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Sarcoidosis and Vasculitis are Connective Tissue Disorders

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Introduction

Granuloma formation is caused by tissue permeability, cell influx, and local cell proliferation, and while the pathogenesis is still unknown, cellular immune system activation and nonspecific inflammatory response are secondary to a number of genetic and environmental factors. Helper and macrophage-derived pro-inflammatory cytokines also stimulate the inflammatory cascade. An indication of the disease's heterogeneity is the diverse prevalence, clinical outcomes, and course observed in various racial and ethnic groups. Numerous primary rheumatic diseases may mimic sarcoidosis or occur simultaneously or in combination with it. Bilateral hilar lymphadenopathy, pulmonary infiltrations, and skin and eye lesions are the most common manifestations of this condition. Two major joint involvements have been described where the locomotor system is involved: chronic and acute forms the acute form, which is the most common, may be the first sign of sarcoidosis and accompany arthralgia, per arthritis, or both. Rarely, chronic sarcoid arthritis is accompanied by other organ involvement or pulmonary parenchymal disease. Between symptomatic and asymptomatic muscular involvement, there are very few reports. There are three distinct types of symptomatic myopathy: acute myositis, palpable nodular myopathy, or chronic myopathy Even though it is uncommon, osseous involvement is frequently linked to multisystem disease and chronic uveitis. In addition to a number of other rheumatic diseases, sarcoidosis was mentioned. Sarcoidosis may resemble these disorders' clinical and laboratory findings, according to some studies. The symptoms of rheumatologic findings are treated with corticosteroids and nonsteroidal anti-inflammatory drugs. Anti-tumour necrosis factor alpha and immunosuppressive medications may be used in patients who do not respond to corticosteroids. The prevalence of rheumatologic symptoms, clinical findings, and treatment of rheumatologic sarcoidosis manifestations are discussed [1].

Description

Clinical findings: ankle redness, swelling, and sensitivity should be noticed. Instead of the typical signs of arthritis, soft tissue ultrasonography reveals periarticular soft tissue swelling. In terms of direct graphs of the ankle, the most common swelling is in the soft tissue, with no changes in the bones or cartilage. Sarcoid arthritis was linked to an increased risk of EN, according to a number of publications. Two out of every three patients with acute sarcoid arthritis were found in a study. However, careful consideration should be given to the differential diagnosis of. Histoplasmosis and coccidioidomycosis should be considered bacterial, viral, and fungal infections when accompanied by hilar lymphadenopathy. Additionally, other causes such as drugs, inflammatory bowel disease, disease, and cancer should be excluded. In patients with acute sarcoid arthritis, the inflammatory cell population is dominated by mononuclear cells. In patients with tenosynovitis, a noncaseating granulomatous reaction was also found on the biopsy [2].

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Patients with diffuse organ involvement, such as chronic uveitis or pulmonary involvement, have a worse prognosis for chronic arthritis. Chronic skin lesions and race are both risk factors for chronic sarcoid arthritis. Knees, ankles, wrists, and the smaller joints in the hands and feet are typically involved. In advanced cases, erosive changes and arthropathy of the Jaccoud type may occur. Swelling, sensitivity, and restricted motion in the soft tissues of the affected area are symptoms of ductility's, which affects the bones and surrounding soft tissue. In severe cases, there may also be severe deformities and broken bones. Mononuclear and polymorph nuclear cells dominate in the articular fluid of chronic sarcoid arthritis, while noncaseating granulomas are found in synovial biopsy. Care should be taken because similar findings can also be found in fungal infections, tuberculosis, berylliosis, and reactions to foreign matter.

Sarcoidosis patients rarely develop involvement of the sacroiliac joint. The data in the literature are scant. Although sacroiliitis is typically unilateral, a biopsy may be necessary to distinguish it from tuberculosis or sacroiliitis caused by another infection. To distinguish patients with ankylosing spondylitis from others, it is recommended to look into other clinical findings. Sacroiliac joint involvement was found to be more common in sarcoidosis patients with female gender, negative symptoms, and bilateral sacroiliitis, according to a study.

Treatment for Sarcoid Arthritis More than half of patients with acute sarcoid arthritis experience spontaneous remission. For rheumatologic sarcoidosis manifestations, there are no approved drugs and no randomized controlled trials. Nonsteroidal anti-inflammatory medications, local corticosteroid injections, or brief, low-dose oral corticosteroids may be necessary in some instances. Some people with Lofgren syndrome and EN may benefit from taking colchicine and hydroxychloroquine. Immunosuppressive medications like methotrexate and azathioprine leflunomide may be considered for patients with corticosteroid-resistant progressive sarcoid arthritis [3]. Anti-tumour necrosis factor alpha medications for sarcoidosis patients have been the subject of discussion. Drugs appear to be a viable treatment option in light of the significant role that alpha plays in the development of granulomas. Some studies have demonstrated the efficacy of anti-drugs in patients with refractory sarcoidosis, but drug-related sarcoidosis has also been reported. B-cell depletion, on the other hand, has been shown to be an effective treatment option in sarcoidosis patients with arthropathy and pulmonary involvement. In patients with pulmonary sarcoidosis and skin involvement, it has recently been reported that golimumab and ustekinumab have no advantage over placebo. Sarcoid myopathy can be treated with corticosteroids. On the response to treatment, findings that were controversial were reported [4,5]. In a trial, response was achieved in all patients with sarcoid myopathy. In a different study, only a few patients had a complete response, while the rest were considered stable and unresponsive. The initial investigation found patients with bone lesions.

Conclusion

Patients with sarcoidosis were looked at in another study, and typical cystic bone lesions were found in them. Sarcoidosis patients with bone involvement were identified based on retrospective data because there were no prospective trials. Other organs, most frequently the lungs, are involved in bone sarcoidosis patients. Bone cysts were found in a group of sarcoidosis patients in a study. Patients were found to have a higher risk of developing bone sarcoidosis as a result of these findings. On the other hand, it was only seen in bone sarcoidosis patients. Granuloma formation is thought to have both direct and indirect effects that could lead to osteopenia and bone resorption, though the pathogenesis is unclear. First, the osteoclasts are directly activated when granulomas form. A sarcoidosis patient's bone biopsy with abnormal bone densitometry revealed per trabecular granuloma and osteoclast.

Acknowledgement

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Conflict of Interest

None.

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