Symptomatic Gastric Sarcoidosis in a Patient with Pulmonary and Neurosarcoidosis

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Introduction

Sarcoidosis involves the pulmonary system in >90% of cases. Extrapulmonary involvement carries significant morbidity and is under diagnosed.

Gastrointestinal (GI) involvement of sarcoidosis is extremely rare. The reported frequency of GI involvement is 0.1-3.4%. It can result in luminal narrowing, ulceration, and, less commonly, bleeding and obstruction.

Case

38-year-old mixed-race man presented to the Emergency Department with intractable nausea, vomiting, and abdominal pain for 1 month.

Past medical history:
Pulmonary and neurosarcoidosis on high dose methotrexate, pulmonary embolism, chronic hypoxic respiratory failure on home oxygen, and steroid-induced avascular necrosis

Initial investigations:
Labs unrevealing. CT abdomen and pelvis unremarkable. Upper GI barium swallow aborted due to vomiting.

Initial interventions:
Anti-emetics, intravenous fluids, pain medication, and a modified diet all did not provide the patient with any relief.

Further investigations:
Upper GI endoscopy: few dispersed erosions in the gastric body (biopsied) and otherwise normal appearances of the esophagus, stomach, and upper duodenum. Biopsies revealed noncaseating granulomas focally present in the lamina propria of the gastric oxyntic mucosa.

Learning Points

Symptoms of gastric sarcoidosis are non-specific and difficult to distinguish from other GI pathologies. A high index of suspicion should be present in patients with existing disease, even if they are already on therapy.

Definitive diagnosis can only be established through endoscopic biopsy, but may still be falsely negative given the patchy mucosal involvement of this disease.

Patients with gastric sarcoidosis can have normal appearing mucosa, therefore random biopsies should be considered.

At present, there are no site-specific treatment algorithms for extrapulmonary involvement.

Literature cited

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