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Lymphocytic interstitial pneumonitis (LIP) as an extraglandular manifestation of primary Sjögren's syndrome: a case report

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INTRODUCTION/OBJECTIVES: Lymphocytic interstitial pneumonitis (LIP) is a disease of unknown etiology, which usually occurs after the age of 50, and is manifested by chronic cough and dyspnea. It is a rare but relatively specific feature of Sjögren's syndrome.
CASE PRESENTATION: A 61-year-old male was hospitalized due to fever, cough and increased inflammatory markers. His chest X-ray and chest CT scan were consistent with interstitial lung disease. CT scan revealed bilateral basal cystic lesions (up to 3 cm in diameter) and thickening of the interlobular septa. Moreover, he complained of dry mouth. His sicca syndrome was confirmed by a low saliva flow rate as well as positive Schirmer test. Laboratory workup revealed an increased erythrocyte sedimentation rate (out of proportion to the C-reactive protein levels), as well as increased rheumatoid factor and positive antinuclear antibodies (double-stranded DNA, SS-A and SS-B). Bone marrow aspiration revealed no sign of hematological disease. Bronchoalveolar lavage cytology was consistent with LIP. The patient was diagnosed with LIP in the context of Sjögren's syndrome and was commenced on prednisone 30 mg with gradual dose tapering. He was also started on hydroxychloroquine and subsequently also on azathioprine as a steroid-sparing agent. The treatment led to normalization of inflammatory markers and improvement of symptoms. A follow-up chest CT scan revealed residual cysts in the lung parenchyma.
CONCLUSION: We presented a patient with Sjoegren's syndrome and LIP with a favorable clinical course. Glucocorticoids are the first line of treatment, however an additional immunosuppressive agent may be added to facilitate disease control and steroid tapering.

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Manifestations of tuberculosis that we rarely think about

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INTRODUCTION/OBJECTIVES: Tuberculosis is a multi-system infectious disease caused by Mycobacterium Tuberculosis. Tuberculosis mostly affects lungs but it can spread in the form of extrapulmonary tuberculosis. Around 4.3% of patients experience ischemic stroke and 1.5-3.4% of them experience pulmonary embolism.
CASE PRESENTATION: A 41-year-old male patient, was admitted to the Emergency Department due to plegic left arm and depressed left corner of the lip. Vital signs were normal, besides low blood oxygen saturation (SpO2). Blood pressure was 134/108 mmHg, heart rate 106 bmp, body temperature 36.8 °C, respiratory rate 22 per minute and SpO2 was 77%. During the physical examination, the left arm was sinking into antigravitational position. Auscultatory, diffuse bilateral crepitations were present. No other abnormalities were noticed. Biochemistry tests showed signs of inflammation (CRP 106.9 mg/L), heart failure (NT pro-BNP: 11214 ng/L) and hypercoagulable state (D-dimer 25). Fresh ischemic lesion of the right frontoparietal lobe was noticed on the CT. Thoracic X- ray showed multiple bilateral spots and an inhomogeneous shaded lung parenchyma. Also, during the CT angiography, multiple emboli were noticed in segmental pulmonary arteries. PCR of the sputum was ordered and the patient tested positive for tuberculosis. The patient was treated with Rifampicin, Isoniazid and Pyrazinamide and two weeks later was discharged from hospital care. Pulmonary rehabilitation was recommended as a further course of treatment.
CONCLUSION: Tuberculosis can affect almost any organ systems. If diagnosed and treated correctly, consequences can be minimized. Also, less common manifestations shouldn't be overlooked, because if neglected, the outcome might be fatal.