Reactivation of old scars: inevitably sarcoid

J S Sorabjee, R Garje

CASE REPORT

A 72 year old man presented with a four week history of a low grade fever (temperature 38.5°C) associated with 5 kg of weight loss. He had been treated with antibiotics empirically by his family practitioner without benefit. Routine investigations including a complete blood count, erythrocyte sedimentation rate (ESR), urinalysis, and chest radiography were normal and he was therefore referred for further consultation. When seen five weeks after the onset of his fever he volunteered a history of swelling, redness, and itching associated with numerous scars that he had acquired almost 50 years previously during his career in professional cricket. Physical examination was entirely normal other than the presence of swelling and discoloration at the sites of four scars on his upper lip (fig 1), back, chest, and neck. In view of a suspicious hilar prominence on chest radiography, computed tomography of his thorax was done; this showed the presence of numerous non-necrotic lymph nodes in the mediastinum but without any lung lesions. Serum angiotensin converting enzyme concentrations were normal as were repeat examinations of his complete blood count, ESR, peripheral smear, and routine biochemistry. A Mantoux test to 5 and 10 tuberculin units was negative.

In view of the above clinical presentation a differential diagnosis of mediastinal tuberculosis, sarcoidosis, and lymphoma was considered. As no peripheral lymph nodes were palpable, a decision was made to perform a scar biopsy before proceeding with a mediastinal lymph node biopsy. This was obtained from the most active scar, which was present on the lower back. Histopathology revealed the presence of numerous non-caseating granulomas enmeshed within the fibrous tissue of the scar. Treatment was instituted with a short course of steroids; after this the patient’s fever settled, he gained weight, and the visible inflammation in the scars regressed completely. Over a period of time the lesions seen on chest radiography regressed on steroid therapy, which was gradually withdrawn.

DISCUSSION

In India sarcoidosis is uncommon but has been recognised with increasing frequency in recent years. In most instances patients present with pulmonary involvement manifested by hilar adenopathy and interstitial lung lesions. Skin manifestations are relatively uncommon (20%–35%) and occur in three broad groups—that is, erythema nodosum, infiltrative cutaneous sarcoidosis, and scar sarcoidosis. Scar sarcoidosis is itself rare (2.9%) with few case reports worldwide and fewer from India. It is especially uncommon in the absence of other skin manifestations of sarcoidosis and takes the form of redness and reactivation of old cutaneous scars. Scar sarcoidosis may precede or accompany systemic sarcoidosis and may be the main manifestation of a relapse. Scar isolated to scars may represent a more benign variant of sarcoidosis, and has been considered to be a systemic autoimmune disease.

Reactivation of old scars appears to be highly specific for sarcoidosis and in this instance the positive skin biopsy mitigated the need for an invasive procedure in the form of a mediastinal lymph node biopsy. In addition to reactivation of scars obtained from previous wounds, scar sarcoidosis has been reported at the sites of previous intramuscular injections, tattoo scars, blood donation venepuncture sites, scars of herpes zoster, and sarcoidosis on ritual scarification, and at the sites of allergen extracts for desensitisation. As in this patient a short course of steroids in moderate doses (30 mg per day in this instance) serves to suppress most of the symptoms of the disease, however in cases where scar sarcoidosis is the only manifestation of the disease, allopurinol in a dose of 300 mg per day has been found to be effective.
It is essential that patients complaining of inflammation at the sites of old scars should be examined and in the appropriate setting investigated for sarcoidosis.

Authors' affiliations
J S Sorabjee, R Garje, Department of Medicine, Bombay Hospital Institute of Medical Sciences, Bombay, India

Correspondence to: Dr Jehangir S Sorabjee, Department of Medicine, Bombay Hospital Institute of Medical Sciences, 12 New Marine Lines, Bombay 400020, Maharashtra State, India; jsorabjee@vsnl.com

Submitted 8 January 2004
Accepted 20 February 2004

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