Title: Pseudotumor Pulmonary Sarcoidosis: A Case Report

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Abstract:

Introduction:

Sarcoidosis is a non-necrotizing systemic granulomatosis of unknown cause with a marked pulmonary tropism. Atypical and unusual pulmonary manifestations in sarcoidosis, notably the pseudotumor form, are possible and should lead us to rule out differential diagnoses.

We report the case of a patient diagnosed with pulmonary pseudotumor sarcoidosis, which rapidly progressed favorably after initiation of corticosteroid therapy.

Medical observation:

Mrs. S. K was 56 years old, with no previous history of the disease. She complained of an isolated dry cough that had been present for 18 months prior to consultation, associated with severe asthenia.

On clinical examination, there were no pleuropulmonary or extra-thoracic abnormalities.

Thoracic computed tomography (CT) revealed a right hilopulmonary tissue infiltrate with multiple parenchymal nodules and mediastinal adenopathies.

Bronchoscopy showed thickening of the right lower lobar bronchial spurs, with a flattened appearance of the middle lobar bronchus, barely passable at its entrance. Staged bronchial biopsies showed only chronic inflammatory remodelling. Bronchoalveolar lavage found lymphocytic alveolitis (≈38%) without noting the presence of neoplastic cells. The BK test was negative.

Given the negativity of the etiological work-up, a scannoguided biopsy was indicated and revealed a confluent epithelio-giganto-cellular granuloma without caseous necrosis on anatomopathological study.

Thoracic MRI revealed an LSD tissue mass lesion with multiple nodules without hypercellularity on diffusion sequences.

The diagnosis of sarcoidosis was accepted, and the ophthalmological examination, biological work-up, ECG and echocardiogram showed no other localization.

In the functional assessment, spirometry confirmed the existence of a slight restrictive ventilatory disorder, with a forced vital capacity of 1.89l, i.e. 67% of the theoretical value. The patient did not desaturate on the walk test.

Corticosteroid therapy was initiated with prednisone 40 mg/day for 2 months. Clinical re-evaluation was favourable, with disappearance of cough and asthenia. Spirometry showed a gain in forced vital capacity of 640 ml. A thoracic CT scan was performed early, still for fear of neoplasia, showed disappearance of the tissue infiltrate with a decrease in the number of nodules and lymph node calcifications.

Conclusion:
The pulmonary manifestations of sarcoidosis are diverse. Classical involvement leads easily to diagnosis. The possibility of an atypical presentation, such as a pseudotumor, should not be ignored. A discrepancy between the extent of radiological lesions and the discretion of the clinical picture should raise the diagnosis, but histological confirmation must always be obtained. Evolution, although unpredictable, is usually towards resolution, either spontaneously or after systemic corticosteroid therapy.

Biography:
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Resident physician in 4th year of training in the Pneumology Department, Hassan II University Hospital Fez Morocco.
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