoidosis 1993;10:957.
existence of sarcoidosis and primary biliary cirrhosis has been suggested, usually by demonstrating the AMA in the presence of either a positive Kveim test or, as in our case, multi-organ granulomas. An increased IgM often adds further weight to the diagnosis of primary biliary cirrhosis. Although the AMA test is positive in 85–99% of cases of primary biliary cirrhosis, it is present in 0.7% of controls as well as other autoimmune and chronic hepatic disorders; its significance in these cases is therefore unclear. More recently the M2 mitochondrial antibody directed at components of the pyruvate dehydrogenase complex on the inner mitochondrial membrane has been shown to be more highly specific for primary biliary cirrhosis,7 and has not previously been reported in sarcoidosis.

These cases of co-existing primary biliary cirrhosis and sarcoidosis, together with the realisation that primary biliary cirrhosis can affect the lung in a similar way to sarcoidosis,7 prompt suggestion of an overlap syndrome that may be of relevance to the myositis noted in our case.

In patients with sarcoidosis muscle granulomas, like those in the liver, are rarely of clinical significance and correlate poorly with symp- toms. They are reported in all cases of sarcoid myositis (itself very rare) and are suggested as a distinguishing feature between polymyositis and the myositis of sarcoidosis.8 Primary biliary cirrhosis frequently overlaps with other auto-immune diseases including those with pul- monary involvement. Cases of polymyositis with primary biliary cirrhosis and a case of polymyositis with pulmonary fibrosis which later developed sarcoid granulomas are also described.7,8,9,10

Although the co-existence of sarcoidosis and primary biliary cirrhosis is rare and granulomatous myositis is an infrequent occurrence in sarcoidosis, we have not seen granulomas in either muscle biopsy specimen and therefore conclude that our case is an overlap between sarcoidosis, primary biliary cirrhosis, and poly-myositis.

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274, GGT 400, AMA 1:2560, IgG 9.24 (0.5–14) g/l, IgM 5.1 (0.5–2) g/l, cholesterol 7.5 mmol/l, CK 34 000 IU/l. Tests for antineutrophil cytoplasmic antibody and extractable nuclear antigen were negative. Biopsy samples of liver and muscle showed no signif- icant change. She continued to be managed with prednisolone 10 mg daily but was disabled by myalgia and proximal weakness.

In 1992 worsening myositis (CK 5148 IU/l) with further decline in liver function (ALP 420, GGT 1132) required the addition of cyclophosphamide, with dramatic improvement in symptoms and biochemistry (CK 134 IU/l, ALP 151, GGT 455). The AMA remained positive. The cyclophosphamide was initially given in pulsed 750 mg doses, later reduced to 50 mg on alternate days. In 1993 a strongly positive mitochondrial M2 EIA was also noted.

Discussion

In 1969 Karlish et al8 reported a patient with cholestasis, mediastinal lymphadenopathy, and positive Kveim and AMA tests. There has fol- lowed a small number of cases14 where the co-
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