Uncommon cause for anorexia and weight loss

Meban Aibor Kharkongor,[1] Kripa Elizabeth Cherian,[2] Thomas Alex Kodiatte,[3] Thomas Vizhalil Paul[2]

[1]Department of General Medicine, Christian Medical College, Vellore, Tamil Nadu, India
[2]Department of Endocrinology, Christian Medical College, Vellore, Tamil Nadu, India
[3]Department of Pathology, Christian Medical College, Vellore, Tamil Nadu, India

Correspondence to
Professor Thomas Vizhalil Paul, thomasvpaul@yahoo.com

Accepted 1 December 2016

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]

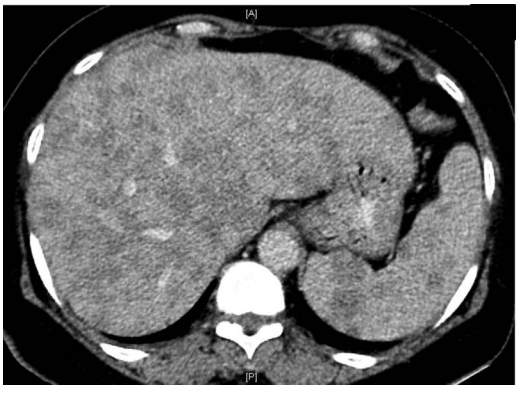

Figure 1 CT scan of the abdomen extensive involvement of liver and spleen.

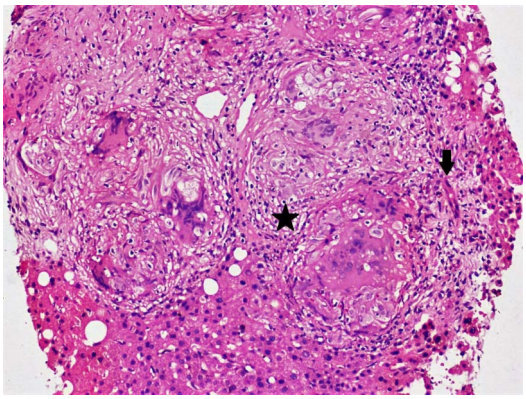

Figure 2 Histopathology of the liver—10xi photomicrograph of a portal (bile duct—arrow) based non-necrotising discrete and confluent epithelioid cell granulomas (star) associated with foreign body type multinucleated giant cells surrounded by dense fibrosis, H&E stain (×100 magnification). H&E, haematoxylin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

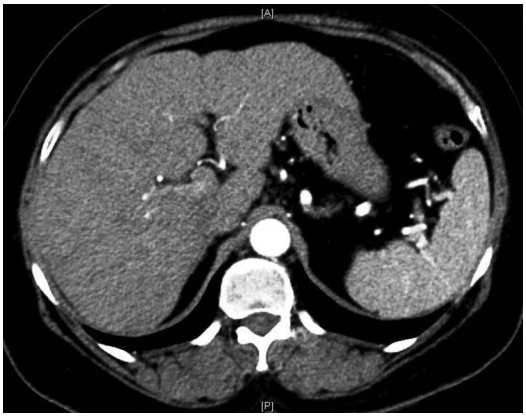

Figure 3 A follow-up CT scan after starting treatment showing reduction in size of hepatic lesions and resolution of splenomegaly.

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.

To cite: Kharkongor MA, Cherian KE, Kodiatte TA, *et al*. *BMJ Case Rep* Published online: [*please include* Day Month Year] doi:10.1136/bcr-2016-218675

Contributors MAK and KEC wrote the manuscript. TAK and TVP reviewed the manuscript and all four finally approved the manuscript.

Competing interests None declared.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

REFERENCES

1 Mahapatra QS, Sahai K, Rathi KR, *et al*. Pulmonary sarcoidosis: an important differential diagnosis in transbronchial lung biopsies. *Lung India* 2014;31:139–41.
2 Johns CJ, Michele TM. The clinical management of sarcoidosis. A 50-year experience at the Johns Hopkins Hospital. *Medicine (Baltimore)* 1999;78:65–111.
3 Kennedy PT, Zakaria N, Modawi SB, *et al*. Natural history of hepatic sarcoidosis and its response to treatment. *Eur J Gastroenterol Hepatol* 2006;18:721–6.