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Lofgren's Syndrome: A Case Report

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Abstract: ***Lofgren's syndrome is an acute form of sarcoidosis, characterized by the triad of polyarthritis, hilar adenopathy and erythema nodosum. Here, we report a 41-year-old male who presented with polyarthralgia and reddish rash all over the body. Skin biopsy revealed the reddish rash to be erythema nodosum. Chest imaging showed enlarged multiple mediastinal lymph nodes. Endosonic fine needle aspiration of mediastinal lymph node showed non-caseating granulomas consistent with sarcoidosis.***

Keywords: Acute Polyarthritis, Erethema Nodosum, Hilar Lymphadenopathy

1.Introduction

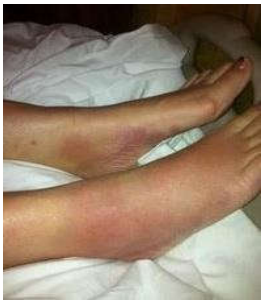
Lofgren's syndrome is characterized by the triad of acute polyarthritis, hilar adenopathy and Erythema nodosum. It is an acute form of sarcoidosis. It is a self-limiting disease with a very good Prognosis.

2.Case History

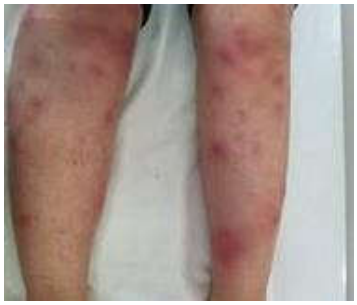
A 41-year-old male presented with multiple joint pain and swelling of 3 weeks duration. Ankles, knees, wrist, proximal interphalangeal and metacarpophalangeal joints were involved. There was associated fever with reddish colored rashes all over the body. He gives history of heaviness in the chest and weight loss since a month. No past history of tuberculosis and Bronchial ashthma.

3.Clinical Examination

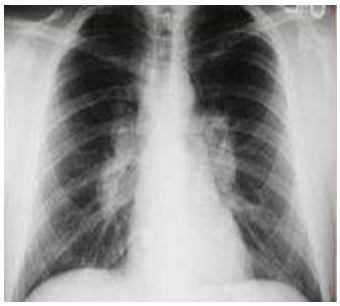
Patient was afebrile. Rashes were seen over the body. Itching all over the body was present. Painful, bright red, subcutaneous nodules on anterior shins were present. Vitally, patient was stable. Pulse were 82/min, BP was 122/78mmHg, Spo2 was 97% at room air. On examining the joints, Significant synovitis around both knees and ankle joints.



Acute Polyarthritis



Erethema Nodosum



Hilar Lymphadenopathy

Investigations

ESR was high [50mm/hr].

RA, ANA and ANCA serology were all negative Serum calcium was 9.2 mg/dl.

Skin biopsy of the reddish rash was consistent with erythema nodosum. Chest radiograph showed bilateral hilar prominence.

CT chest revealed multiple enlarged mediastinal lymphnodes in paratracheal, pretracheal, subcarinal, prevascular, right and left hilar regions.

Angiotensin converting enzyme level was within the normal range [38 U/L].

Endosonic fine needle aspiration of mediastinal lymphnode showed non-caseating granulomas consistent with Sarcoidosis.

Diagnosis

The symptoms, clinical findings, imaging and biopsy results in our patient fulfilled the triad of acute polyarthritis, hilar adenopathy and erythema nodosum and thus, diagnosed as Lofgren's syndrome.

Siltzbach Radiographic Classification of Sarcoidosis

Stage	Radiographic Pattern	Frequency of Presentation	Frequency of Spontaneous and Radiographic Evidence
0	Normal	10%	
I	Hilar Lymphadenopathy	20%	50-90 %
II	Hilar adenopathy and abnormal lung parenchyma	50%	40-70 %
III	Abnormal lung parenchyma	20%	10-20 %
IV	Parenchymal fibrotic change with architectural distortion	< 5 %	0%

Treatment

The patient was managed with low dose Steroids and NSAIDs.

4.Discussion

1. Biopsy is definitive diagnosis of sarcoidosis.
2. Differential diagnosis can be fungal infection, tuberculosis, lymphomas, and bronchogenic carcinoma.3. Histopathology of the lymph nodes reveals Non-caseating granulomas.
3. Related to HLA-B8 and DR3 in Caucasians.
4. Chest radiographic findings are seen in Approximately 90 % of patients with sarcoidosis. Hilar prominence is characteristic of lofgrens.
5. Our case can be categorized as stage1, According to Siltzbach classification, based on the presence of bilateral hilar with mediastinal adenopathy, without pulmonary infiltrates.
6. Treatment: NSAIDs + Bed rest
7. Steroids can be used in serious arthritis, Hypercalcemia, and granulomatous skin lesions

5.Conclusion

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.

Reference

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