Lofgren’s syndrome – A Case Report

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INTRODUCTION

1) Lofgren’s syndrome is characterized by the triad of acute polyarthritis, hilar adenopathy and erythema nodosum.
2) It is an acute form of sarcoidosis1.
3) It is a self-limiting disease with a very good prognosis1.
4) Non steroidal anti-inflammatory drugs (NSAIDs) and steroids along with supportive care and close monitoring, remains the mainstay for treatment1.

CASE HISTORY

A 41-year-old male presented with multiple joint pain and swelling of 3 weeks duration.

Ankles, knees, wrist, proximal interphalangeal and metacarpophalangeal joints were involved.

There was associated fever with reddish colored rashes all over the body.

He gives history of heaviness in the chest and weight loss.

There was no past history of tuberculosis and bronchial asthma.

DIAGNOSIS

The symptoms, clinical findings, imaging and biopsy results in our patient fulfilled the triad of acute polyarthritis, hilar adenopathy and erythema nodosum.

The patient was managed with low dose steroids and NSAIDs.

EXAMINATION

1) Afebrile and hemodynamically stable.
2) Significant synovitis around both knees and ankle joints.
3) ESR was high [50mm/hr].
4) RA, ANA and ANCA serology were all negative
5) Serum calcium was 9.2 mg/dl.
6) Skin biopsy of the reddish rash was consistent with erythema nodosum.
7) Chest radiograph showed bilateral hilar prominence.
8) CT chest revealed multiple enlarged mediastinal lymphnodes in paratracheal, pretracheal, subcarinal, prevascular, right and left hilar regions (Figure: 1,2).
9) Angiotensin converting enzyme level was within the normal range [36 U/L].
10) Endoscopic fine needle aspiration of mediastinal lymphnode showed non-caseating granulomas consistent with sarcoidosis (Figure: 3,4).

DISCUSSION

1) Sven Lofgren first described in 1953.
2) Biopsy: definitive diagnosis of sarcoidosis.
3) Differentials: fungal infection, tuberculosis, lymphomas, and bronchogenic carcinoma.
4) Histopathology of the lymph nodes reveals non-caseating granulomas.
5) Closely related to HLA-B8 and DR3 in Caucasians2.
6) Chest radiographic findings are seen in approximately 90 % of patients with sarcoidosis.
7) Our case can be categorized as stage 1, according to Siltzbach classification, based on the presence of bilateral hilar with mediastinal adenopathy, without pulmonary infiltrates.
8) Treatment: NSAIDs + Bed rest
9) Steroids can be used in serious arthritis, hypercalcemia, and granulomatous skin lesions3.

CONCLUSIONS

1) Lofgren’s syndrome can present as fever with generalized rash and arthralgia.
2) Lofgren’s syndrome mimics viral exanthematous fever.
3) Lofgren’s syndrome has a very good prognosis.

REFERENCES