Sarcoidosis Mimicking Multiple Myeloma.

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Sarcoidosis Mimicking Multiple Myeloma

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DISCUSSION

• A 70-year-old Caucasian female presented to the emergency department with symptoms of confusion and low back pain. She was found to have an elevated calcium level of 14 mg/dL, creatinine of 3.8 mg/dL with a baseline of 1.3 mg/dL, and a hemoglobin of 10 g/dL with a baseline of 12 g/dL.

• X-ray imaging of the lumbar spine was concerning for a compression fracture with osteolytic changes.

• She was treated with intravenous hydration and calcitonin with correction of her renal and electrolyte abnormalities.

• Her presentation raised concern for multiple myeloma and work up was initiated.

• Surprisingly, the bone marrow biopsy demonstrated granulomatous inflammation.

• In addition, laboratory data revealed SPEP/UPEP negative for monoclonal gammopathy, as well as elevated 1,25-dihydroxyvitamin D and angiotensin converting enzyme (ACE) levels.

• A skeletal survey was performed for completion and was unremarkable for additional bony abnormalities.

• Additional laboratory data performed in context of hypercalcemia work up was also unrevealing as seen in Table 2.

• Inconsistent with the diagnosis, CT of the chest was negative for parenchymal or lymph node involvement of the pulmonary system.

• Patient also displayed potential cardiac manifestations of her disease given history of conduction abnormalities requiring a pacemaker as well as a diagnosis of diastolic dysfunction.

• This information supported the diagnosis of sarcoidosis.

• Isolated extrapulmonary manifestations of sarcoidosis are rare and present in less than 10 percent of reported cases.1

• Bone marrow involvement has only been described in less than 5 percent of cases.2

• This is potentially due to a low number of bone biopsies performed and could underrepresent the true incidence of bone marrow sarcoidosis.2

• Sarcoi can present as sclerotic or lytic lesions on radiographic data.6

• Hematologic abnormalities can be seen in up to 30 percent of cases.5

• Steroids are first line therapy for any manifestation of sarcoidosis.2

• While there is a broad differential for granulomatous lesions the clinical picture of the patient presented is less likely a result of other infectious, vasculitic, neoplastic, or chemical/environmental etiologies.

Table 1. Manifestations of Sarcoidosis

<table>
<thead>
<tr>
<th>Manifestation</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulmonary</td>
<td>&gt;90%</td>
</tr>
<tr>
<td>Cardiac</td>
<td>5%</td>
</tr>
<tr>
<td>Cutaneous</td>
<td>20-35%</td>
</tr>
<tr>
<td>Neurological</td>
<td>5%</td>
</tr>
<tr>
<td>Osseous</td>
<td>10-60%</td>
</tr>
<tr>
<td>Hyperemia</td>
<td>3-13%</td>
</tr>
<tr>
<td>Renal</td>
<td>10-20%</td>
</tr>
<tr>
<td>Gastrointestinal/Heptic</td>
<td>50-80%</td>
</tr>
</tbody>
</table>

Table 2.

<table>
<thead>
<tr>
<th>Test</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parathyroid Hormone</td>
<td>52 pg/mL</td>
</tr>
<tr>
<td>Parathyroid Related Peptide</td>
<td>14 pmol/L</td>
</tr>
<tr>
<td>Angiotensin Converting Enzyme</td>
<td>39.5 UI/mL</td>
</tr>
<tr>
<td>25D-Dihydroxycholecalciferol</td>
<td>30 ng/mL</td>
</tr>
<tr>
<td>Alkaline Phosphatase</td>
<td>98.5 U/L</td>
</tr>
</tbody>
</table>

Table 2.

Reference:


