

# Uncommon cause for anorexia and weight loss

Meban Aibor Kharkongor,<sup>1</sup> Kripa Elizabeth Cherian,<sup>2</sup> Thomas Alex Kodiatté,<sup>3</sup> Thomas Vizhalil Paul<sup>2</sup>

<sup>1</sup>Department of General Medicine, Christian Medical College, Vellore, Tamil Nadu, India

<sup>2</sup>Department of Endocrinology, Christian Medical College, Vellore, Tamil Nadu, India

<sup>3</sup>Department of Pathology, Christian Medical College, Vellore, Tamil Nadu, India

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

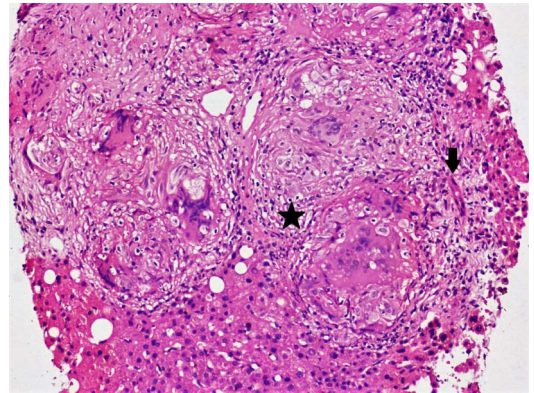
Accepted 1 December 2016

## DESCRIPTION

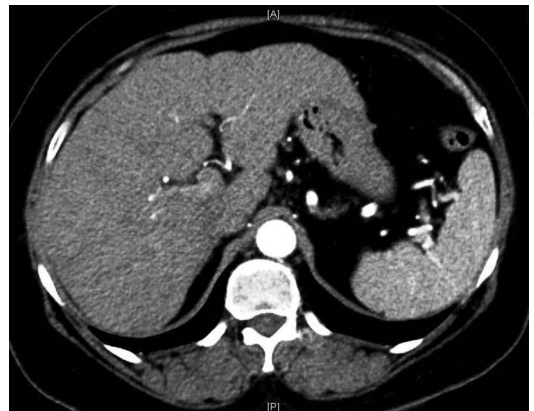
A 51-year-old woman presented with anorexia, abdominal fullness and weight loss of 1 year duration. There was a history of bilateral facial paralysis 4 years ago. There was no history of fever, cough polyarthralgia or altered bowel habits. Examination revealed bilateral lower motor neuron type facial 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).

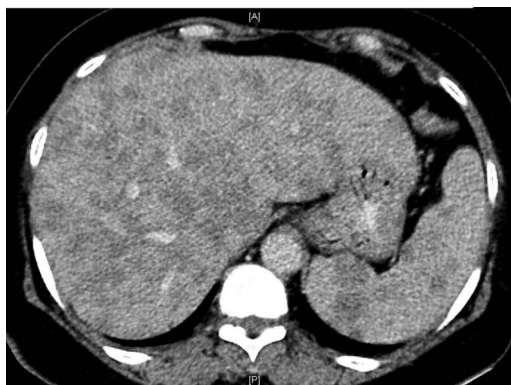
A systemic disease with protean manifestations, diagnosis of sarcoidosis requires a high index of suspicion and demonstration of non-caseating granulomas.<sup>1</sup> Other conditions such as tuberculosis, chronic fungal infections and lymphoma have to be excluded. Patients with extensive organ involvement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



**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.



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

## 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.

**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, Rathii 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.

Copyright 2016 BMJ Publishing Group. All rights reserved. For permission to reuse any of this content visit <http://group.bmj.com/group/rights-licensing/permissions>.  
BMJ Case Report Fellows may re-use this article for personal use and teaching without any further permission.

Become a Fellow of BMJ Case Reports today and you can:

- ▶ Submit as many cases as you like
- ▶ Enjoy fast sympathetic peer review and rapid publication of accepted articles
- ▶ Access all the published articles
- ▶ Re-use any of the published material for personal use and teaching without further permission

For information on Institutional Fellowships contact [consortiasales@bmjgroup.com](mailto:consortiasales@bmjgroup.com)

Visit [casereports.bmj.com](http://casereports.bmj.com) for more articles like this and to become a Fellow