A LITTLE RASH AND SOME SWELLING DOWN THERE

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Introduction

Sarcoidosis is a granulomatous disease of unknown etiology that affects people worldwide. In the United States, the incidence of sarcoidosis ranges from 5-40 out of every 100,000, but is widely unknown. Clinical manifestations vary greatly, but in as many as half of cases it is found incidentally on chest x-ray (CXR) prior to the onset of symptoms. The incidence of epididymal sarcoidosis is between 0.2 and 5 %.

Case Report

A 29 year old African-American male without past medical history presented to the Emergency Room with the complaint of a 2 month history of diffuse, pruritic rash to his extremities and mild right scrotal swelling. He denied fevers, recent illnesses, cough, dyspnea, genitourinary complaints, but admitted to weight loss over the last year, occasional constipation and right ankle arthralgias. His physical exam was notable for hyperpigmented nodules on his extremities (Figures 1a-c) and a nontender, right scrotal mass. Initial labs were unrevealing. A testicular ultrasound (Figure 3) revealed a small epididymal cyst. Pre-op screening for the cyst removal noted a normal EKG, but an abnormal chest x-ray that was suspicious for tuberculosis illustrating a diffuse reticulonodular, miliary pattern with mediastinal lymphadenopathy (Figure 2a). A chest CT confirmed these results (Figure 2b). The patient was admitted for possible tuberculous involvement and was ruled out with three negative acid-fast bacilli smears and cultures. A bronchoscopy and skin biopsies were performed noting non-necrotizing granulomas (Figure 4a). All infectious and vasculitis work up was negative, aside from a positive ANA, 1:80. A slit lamp exam was normal. Epididymal cyst removal as an outpatient confirmed the diagnosis of sarcoidosis by revealing non-caseating granulomas similar to the previous biopsies (Figures 4b-c). The patient was discharged and started on low dose prednisone as an outpatient.

Discussion

Sarcoidosis is a granulomatous disease that affects people worldwide. In the United States, the incidence of sarcoidosis ranges from 5-40 out of every 100,000, but is widely unknown and is prevalent in African-Americans. The male to female ratio is approximately 2:1. The incidence peaks in those aged 25-35 years and again for women between the ages of 45-65.

Clinical manifestations of sarcoidosis present based on organ involvement, but also include vague symptoms such as fatigue, fever, and weight loss. Sarcoidosis most often affects the lung and manifests as cough, dyspnea, or chest pain. Sarcoidosis is often found incidentally on CXR (50%) prior to symptom onset. CXR findings usually include bilateral hilar adenopathy and reticular opacities. Often these CXR findings can resemble findings associated with tuberculosis, malignancy, fungal infections, etc. Sarcoidosis can also have several systemic, extrapulmonary manifestations; however, these are less likely to be the presenting symptom. Extrapulmonary sarcoidosis includes cutaneous lesions (25%), urethra (20%), neurological (5%), uveitis, and scrotal masses (0.2-5%). Epididymal involvement by sarcoidosis is usually unilateral, nodular and painless. Bilateral lesions are less common and reported in less than a third of patients with epididymal sarcoidosis.

Diagnosis of sarcoidosis is made by excluding other possible causes and by histopathologically showing non-caseating granulomas in the tissue. Treatment for sarcoidosis is mostly symptomatic in nature and is reserved for those who have extrapulmonary sarcoidosis involving critical organs. Corticosteroid therapy is the mainstay of treatment; however, immunosuppressants are also utilized.

Conclusions

Sarcoidosis is a granulomatous disease of unknown etiology that affects people worldwide. In the United States, the incidence of sarcoidosis ranges from 5-40 out of every 100,000, but is widely unknown and is prevalent in African-Americans. The male to female ratio is approximately 2:1. The incidence peaks in those aged 25-35 years and again for women between the ages of 45-65. Clinical manifestations of sarcoidosis present based on organ involvement, but also include vague symptoms such as fatigue, fever, and weight loss. Sarcoidosis most often affects the lung and manifests as cough, dyspnea, or chest pain. Sarcoidosis is often found incidentally on CXR (50%) prior to symptom onset. CXR findings usually include bilateral hilar adenopathy and reticular opacities. Often these CXR findings can resemble findings associated with tuberculosis, malignancy, fungal infections, etc. Sarcoidosis can also have several systemic, extrapulmonary manifestations; however, these are less likely to be the presenting symptom. Extrapulmonary sarcoidosis includes cutaneous lesions (25%), urethra (20%), neurological (5%), uveitis, and scrotal masses (0.2-5%). Epididymal involvement by sarcoidosis is usually unilateral, nodular and painless. Bilateral lesions are less common and reported in less than a third of patients with epididymal sarcoidosis. Diagnosis of sarcoidosis is made by excluding other possible causes and by histopathologically showing non-caseating granulomas in the tissue. Treatment for sarcoidosis is mostly symptomatic in nature and is reserved for those who have extrapulmonary sarcoidosis involving critical organs. Corticosteroid therapy is the mainstay of treatment; however, immunosuppressants are also utilized.

References

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