HPI: 31-year-old African-American male presented for evaluation of a mildly tender lesion on the nose for 3 months duration. Prior evaluation by pulmonology for a chronic dry cough revealed bilateral hilar lymphadenopathy, biopsy on mediastinoscopy was inconclusive. The patient was placed on a prednisone taper, and 10mg daily of prednisone thereafter without improvement of symptoms.

PMHx, SocHx, FamHx – Non-contributory.

ROS: (+) migratory arthralgias, fatigue, fevers, dry cough, visual changes.

PE: 3 mm skin-colored papule with yellowish-green hue on nasal tip (Fig. 1). Scattered 0.5-1.5 cm firm, slightly tender subcutaneous nodules on the left upper arm (Fig. 2, Fig. 3), and right lower back (Fig. 4).

DISCUSSION

Lofgren’s syndrome is an acute form of sarcoidosis characterized by the triad of hilar lymphadenopathy, polyarthralgias, and erythema nodosum.

There is a bi-modal age distribution with peaks at ages 25-35 and 45-65 and it is more common in males and patients of Scandinavian and Irish descent; rare in African-Americans.

Patients may exhibit symmetric red-brown or yellow-brown to erythematous-violaceous papules and plaques. Most cases resolve spontaneously within 1 year. After onset of symptoms, 8% of patients have active disease at 2 years; 6% have recurrent episodes up to 20 years after diagnosis.

Elevated ACE level at diagnosis predicts persistent or recurrent disease. This patient was symptomatic with elevated ACE level despite being on daily prednisone.

The duration of symptoms in our patient along with his ethnic background make this case a unique and interesting presentation of Lofgren’s syndrome.

REFERENCES