Letter in Reply: A Case of the Great Imitator

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ARTICLE INFO
Article history:
Received: 21 April 2020
Accepted: 21 April 2020

ONLINE:
DOI 10.5001/omj.2020.126

Dear Editor,

We want to thank the authors for their interest in our manuscript and their valuable comments.[1] We agree that the cutaneous manifestation of sarcoidosis is a great imitator of different dermatological conditions. With regards to the penile lesion, it was a small nodule with no skin ulceration as compared to some of the previous case reports.[2,3] Therefore, we thought that including the patient's image of the penile nodule, in this case, would not provide any additional information to that provided by the existing images.

As the authors correctly mentioned, while there is an emerging association between granuloma annulare and sarcoidosis in several case reports, proving that granuloma annulare might be a precursor for sarcoidosis is an interesting area for future research. However, this cannot be confirmed at present, based on the scarce, currently available evidence.[4]

Measuring the serum angiotensin converting enzyme (ACE) level lacks the specificity for the diagnosis of sarcoidosis. There are conflicting data about the correlation between high serum ACE and cutaneous manifestation in sarcoidosis. Sejdic et al,[5] investigated the clinical and laboratory significance of high ACE in patients with sarcoidosis. Recruited subjects were divided into two groups based on ACE levels (high ACE versus normal ACE). The authors concluded that arthritis followed by skin and eye manifestations were the most common extra-pulmonary manifestations in patients with sarcoidosis, regardless of ACE level.

While there are comprehensive guidelines about the treatment of pulmonary sarcoidosis, controversy exists for the best approach in managing patients with renal manifestations and hypercalcemia, which our patient had.[6] Generally, hydration with normal saline and glucocorticosteroids are recommended.[6] Patients with symptomatic hypercalcemia or asymptomatic severe hypercalcemia (serum corrected calcium ≥ 3.5 mmol/L) should be treated. In our case, the initial serum calcium level was 3.35 mmol/L, which was in the upper range of the moderate category, and the decision was to treat him as severe asymptomatic hypercalcemia, especially given the renal impairment. Our patient received initial hydration with normal saline, which was suboptimal in correcting his serum calcium level and, ultimately, calcitonin was required as an alternative option. Fortunately, he showed a remarkable response to calcitonin. Therefore, glucocorticosteroid therapy in our patient was not prescribed solely for isolated and asymptomatic stage I pulmonary sarcoidosis. Rather, it was given in view of sarcoidosis with renal involvement and hypercalcemia.

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