Anal manifestation of sarcoidosis

 Manifestation anale d’une sarcoïdose

Introduction
Sarcoidosis is a complex systemic disorder of unknown aetiology characterized by the formation of immune granulomas in involved organs. Common localizations are the lungs, the lymphatic system, the skin and the eyes [1]. Gastrointestinal tract involvement is rare [2] and anal manifestation of sarcoidosis seems extremely rare.

Case report
A 34-year-old woman consulted for an anal pain, she had for the last 3 months, especially during bowel movements. She had a 7-year history of pathologically confirmed mild and stable typical thoracic and cutaneous sarcoidosis. No treatment was required until this event linked to the occurrence of two ulcerations of the anal margin (figure 1). There was no abscess nor infection. Endoanal and rectal examination was normal. There was no inguinal node enlargement. The patient was in good general condition besides fatigue; cutaneous and thoracic sarcoidosis localizations were stable. Routine laboratory tests results were normal. Biopsy of one of the ulcerations was performed and histological sample is shown in figure 2.

Histopathology analysis demonstrated multiple non-necrotic and well-circumscribed dermal granulomas extending through the whole thickness of the dermis and composed of epithelioid histiocytes and multinucleate giant cells with only a sparse infiltrate of lymphocytes at the periphery (figure 2). Taking into account the medical history; these features were highly consistent with sarcoidosis. So, therapy with prednisone (15 mg/d) and hydroxychloroquine (400 mg/d) was initiated. Symptomatic improvement was rapid and complete healing of ulcerations was noted after four weeks (figure 3).

Discussion
We found only one report mentioning anal manifestation of sarcoidosis, in a patient with fistula [3]. For our patient, the differential diagnosis mainly included infectious diseases like tuberculosis, syphilis, infections with cytomegalovirus, herpes simplex virus, Mycobacterium avium/intracellulare, and Crohn’s disease [1,3]. The patient’s medical history was so suggestive that we decided to start the treatment. The diagnosis of anal sarcoidosis was reinforced by a significant clinical response. Moreover, there was a return of the anal symptoms after treatment discontinuation, followed by a rapid recovery when the treatment was resumed with further control under hydroxychloroquine 400 mg/d and prednisone 8 mg/d.

Figure 1
Ulcerations of the anal margin

Figure 2
Biopsy from anal ulceration
Disclosure of interest: the authors declare that they have no competing interest.

References