ORIGINAL RESEARCH PAPER

Medicine

KEY WORDS:

SARCOIDOSIS, A CHALLENGE IN CLINICAL PRACTICE

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INTRODUCTION

Sarcoidosis is a complex systemic inflammatory disease that in some cases can reach chronicity. It is prevalent in young women, it is of unknown cause that affects the respiratory system and lymph nodes.In addition, it can show predilection for other organs such as: skin, eyes, peritoneum, liver, joints and heart, with granuloma formation (nodules and masses abnormal).

For the diagnosis, the radiological clinical findings and the report of a biopsy of non-caseous granulomas of epithelioid cells should be correlated.

Given the aforementioned, the clinical case of a patient who was admitted to the "Hospital General IESS Quito Sur" is presented. Which shows a rare evolutionary course that could even be confused with a diagnosis compatible with tuberculosis and histoplasmosis.

CASE REPORT

A 37-year-old female patient, without a significant clinical history, who is admitted due to abdominal pain after 15 days, accompanied by vomiting, bloating and hyporexia. In addition to dyspnea grade II. It was associated with acute surgical abdomen in suspicion of peritonitis and pleural effusion.It underwent an exploratory surgical procedure where it was evidenced: the peritoneal cavity with 4200 cc ascitic fluid, nodular infiltrates in: peritoneum, intestinal handles, spleen liver, uterus and annexes, bladder and omentos. And adhesions between omentum and anterior peritoneum, intra-abdominal tumors, hypotrophic left ovary, 2x2cm stony right ovary were not palpated. He was placed into the 5th intercostal space in the right anterior axillary line without complications (gas and approximately 250 cc of cetrine fluid are obtained).

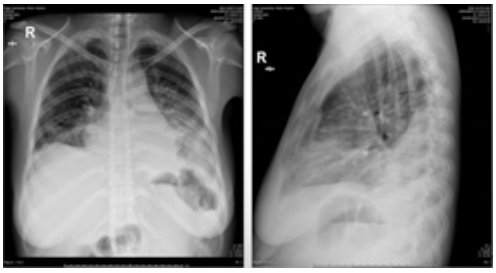
Subsequently, he enters the intensive care unit (UTI) for persistent hypotension that does not respond to crystalloids, more respiratory acidosis and general condition, with hemodynamic instability. It evolves adequately in UTI with low doses of vasoactive and lower thoracic drainage. It is possible to withdraw vasoactive agents, although it persists with hypotension, but without signs of low expense, so it is a graduate of the ICU in the internal medicine service.

In Internal Medicine it refers to asthenia and hyporexia, with general malaise, without abdominal pain and persistent recurrent fever. To the physical examination: conscious, oriented. Lungs: with thin crepitants left basal Abdomen: with slight pain on deep palpation.

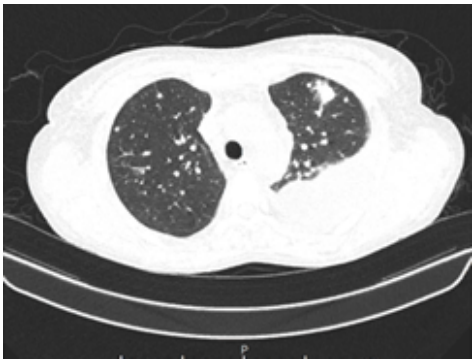
Among the main presumptive problems found were: Infiltrative peritoneal disease, Peritonitis of etiology to be filmed, polyserositis, shock of unfiltered etiology. And the differential diagnoses are described in Table 1.

DIAGNOSTICO DIFERENCIAL
PERITONITIS GRANULOMATOSA
- INFECCIOSA
TUBERCULOSIS
HISTOPLASMOSIS
VIH
- NO INFECCIOSA
SARCOIDOSIS
- TUMORAL
MESOTELIOMAS
TUMORES METASTÁSICOS PERITONEALES
PSEUDOMIXOMA PERITONEAL
MICROPAPILOMATOSIS SEROSA PERITONEAL
ENFERMEDADES DEL TEJIDO CONECTIVO

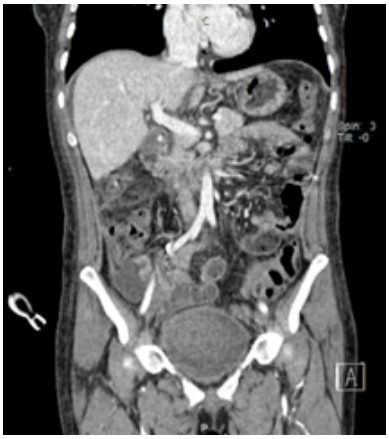
In the complementary exams it was found: Hematic Biometrics; leukocytes: 12.49, neutrophils: 94.4, hemoglobin: 8.8 mg / dl. Hematocrit: 27.3%, Platelets: 287000, Glucose: 74 mg / dl, TSH hypopituitarism: low 0.67 and Cortisol at 4.62. EMO: Non-infectious, heoculture, urine culture: negative, HIV: (-) A chest x-ray that revealed bilateral hilar lymphadenopathy along with signs of atelectasis in the bilateral pulmonary fields and right pleural effusion Figure 1.



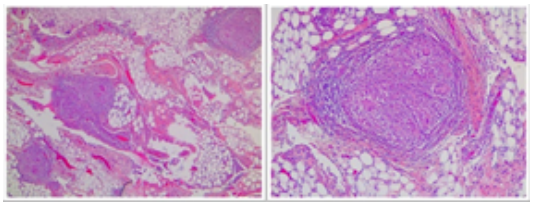
Tomography was performed which describes a thickening of the walls of the greater curvature of the stomach measuring 18mm. An increased peritoneum of density is seen in the region of the left flank and posterior of right predominance, with involvement of mesenteric fat with a heterogeneous dirty peritoneum. Draws attention to the thickening of the walls of the cecum and ascending colon, measuring 10mm, which capture contrast. In the pulmonary windows right basal pleural effusion is observed accompanied by atelectasis of the lower lobe. Figure 2.



The peritoneum biopsy result is described in Figure 3.



You were asked for special PAS, Ziehl and Grocot colorations. Negative for microorganisms. Negative sputum culture and BAAR.



CONCLUSIONS

Sarcoidosis is a multisystemic disease belonging to the family of granulomatous conditions, characterized by the presence of non-casing granulomas in the affected organs in which cultures for mycobacteria and fungi, capable of producing a similar clinical and histopathological picture, have been negative It has a universal distribution and so far no responsible agent has been isolated.

From the evolutionary picture of the patient, it cannot be ruled out that she had tuberculosis or associated histoplasmosis. Due to the fact that she initially presented serious complications, the disease was not manifested by typical skin or eye lesions.

The cause of sarcoidosis remains unknown. Even when clinically it manifests itself in a very diverse and unpredictable way, its prognosis is not bad, since up to two thirds of patients have a regression or improvement of symptoms over the years. Only a small minority present the disease chronically and, only in some very severe cases - due to progressive respiratory failure, leads to death.

The onset of steroid therapy in patients with an underlying infection may accentuate any possible life-threatening complications.

Given the heterogeneity of the clinical manifestations, the uncertain clinical course and the potential adverse effects of the medication, management becomes difficult. Patients are mostly seen without treatment, due to the possibility of spontaneous healing.

Due to the conditions of soon return to daily activities, and the domicile in a rural area, the patient and family members request voluntary discharge, she leaves with a reserved prognosis because during her stay she maintained hypotension without signs of low expense and with persistent fever.

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