Recurrent Massive Pleural Effusion with Neurosarcoidosis: A Rare Presentation of Sarcoidosis

Sir,

The case report entitled “Recurrent Massive Pleural Effusion with Neurosarcoidosis: A Rare Presentation of Sarcoidosis” was read by us with great interest and we would like to offer the following comments:

a. Pleural biopsy in this case revealed noncaseating granulomas and in view of recurrent pleural effusion with no response to ATT even after three months, there was ample evidence for authors to start an aggressive search for nontubercular causes of pleural effusion, especially sarcoidosis.

b. Patients with sarcoid pleural effusion usually have extensive parenchymal disease (radiographic stage II or stage III) and frequently have extrathoracic sarcoidosis. At this stage the patient should have been subjected to HRCT-Thorax and other relevant investigations to rule out pulmonary and extrathoracic sarcoidosis. Also in view of patient developing cardio pulmonary arrest during thoracoscopic pleural biopsy, there was an indication to evaluate for cardiac sarcoidosis.

c. As pleural biopsy had revealed non caseating granulomas and there was no response to ATT, there was no rationale for continuing ATT for four more months and starting second line ATT after chest imaging findings.

d. Although the patient presented with pleural effusion, she did have sarcoidosis of other organs which was picked up later. Hence, the appropriate title of case report in this case should have been ‘Multiorgan Sarcoidosis with Rare Massive Pleural Effusion’.

e. Patients with multiorgan sarcoidosis with neurosarcoidosis are usually put on high dose (1mg /kg body wt) steroids. Authors have given higher than recommended dose [Inj Methyl Prednisolone 125mg iv 8 hourly] but have mentioned different dosage schedule in discussion. This needs clarification.

f. Authors have discussed mainly bilateral effusion in sarcoidosis, whereas this patient had only unilateral effusion.

Reply from Author

Sir,

Firstly I would like to thank Dr. Barthwal for his keen interest and perusal of the case report and for highlighting several debatable points in this interesting case. I would like to offer my clarifications on the points raised by him.

a. Our patient had initially, recurrent left sided pleural effusion with no other cardiovascular or neurological symptoms. S.ACE levels, liver and renal function tests,ECG were normal. Initial CT thorax with contrast was done and it was normal hence it was not mentioned. So the patient was referred for a thoracoscopic pleural biopsy to find cause of recurrent effusion after three months of AKT.

b. In hindsight it is possible that patient had cardiac involvement due to sarcoidosis is due to which she developed cardiac arrest during procedure. However there is no documentation of cardiac involvement such as arrhythmias, pericardial effusion or cardiac failure pre or post operative as confirmed by the initial and follow up ECGs and 2D echo reports.

c. A review of available literature on this topic shows that noncaseating granulomas can be present in tuberculosis To quote from textbook of tuberculosis 2nd edition by W.N.Rom and S.M.Garay “when TB is clinically likely, demonstration of granulomatous inflammation (caseating or non-caseating) on histopathological examination of pleural biopsy tissue has traditionally been accepted as the single best test, essentially proof positive of pleural tuberculosis”

d. Yes. This case could also have been named as multi organ sarcoidosis with rare massive pleural effusion.

e. A review of literature in ERJ and ATS statement on sarcoidosis supports the use of high dose systemic steroids in acute neurosarcoidosis and ocular sarcoidosis. High dose steroids had been given in our patient for 1 week in tapering doses and was followed by oral corticosteroids in dosages as mentioned in the discussion.

f. We have discussed both unilateral and bilateral effusion. However the references were of bilateral effusion as we could not find a reported case of unilateral recurrent massive effusion in sarcoidosis.

References


MS Barthwal*, CDS Katoch*, Manu Chopra**
*Senior Advisor; **Resident, Dept of Pulmonary, Critical Care & Sleep Medicine, Military Hospital (Cardiothoracic Centre), Pune

TK Jayalakshmi*
*Assoc. Professor, Dept. of Pulmonary Medicine, Dr. DY Patil Hospital, Mumbai

Received: 17.05.2010; Accepted: 17.06.2010