Sarcoidosis - “The Great Imitator”
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INTRODUCTION
- Sarcoidosis is a non-caseating granulomatous disease, known for a distinct range of presentations.
- Its ability to mimic infections, lymphoproliferative and autoimmune disorders turns it into an arduous diagnostic challenge.
- Our case highlights the conspicuous ability of sarcoidosis to masquerade as alternate diagnosis in an immigrant patient.

CASE PRESENTATION
- A healthy 35-year-old male of Hispanic/African descent presented with exertional dyspnea, fatigue of 1-month duration and unintentional weight loss, associated with polydipsia and polyuria.
- He immigrated from Brazil 10 years ago.
- He worked in construction with known occupational dust exposure, was compliant with personal protective equipment.
- Physical examination was significant for inspiratory crackles in bilateral lower lung fields.
- Biochemical analysis was remarkable for elevated serum creatinine of 1.69 mg/dL.
- He was admitted with strong suspicion for milary tuberculosis after chest CT revealed hallmark diffuse parenchymal micronodularly with bulky mediastinal lymphadenopathy.

Patient underwent:
- Bronchoscopy with BAL and endobronchial US-guided FNA for cytology of mediastinal lymph nodes,
- Transbronchial biopsy of the RUL to rule out disseminated fungal infection, lymphoma and sarcoidosis.
- Further workup was performed in light of persistently elevated creatinine, elucidating critical hypercalcemia of 13.8 mg/dL, which explained excessive thirst, polyuria and kidney injury.

CONCLUSION
- He was treated with intravenous fluids, calcitonin and bisphosphonate.
- Eventually, biopsy showed non-necrotizing granulomas in both pulmonary parenchyma and cell block from lymph node, while AFB, QuantIFERON, fungal culture and cytology returned negative.
- Angiotensin-converting enzyme and 1.25-Dihydroxyvitamin D were significantly elevated at 130 U/L and >200.0 pg/mL respectively.
- A final diagnosis of stage 3 pulmonary sarcoidosis was made.
- The patient was started on long term oral prednisone with prophylactic Trimethoprim-Sulfamethoxazole and discharged home with a plan for outpatient cardiac MRI to rule out cardiac sarcoidosis.
- As sarcoidosis can have a broad range of presentations, the value of complete history and thorough evaluation of every symptom is of paramount importance.
- Physicians must maintain caution not to mislabel patients with tuberculosis when evaluating those from endemic areas. As in our case, sarcoidosis presented as the “great imitator”, masking itself in micronodular pulmonary disease with milary pattern in an immigrant patient.
- We must maintain a commitment to open-minded approach when diagnosing patients from ethnic minority groups.