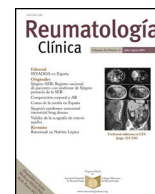




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Images in Clinical Rheumatology

## Conjunctival ocular sarcoidosis as the first manifestation of the disease<sup>☆</sup>



### Sarcoidosis ocular conjuntival como primera manifestación de la enfermedad

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A 59-year-old woman with a history of acute bilateral conjunctival lesion episodes since the age of 18, with nodular characteristics, under 2 mm in diameter, yellow-erythematous with conjunctival erythema, some painful, requiring topical treatments. At the age of 57 years, polyarthritis was added to the clinical background.

**Laboratory:** anaemia of chronic diseases, erythrocyte sedimentation rate of 60 mm/h and C-reactive protein of 12. Rheumatoid factor, anti-CCP negative, FAN (HEp-2), ENA (Ro, La, RNP, Sm), anti-DNA and HLA-B27 negative, C3, C4 and angiotensin converting enzyme normal. Serologies for HIV, VDRL, HCV, HBV, EBV, CMV, parvovirus, chlamydia and Chagas negative. Chest X-ray and high-resolution tomography of the chest, abdomen and pelvis: normal. Magnetic resonance imaging of the brain with gadolinium: space-occupying lesion in the left sellar region measuring 10 × 10 mm, with involvement of the cavernous sinus, where it encompasses the left internal carotid artery. A respected flow void was observed

in the intracavernous internal carotid artery. Biopsy of conjunctival nodules: diagnosis of sarcoidosis (Fig. 1).

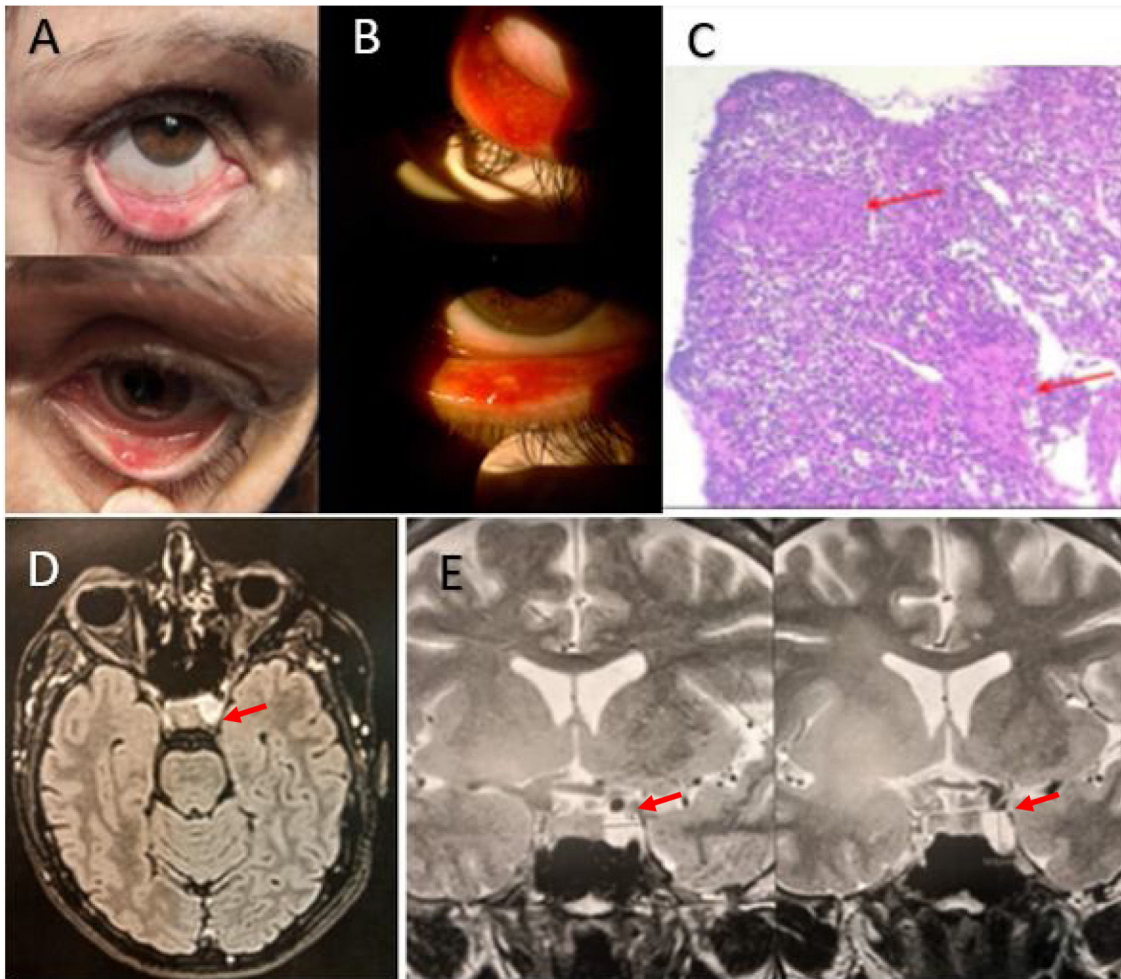
Since the onset of joint symptoms, treatment was with methotrexate, and subsequent addition of leflunomide. Following flare-up of the conjunctival lesions and arthritis and after diagnosis of sarcoidosis by biopsy, adalimumab was indicated. A marked improvement was observed after one week of treatment and complete remission after one month.

Ocular involvement in sarcoidosis occurs in up to 25% of patients, with ocular involvement being the form of presentation in less than 5%. The most common ocular involvement is uveitis and less frequently conjunctival, corneal, scleral, lacrimal and adnexal involvement (less than 40%). Conjunctival biopsy is a simple and useful procedure for patients with conjunctival nodules. A high index of suspicion is necessary for early diagnosis and treatment, preventing sequelae and improving the patient's quality of life<sup>1–8</sup>.

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**Fig. 1.** Clinical, imaging and pathological anatomical observations of hierarchy. A: Nodular conjunctival lesions on an erythematous base. B: Multiple rounded yellow-erythematous lesions, smaller than 2 mm in diameter. C: Biopsy of conjunctival nodules, showing non-caseating granulomas, compatible with sarcoidosis (red arrows) (courtesy of Dr Naves Ariel, Anatomic Pathology, Instituto de Histopatología, Rosario, Santa Fe, Argentina). D: Axial MRI with left selar space-occupying lesion (red arrow). E: MRI sagittal view, lesion of 10 × 10 mm, with involvement of the cavernous sinus, where it engulfs the left internal carotid artery (red arrows).

**Conflict of interests**

The authors have no conflict of interests to declare.

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