Chronic sialadenitis caused by sarcoidosis: A Case Report

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INTRODUCTION

Sarcoidosis is a systemic granulomatous, non-infectious multifocal disorder of unknown etiology, characterized by the presence of non-caseous epithelioid granuloma in the tissue1,2. About 20 to 40% of the patients are symptom-free and their disease is found through routine radiographic tests1. The hypothetical causal agents include environmental and autoantigen aspects3-5. The goal is to report a rare case6 of chronic sialadenitis having sarcoidosis as the cause.

CASE REPORT

Male patient, 41 years old, had a face swelling, reduced salivation, red eyes and dysphagia for months. He had a uniform and bilateral enlargement of the parotid and submandibular gland (Fig. B) - painless, firm, smooth and mobile; with hyperemia of the ocular conjunctiva (Fig. A). During routine exams, the chest x-ray showed an image suggesting the presence of a peribronchovenous infiltrate, without clinical significance. The patient was referred to incisional biopsy of the right submandibular gland and smaller salivary gland of the lower lip. Histopathology reported Chronic Granulomatous Sialadenitis, a matching diagnosis of sarcoidosis. The patient returned to the ward with a history of past use of non-hormonal anti-inflammatory agent (without medical instruction), with total remission of signs and symptoms.

DISCUSSION

Sarcoidosis is usually acute in onset, with more common clinical symptoms of dyspnea, dry cough, chest pain, fever, malaise, fatigue, arthralgia and weight loss1 and, about 20% of the patients are asymptomatic1. The lungs, lymph nodes, skin, eyes and salivary glands are the most affected organs1,2. Skin lesions such as plaques and nodules, nasal mucosa and liver granulomas may also be present2. The lymphoid tissue is involved in almost all the cases and the salivary gland swelling, xerostomia and eye involvement may combine and mirror Sjögren Syndrome2, which led us to do the lower lip salivary gland biopsy.

The respiratory system is usually the one most involved, and 90% of the patients have an abnormal chest x-ray1,3,5. The most common symptoms are dyspnea, fever, fatigue and dry cough2, which did not happen to our patient.

Eye lesions are seen in approximately 25%6. Inflammation on the anterior uveal interval is the most common eye lesion. The patients complain of visual alteration and photophobia. The lesions are chronic and can progress to blindness2,2. It rarely involves the oropharynx, more frequently appearing as an isolé submucosal mass or area of granularity1,2,6. The facial is the most affected cranial nerve1. Our patient complained of dysphagia; however, we believe it was a symptom related to reduced salivation.

Histopathology helps in the diagnosis, which was fundamental in our case. There were no morphological aspects suggesting Miculicz/Sjögren syndrome, and both fungi (Grocott) and mycobacterium (Ziehl-Neelsen) tests turned out negative. In figure C we notice granulomas made up of epithelioid cells and multinucleated gigantic cells (arrow).

REFERENCES
