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SARCOIDOSIS IN A PATIENT WITH RHEUMATOID ARTHRITIS

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BACKGROUND

Sarcoidosis is a granulomatous disease of unknown etiology involving lungs, lymph nodes, skin, eyes, and musculoskeletal system. Pulmonary involvement is the most frequent, with variable respiratory symptoms, bilateral hilar adenopathy and reticular opacities. Rheumatic manifestations are among the most significant extrapulmonary disorders, with nondeforming arthritis and the involvement of ankles is highly suggestive. Rheumatoid factor can be positive, but anti-CCP is usually negative. When there is no spontaneous remission, treatment is based on corticosteroids, hydroxychloroquine, colchicine, methotrexate, azathioprine, leflunomide, TNF inhibitors or anti-CD20.

CASE REPORT

A 61-year-old female with rheumatoid arthritis for 2 years (high rheumatoid factor and anti-CCP titers), after chikungunya, without adequate adherence to treatment, presenting dry cough, nocturnal wheezing, afternoon fever (38 °C) and weight loss since October 2019. She had prednisone 10 mg/day without medical orientation. Dyspnea when performing small and medium efforts associated with retrosternal and dorsal pain was reported. Upon physical examination, it was noticed reduced vesicular murmurs in bases, tachypnea, desaturation and bilateral hand arthralgia (with absence of arthritis or deformities). Increased PCR (13.2 g/dL) and ESR (42 mm) were observed. Due to these findings, she underwent the following tests: Radiography of hands showing bilateral narrowed interphalangeal joint spaces and proximal interphalangeal joint surfaces sclerosis (Fig. 1); spirometry evidencing moderate restrictive disorder with normal carbon monoxide diffusion capacity; chest computed tomography (CT) revealing diffuse perilymphatic reticulonodular infiltrate, predominating in peribronchovascular region, pronounced in the upper lobes, paratracheal, pretracheal and right hilar lymph nodes (Fig. 2). Tuberculosis investigation results were negative in two samples. Transbronchial cryobiopsy showed a non-necrotizing chronic granulomatous parenchymal inflammatory process, corroborating with the hypothesis of sarcoidosis (Fig. 3). Oral corticosteroid therapy (prednisone 40 mg/day) was optimized, leading to a significant clinical improvement. On outpatient reassessment after two weeks, the patient denied dyspnea or fever (using prednisone). Treatment with corticosteroid at a dose of 40 mg/day was continued, since some cases evolve to complete remission. After case discussion with a pneumologist, it will be considered the association of azathioprine if remission is not achieved in the next evaluation.

Figure 1. X-ray of hands: bilateral narrowed interphalangeal joint spaces and proximal interphalangeal joint surfaces sclerosis.

Figure 2. Chest CT: diffuse perilymphatic reticulonodular infiltrate, predominating in peribronchovascular region, pronounced in the upper lobes; paratracheal and right hilar lymph nodes.

Figure 3. Non-necrotizing granuloma.

CONCLUSION

Sarcoidosis could be overlapped to a great number of rheumatologic diseases (Sjögren's syndrome, systemic sclerosis, ankylosing spondylitis, systemic lupus erythematosus and rheumatoid arthritis), and differential diagnosis is recommended, since some clinical characteristics are common to both entities.