treatment of a cystic infection requires antibiotics that will penetrate the cysts, a characteristic of only a few antibiotics, including trimethoprim-sulfamethoxazole, chloramphenicol, and ciprofloxacin and when the pain is disabling, decompression of the cysts is indicated. Therefore, we aspirated one cyst percutaneously under ultrasonographic guidance and aspirated fluid was sent for the laboratory examination. Antimicrobial agent (Ciprofloxacin) was prescribed in a dose of 500 mg two times a day for ten days and discharged.

As disease progresses more and more cysts appear in both kidneys and liver, and gradually hypertension appears to result from the activation of the renin-angiotensin-aldosterone system, presumably by stretching and attenuation of intrarenal vessels around cysts, causing areas of distal ischemia. However, hypertension is not the feature in our case. There is slow deterioration in renal function but liver function generally preserved very well.

Diagnosis is mainly based on imaging studies. Ultrasonographic examination is good to know the cystic involvement of liver as well as other organs. Computer tomography with contrast enhancement appears to be somewhat more sensitive than ultrasonography and may correctly diagnose some cases missed by ultrasonography.

**REFERENCES**


**Acute Sarcoïdosis – Heefordts-Waldenstrom Syndrome**

Sir,

While there is sparse literature on the typical presentation of sarcoidosis, very little has been documented regarding the uncommon manifestations of sarcoidosis from India. Keeping these facts in mind we report here the uncommon manifestations observed in a biopsy proven patient with acute sarcoidosis.

A 48 years female who is a housewife from Mysore presented with symptoms of fever, painless swelling of
both sides of face, swelling of both eyelids, dryness of mouth with itching of eyes, reddish skin lesions over legs of one month duration. The fever was mild to moderate in degree and used to appear in the evening hours. Two years back she had developed generalized weakness with severe loss of appetite and nausea which lasted for about 4-6 months. During this period patient developed disturbances in vision and left sided facial weakness. Symptoms resolved without being diagnosed of her illness during this period. 17 years back she underwent surgery for bilateral renal calculi.

On examination, patient was moderately built and nourished. There was no pallor, cyanosis, clubbing or lymphadenopathy. Patient was mildly febrile. There was bilateral lacrimal and parotid gland enlargement, which were non-tender. There was left sided LMN type of facial paresis. Erythematous plaques were present in both lower limbs. Vital parameters were within normal limits. The cardiovascular and respiratory system examination findings were within normal limits. CNS examination was within normal limits except for facial paresis. Ocular examination showed candle wax dripping along inferior nasal branch of retinal veins.

Routine investigations like Hb%, TC, DC, platelet count, peripheral smear were within normal limits. ESR was increased (70 mm/hr). FBS, blood urea, S. creatinine, S électrolytes, LFT, S. calcium, thyroid profile and routine urine examination were normal. HIV (Elisa) was non reactive. ACE was elevated /g259 86 u/l (N-8-52 u/l). Ultrasound examination of abdomen was normal except for post-hysterectomy status. Schirmers test right eye- 2mm, left eye /g259 0. Mantoux test was negative with no induration seen after 48 hrs. Specific gravity of urine was within normal limits. Chest X-ray showed features of reticular shadows in lower zones bilaterally. CT of thorax showed patchy areas of ground glass opacities and increased reticular shadows in both lung fields mainly in lower lobes with no pulmonary mass lesion, no pleural effusion and no mediastinal lymphadenopathy. CT features were suggestive of early stage of ILD with suspected sarcoidosis. Biopsy of the skin plaques was done from leg. Epidermis appeared normal. Dermis showed multiple discrete naked non caseating granuloma composed predominantly of epithelioid cells, very few lymphoid cells and occasional multinucleated giant cells. Granulomas were present around the adnexa also. The histological features were suggestive of sarcoidosis. Patient was treated with oral prednisolone for one month after which it was stopped. There was an improvement in patient’s clinical status after treatment.

The uncommon manifestations present in this patient of acute sarcoidosis were Unilateral LMN type of facial palsy, Bilateral Parotid and lacrimal glands involvement and Sicca syndrome.®

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Fig. 1 : Unilateral LMN facial palsy, bilateral lacrimal and parotid glands enlargement.

Fig. 2 : Biopsy of skin plaque showing non caseating granuloma.

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