Dear Editor

Atypical localization of pulmonary infiltrates in sarcoidosis

Sarcoidosis is a systemic granulomatous disease of unknown aetiology that most commonly involves the lung (1). More than 90% of patients with sarcoidosis will show abnormalities on chest X-ray films sometime during the course of their disease (1). The common roentgenographic presentations of pulmonary sarcoidosis are well known, and include lymph node enlargement and/or diffuse, parenchymal interstitial infiltrates (2). We report an unusual case of thoracic sarcoidosis which showed bilateral, peripheral, patchy parenchymal infiltrates of the lung, without any mediastinal or hilar lymphadenopathy.

A 27-year-old female patient was admitted to our outpatient clinic with an abnormal chest X-ray film which had been taken during a routine check-up examination. They started anti-tuberculosis therapy with three drugs in the other hospital to which she had referred before. When there was no change in the chest X-ray film after 2 months of treatment, she referred to our department for further examination.

Physical examination revealed normal findings. Chest radiograph showed bilateral, diffuse, patchy infiltrations being more prominent in the peripheral regions. Smear and culture of the sputum were negative for acid-fast bacilli. Erythrocyte sedimentation rate, complete blood count (including differential count of the white blood cells), serum electrolyte concentrations and kidney and liver function tests were in normal ranges. ACE concentration was 5 U l⁻¹. Arterial blood gases revealed; pH 7.43, PCO₂ 35 mmHg, PO₂ 80 mmHg and HCO₃⁻ 24 mEq l⁻¹. Pulmonary function tests showed mild small-airway obstruction, restriction and decrease in the diffusion capacity of the lung. Computed tomography of the thorax disclosed diffuse, bilateral, multiple infiltrative lesions being more prominent at the periphery of the lung. Gallium scanning of the lung was normal. Thoracotomy was performed to obtain a specimen, which on examination revealed granulomatous disease consistent with sarcoidosis.

We started to treat the patient with corticosteroid drugs, and noticed improvement in her chest X-ray films from the end of the first month of therapy, at the monthly follow-up visits. She developed spontaneous pneumothorax on the third month of treatment, for which she has been treated in our radiology department by tube drainage using a Heimlich valve. She recovered in 24 h and is still receiving tapered doses of corticosteroid therapy.

Isolated, peripheral parenchymal infiltrates in the lung are a rare initial manifestation of sarcoidosis (3). Glazer et al. (1) mentioned eight patients having infiltrates of this type, all of whom had hilar or mediastinal adenopathy. Scott and Pinstein (4) described a case with a chest X-ray film which showed mainly peripheral pulmonary infiltrates without any mediastinal or hilar adenopathy. Also, Judson et al. (3) presented a patient with chest CT scans showing isolated, peripheral pulmonary infiltrates. As a result, to our knowledge, our case is the third sarcoidosis case in which the chest CT scans showed isolated, peripheral pulmonary infiltrates.

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7 September 1994

References