SARCOIDOSIS OF THORACIC ORGANS IN COMBINATION WITH SKIN DISORDER

*Bilchenko O.S, Savoskina V.A, Krasovskaya E. A.*

*Kharkiv National Medical University*

*Department of Propaedeutics of Internal Medicine No. 2 and Nursing Kharkiv Medical Academy of Postgraduate Education, Kharkiv, Ukraine*

Sarcoidosis is among the multisystem granulomatous diseases of unknown etiology. Granulomatous inflammation is caused by the immune response. The basis of immunoparhogenesis of lung sarcoidosis is the delayed-type reaction (DTR).

A hypothesis is widely spread about the multifactor nature of the disease, but the most likely cause is infection.

Most often, the disease manifests itself in the thoracic organs affect. At the same time, in 15-50% of cases, the skin is affected. External manifestations of sarcoidosis of the skin are diverse. The clinical manifestations of sarcoidosis of the thoracic organs are polymorphic.

Experts differentiate specific and nonspecific forms of skin sarcoidosis. Specific include: 1. Small nodular form of sarcoid, 2. Diffuse-infiltrative sarcoid, 3. Besnier-Tennesson lupus pernio, 4. Angiolipomas, 5. Ulcerative sarcoid, 6. Scar sarcoid.

Nonspecific lesions include nodular eiythema (Darie-Russi subcutaneous sarcoid), accompanied by fever and arthralgia. The following clinical forms are distinguished:

• Lofgren syndrome: bilateral increase in the basal lymph nodes, erythema nodosum and arthritis. The first clinical manifestation is often erythema nodosum. As a rule, it regresses spontaneously.

• Heerfordt disease: fever, parotid enlargement, iridocyclitis and facial nerve damage.

We observed 12 patients with sarcoidosis with lesions of the thoracic organs and skin. All patients first consulted a dermatologist or a cosmetologist for skin disease. As a result of dermatoscopy and histological studies, nodosum erythema was diagnosed in 4 patients; one patient had Besnier-Tennesson lupus pernio, three had Lofgren syndrome, three had microfocal scar sarcoidosis, one had Heerfordt disease.

In the X-ray study of all patients, a bilateral increase in bronchopulmonary lymph nodes without dissemination was observed. Patients were referred to a pulmonologist. The duration of the disease was from 1 month to 2 years. An acute onset was noted in 3 patients with Lofgren syndrome (erythema nodosum, pain, swelling of the ankles, fever, symptoms of intoxication). In 30% of patients, the disease was asymptomatic. In others, the onset of the disease was gradual. The most common and chief complaint was mild dyspnea. All the patients had a computed tomography of the thoracic organs. Based on the results of the examination, an increase in paratracheal, para-aortic and bifurcation lymph nodes was detected. In 1 patient, in addition, a lesion of intra-abdominal lymph nodes was detected. The Mantoux reaction with 2 ТЕ was negative. All patients were HIV-negative, ELISA test for syphilis was negative. When examined for intracellular infection, as well as herpes simplex virus 1.2, IgG was detected in 5 patients. In the study of blood in 4 patients, lymphopenia was detected, all patients had an increase in ESR up to 30 mm per hour. The content of Ca in the blood exceeded 2.55±о.2б mmol/L. All patients were examined for IgG level to cytomegalovirus, Epstein-Barr virus, and herpes simplex virus type 1,2. Six patients (60%) experienced an increase in the titer of these antibodies to 15.8+ 5.9, indicating a chronic carrier state of herpetic infection.

The results of clinical observation. Patient A., born in 1962, previously lived in Turkmenistan, was referred to a dermatologist with a diagnosis of discoid lupus erythematosus. Anamnesis showed that he had been ill since childhood, after 1980 since military service the disease aggravated (after hypothermia). Worsening in the autumn-winter period: the disease manifested in the form of pustular rash, severe pain. In this case, tactile, temperature and pain sensitivity are preserved. The patient was repeatedly observed by dermatologists and underwent courses of treatment for chronic pyoderma at the regional VD clinic. Received medication with antibiotics, cryodestruction of foci was carried out without any effect. The diagnosis of pulmonary tuberculosis was excluded. Since 2005, bronchial asthma has been diagnosed, treated with PSL, with no improvement in dermatological symptoms. In 2012, when contacting dermatologists after the scrapes, a fungal skin lesion was excluded. A serological test for syphilis: ELISA for syphilis was negative, Treponema Pallidum Hemagglutionation test was negative. Antibodies

to HIV and the causative agent of tuberculosis were negative. In bacteriological culture, S. aureus 10\*6 CFU/ml, S. haemolyticus 10\*5 CFU/ml were isolated from the foci on the skin.

LE cells were not detected, lupus anticoagulant was negative. According to dermatoscopy, neovascularization had been detected, there was a yellowish color on the pink background. Histological examination revealed thinning of the epidermis, in the dermis throughout the thickness there were massive granulomatous infiltrates consisting of epithelioid cells, lymphocytes, histiocytes, giant cells, as well as abscesses, neutrophils, granulation. Tubercle-like structures were morphologically defined. Acid fast stain and Romanovsky-Giemsa stain: specific structures characteristic for skin tuberculosis and leishmaniasis were not detected. With CT of thoracic organs, the patient was found to have enlarged paratracheal, paraaortic and bifurcation lymph nodes. Based on clinical observation, skin histology data, sarcoidosis of the chest lymph nodes, Besnier-Tennesson lupus pernio were diagnosed.

The diagnosis of sarcoidosis is complex, since the lesions of the thoracic organs do not have specific symptoms and are often considered as other pulmonary diseases. Sarcoidosis of the skin is the most objective visual manifestation of the disease: at early stages of its development it is diagnosed by specific clinical manifestations, the diagnosis is objectified by dermatoscopic and histological methods.