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A 70-year-old male patient with sarcoidosis-lymphoma syndrome

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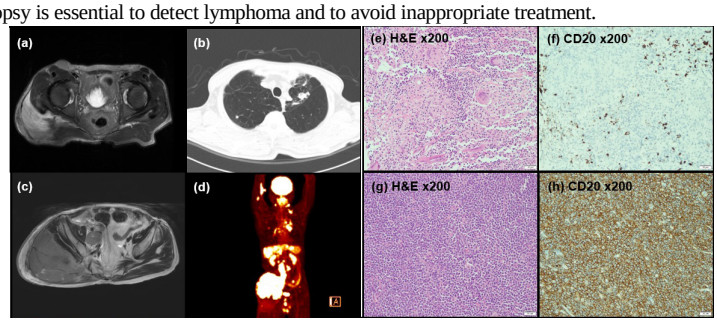
Sarcoidosis is a chronic granulomatous inflammatory disorder involving multiple organs. Sarcoidosis and lymphoma are different disease entities, but rarely are two diseases together, called sarcoidosis-lymphoma syndrome. The 70-year-old man presented with a one-month history of painless masses on right inguinal area and buttock. His body weight decreased by 7kg over 6 months but he denied other systemic symptoms. WBC and C-reactive protein were normal. Serum creatinine was 1.8mg/dL, and ionized calcium 1.69mmol/L. Serum angiotensin converting enzyme (ACE) was over the detection limit (> 150IU/L). Pelvis MRI(a) showed infiltrative masses on right gluteus muscle and enlarged inguinal lymph nodes. Chest CT(b) showed multiple calcified/non-calcified nodules on both lungs. Needle biopsy of the buttock mass(e, f) showed chronic non-caseating granulomatous inflammation with many multinucleated giant cells. AFB and GMS staining, and tuberculosis PCR were negative. Bacterial/fungal/tuberculosis cultures from bronchial washing samples were negative. Pulmonary functional test showed moderate obstructive pattern with decreased diffusing capacity. There was no uveitis on ophthalmologic examination. Sarcoidosis was diagnosed, based on the pathological findings, hypercalcemia, azotemia, elevated ACE level, and lung nodules. The patient was prescribed methylprednisolone 40mg/day and then slowly tapered dose. Both inguinal and buttock masses decreased. Azotemia and hypercalcemia had been restored. Nine months later, the inguinal and buttock masses suddenly grew with pain and heating sense. On pelvis MRI(c), there were no evidence of infection, but the size of the buttock masses increased. PET/CT(d) showed hypermetabolic lesions on buttock, inguinal area, liver, lung, and bone. Excisional biopsy of the inguinal mass(g, h) was performed and diffuse large B-cell lymphoma was diagnosed. He was treated with chemotherapy (R-CHOP). Sarcoidosis-lymphoma syndrome is rare but exists. On medical follow up of sarcoidosis, unexplained worsening sarcoidosis must raise suspicion of lymphoma. Excisional biopsy is essential to detect lymphoma and to avoid inappropriate treatment.



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Case Report: A case of eosinophilic pneumonia in a diborane(B2H6) use worker

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Introduction: Eosinophilic pneumonia (EP) is an important subset of pulmonary disease which presents with pulmonary infiltrates of eosinophils. Drugs and toxins are the major causes of secondary EP. Diborane(B2H6) is a colorless gas at room temperature used many fields of chemical and semi-conductor industry as a reducing and a doping agent. Acute B2H6 inhalation can induce pulmonary injuries and two cases of acute pneumonitis have been reported in 1956 and 1958. However, EP induced by B2H6 has not been reported. This is a case report of EP which developed in a B2H6 worker. **Case report:** A 45-year-old man visited the emergency room with cough, dyspnea and fever. He started B2H6 removal work 14 days ago and his symptoms developed from 7 days after work. In chest computed tomography (CT) scan, multiple ill-defined tiny centrilobular nodules and multifocal patchy ground glass opacities (GGO) were observed in both lungs. Eosinophilia was present in peripheral blood (WBC: 7,170/㎣, neutrophil: 59.8%, lymphocyte: 18.5%, monocyte: 10.9%, eosinophil: 10.7%, basophil: 0.1%). Arterial blood gas analysis revealed mild hypoxemia (pH 7.433, $PaCO_2$ 31.4 ㎜Hg, PaO_2 64 ㎜Hg, HCO^3 20.5 ㎜ol/L, SaO_2 92.7%). Bronchoalveolar lavage fluid (BALF) analysis showed marked increase in eosinophil fraction (2,320 cells/㎖ with a differential of eosinophils 53%, macrophages 28%, lymphocyte 12%, neutrophil 6% and basophil 1%). Histopathologic examination of transbronchial lung biopsy(TBLB) specimens showed infiltration of eosinophils. Therefore, we diagnosed as an EP associated with B2H6 by confirmation of eosinophilic infiltration in lung biopsy and increased eosinophilic fraction more than 25% in BALF even though we could not conduct an inhalational provocation test with B2H6 and measurement of B2H6 concentration in the blood or BALF. The patient was treated with intravenous methylprednisolone (1㎎/㎏). After 7 days of treatment, the extent of multifocal GGO decreased in chest CT scan and the patient's symptoms were improved. **Summary:** We report a case of EP in a B2H6 use worker which was diagnosed with BALF analysis and histopathology of TBLB, and improved after corticosteroid treatment.

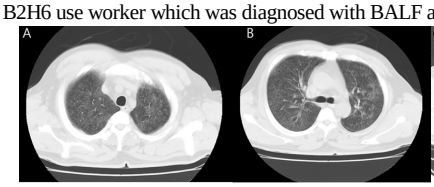

Figure 1. Chest computed tomography on admission showed multiple ill-defined tiny centrilobular nodules and multifocal patchy ground glass opacities in both lungs.

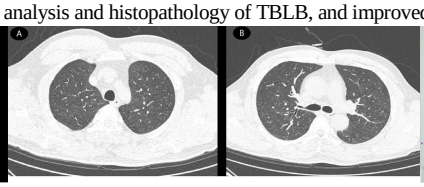

Figure 2. After 7 days intravenous corticosteroid treatment, the extent of multiple ill-defined tiny centrilobular nodules and multifocal patchy GGO markedly decreased in both lungs on chest computed tomography.

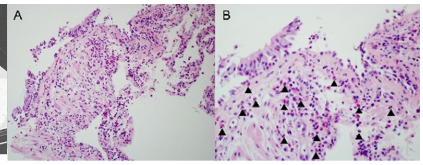

Figure 3. The histopathologic examination of transbronchial lung biopsy specimens revealed eosinophilic infiltrations (B: arrow head) with lymphocytes and plasma cells (A: ×200, B: ×400)