

Uncommon cause for anorexia and weight loss

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DESCRIPTION

A 51-year-old woman presented with anorexia, abdominal fullness and weight loss of 1 year duration. There was a history of bilateral facial paralysis 4 years ago. There was no history of fever, cough polyarthralgia or altered bowel habits. Examination revealed bilateral lower motor neuron type facial palsy and non-tender hepatomegaly. Haematological workup revealed normocytic normochromic anaemia (9 g/dL) with an elevated erythrocyte sedimentation rate (85 mm/hour) and a WCC of 8800/cu.mm. Her blood biochemistry showed increased levels of alkaline phosphatase—685 U/L (40–125), gamma-glutamyltransferase of 1251 U/L (<38) and angiotensin-converting enzyme—102 U/L (8–52). A CT scan of the thoraco-abdomen displayed hepatomegaly with multiple ill-defined hypodense nodules, splenomegaly with hypodense lesions (figure 1). There was evidence of hilar lymphadenopathy. A liver biopsy was performed which showed non-necrotising granulomatous inflammation with lymphohistiocytic aggregates. A diagnosis of sarcoidosis was made in the view of symptoms, elevated ACE and multiorgan involvement (figure 2).

She was started on oral prednisolone at 0.5 mg/kg/day and on follow-up visit after 3 months, the patient showed remarkable improvement with a reduction in serum alkaline phosphatase (184 U/L), a decrease in size of hepatic lesions and resolution of splenomegaly on repeat imaging (figure 3).

A systemic disease with protean manifestations, diagnosis of sarcoidosis requires a high index of suspicion and demonstration of non-caseating granulomas.¹ Other conditions such as tuberculosis, chronic fungal infections and lymphoma have to be excluded. Patients with extensive organ involvement require treatment with glucocorticoids which is the mainstay of therapy.² The prognosis of patients with hepatic involvement is guarded with one-third of patients showing complete remission, one-third showing partial improvement with therapy.³

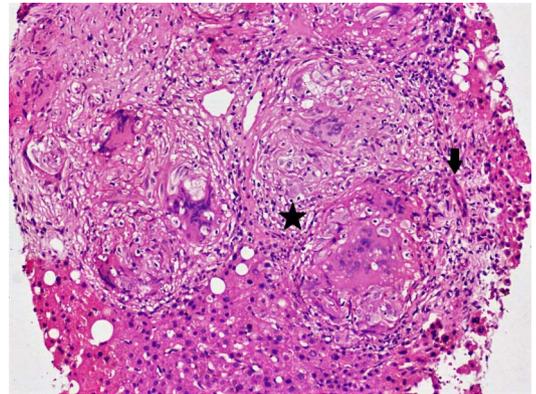


Figure 2 Histopathology of the liver—10xi photomicrograph of a portal (bile duct—arrow) based non-necrotising discrete and confluent epithelioid cell granulomas (star) associated with foreign body type multinucleated giant cells surrounded by dense fibrosis, H&E stain (×100 magnification). H&E, haematoxylin and eosin.



Figure 3 A follow-up CT scan after starting treatment showing reduction in size of hepatic lesions and resolution of splenomegaly.



Figure 1 CT scan of the abdomen extensive involvement of liver and spleen.

Learning points

- ▶ Sarcoidosis is a systemic disease characterised by non-caseating granulomas.
- ▶ Its presentation can range from being asymptomatic with biochemical abnormalities to extensive organ infiltration.
- ▶ A high index of suspicion with histological evidence of non-caseating granulomas aids in diagnosis.
- ▶ Prompt initiation of systemic steroids helps in amelioration of symptoms and objective evidence of improvement on biochemistry and repeat imaging.



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