Persistent Lymphocytosis: An Unusual Feature in Sarcoidosis

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Abstract
Persistent lymphocytosis as a presenting sign in sarcoidosis is described in a 61-year-old man. Lymphocytosis is an unusual finding in sarcoidosis. The case presented seems to suggest that sarcoidosis should be considered in the differential diagnosis of lymphocytosis.

Introduction
Lymphopenia is a common finding in sarcoidosis. However, normal lymphocyte counts are not unusual and are associated with good prognosis [1]. We describe a patient who presented with a high lymphocyte count which persisted over a long follow-up period and disappeared after treatment for neurosarcoidosis. To the best of our knowledge such prolonged lymphocytosis has not been reported in sarcoidosis.

Case Report
A 61-year-old man was referred in January 1976 to the Department of Hematology because of a persistent finding of lymphocytosis of 12–13 × 10^9/l. The physical examination revealed bilateral enlarged axillary lymph nodes, hepatomegaly 5 cm below the right costal margin and mild splenomegaly. Laboratory examinations revealed WBC 16.9 × 10^9/l, 78% lymphocytes, 18% neutrophils, 4% monocytes, hemoglobin 14 g/dl, the platelet count was 208 × 10^9/l. Bone marrow aspiration showed normocellular marrow with a normal myeloid erythroid ratio and a mild increase in lymphocytes. The estimation of lymphocyte subpopulations in the peripheral blood revealed 73% E-rosette-forming cells and 15% of cells bearing surface immunoglobulin, using standard techniques [2]. Immunotyping with OKT-S reagents [3] of the peripheral blood lymphocytes showed 15–20% suppressor cells (T8) and 35–40% helper cells (T4) with a normal T4:T8 ratio. Serum calcium, liver and kidney function tests, immunoelectrophoresis, and
Quantitation of immunoglobulins were normal. Tests for EB virus, cytomegalic virus and toxoplasmosis were negative. X-ray examination of the chest was normal. Axillary lymph node and liver biopsies revealed noncaseating granulomas suspicious of sarcoidosis (fig. 1, 2); Kveim-Siltzbach test confirmed this diagnosis (fig. 3). Skin tests with PPD, trichophyton, streptokinase-streptodornase were positive, whereas the test with Candida albicans was negative.

In the following 8 years the clinical course of the patient was unremarkable. Lymphocytosis of 8–12 × 10⁹/1 persisted. In January 1984 the patient began to complain of vertigo, gait instability and blurred vision. The neurologic and ophthalmoscopic examinations were normal. Brain radionuclide scan, computerized tomography scan and electroencephalogram were normal. Lumbar puncture disclosed a protein level of 142 g/l, glucose 82 g/l and 0.3 × 10⁹/1, cells all being mature lymphocytes; 68% of them were E-rosette-forming cells. The cerebrospinal fluid culture, a serologic test for syphilis, Ziehl-Neelsen test and the stain for Cryptococcus neoformans were all negative. Central nervous system involvement by sarcoidosis was considered. Treatment with prednisone, 60 mg/day, resulted in resolution of the neurologic symptoms and clearing of lymphocytosis in cerebrospinal fluid within 6 months. The lymph nodes, liver and
spleen all regressed. The lymphocytosis disappeared and lymphocyte counts stabilized around $2.5 \times 10^9/\text{l}$.

References

Comments
Lymphopenia is a common finding in sarcoidosis [4] and was found to be due to a reduction in T lymphocytes [5]. Our patient presented with absolute mature lymphocytosis of $8–13 \times 10^9/\text{l}$ which persisted