Crohn’s colitis and sarcoidosis

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Summary: We report a patient with both sarcoidosis and Crohn’s colitis, an association not previously documented. We review the literature and discuss the areas of overlap in these two conditions.

Introduction

Sarcoidosis and Crohn’s disease are both granulomatous diseases of unknown aetiology, but rarely occur together in the same patient. We present a patient with well documented Crohn’s colitis and sarcoidosis. Review of the literature suggests that overlap cases of Crohn’s colitis and sarcoidosis can occur and may cause diagnostic difficulty.

Case report

In April 1982 a 29 year old doctor presented with a 4 week history of diarrhoea occurring 6 to 7 times a day and associated with the passage of blood and mucus. She had suffered from intermittent mild attacks of diarrhoea for a number of years, most marked during her 2 previous pregnancies. Physical examination was normal. Abnormal laboratory investigations included a white cell count of $11.8 \times 10^9$/l and an erythrocyte sedimentation rate (ESR) of 28 mm/h. Haemoglobin, serum albumin and ESR were normal. Three weeks later she developed bilateral Bell’s palsy and acute anterior uveitis. A chest X-ray showed bilateral hilar adenopathy and she was admitted to hospital for investigation of probable sarcoidosis. Lymph nodes obtained at mediastinoscopy showed masses of non-caseating granulomata. The serum angiotensin converting enzyme activity was raised at 41.8 U/ml (normal less than 30 U/ml). Sputum cultures for *M. tuberculosis* were negative. Pulmonary function tests, including diffusing capacity for carbon monoxide, and serum and urinary calcium levels were normal. A diagnosis of sarcoidosis was thus confirmed and treatment with high dose oral steroids was started. She recovered rapidly and gained weight though she was left with some residual facial weakness. After 2 years of follow-up the bilateral lymphadenopathy has regressed but she has developed bilateral pulmonary infiltrates, with, however, excellent preservation of pulmonary function. She has had no further symptoms from her Crohn’s disease.

Discussion

The concurrence of Crohn’s disease and sarcoidosis is very rare. Only three definite cases (Oakley et al., 1983; Padilla & Sparberg, 1972; Dines et al., 1971) and two possible cases (Dines et al., 1971; Morland, 1947) have been described in the literature. From the known prevalence of sarcoidosis (33 per 100,000: Logan, 1964) and the known incidence rate for Crohn’s

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theory that the pathogenetic mechanisms in sarcoidosis and Crohn's disease may have shared features.

Sarcoidosis of the intestinal tract has also been thought to be uncommon but there is some evidence that this may not be so. Chinitz et al. (1985) reviewed 20 patients with symptomatic gastric sarcoidosis and Palmer (1958) showed that as many as 10% of sarcoid patients had non-caseating granulomata in gastric mucosal biopsy specimens despite normal gastrointestinal appearances. Isolated case reports of symptomatic and asymptomatic sarcoidosis of the intestine have appeared over the years (Sprague et al., 1984; Kohn, 1980; Gould et al., 1973; Gourevitch & Cunningham, 1959; Aaronson et al., 1975; MacFarlane, 1955; Raven, 1949) although in many of these the diagnosis of systemic sarcoidosis was somewhat tenuous. Konda et al. (1980) described an interesting patient who presented with granulomatous hepatitis, a diffuse skin rash and was found to have a cobblestone appearance of the gastric mucosa and a diffusely friable rectal mucosa. Biopsies of the skin, rectum, stomach and an episceral node all showed non-caseating granulomata. It must be a question of definition as to whether this patient had sarcoidosis with intestinal involvement, or Crohn's disease in addition to sarcoidosis.

In summary, Crohn's disease and sarcoidosis very rarely occur together. They share many clinical and immunological features and recent studies have suggested that similar pathogenetic mechanisms may be involved in these two diseases. Further study of such overlap syndromes (James & Sharma, 1985) may provide clues to the aetiology of these granulomatous disorders.

References


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