37 YOM originally from Eritrea (lived also in Sudan, Uganda and Kenya) presented after starting to have left knee pain, then generalized weakness, fatigue, rash and 20 lb weight loss. In July found to have right upper lobe lung consolidative mass as well as lytic bone lesions. No known history of cancer or sarcoidosis. Lung CT shows no perilymphatic nodules or fibrosis.

Bronch in July of lung lesion. Had initial PCR positive for mTB and after short course RIPE, was determined it was a lab error and was NOT positive.

RUL Mass

Final Diagnosis

A & B: Lung, right upper lobe, transbronchial biopsy:

- Noncaseating granulomas.
- See comment.

Diagnosis Comment

Lung parenchyma fragments measuring up to 2 mm in greatest dimension show non-caseating granulomata in a background of chronic inflammation and thickened interstitial spaces.

Focal cellular atypia is favored to be reactive.

Clinical Information

Large RUL mass like consolidation

Addendum

Special stains:

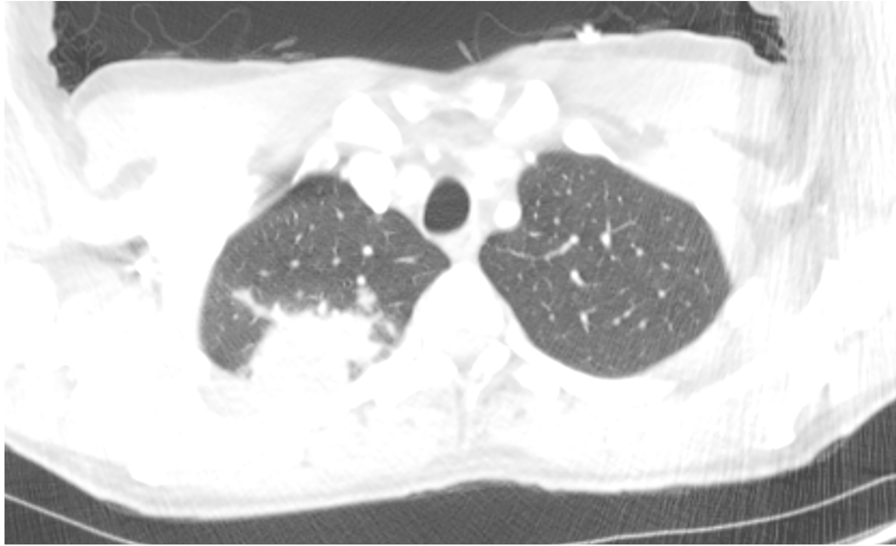
-AFB: Negative

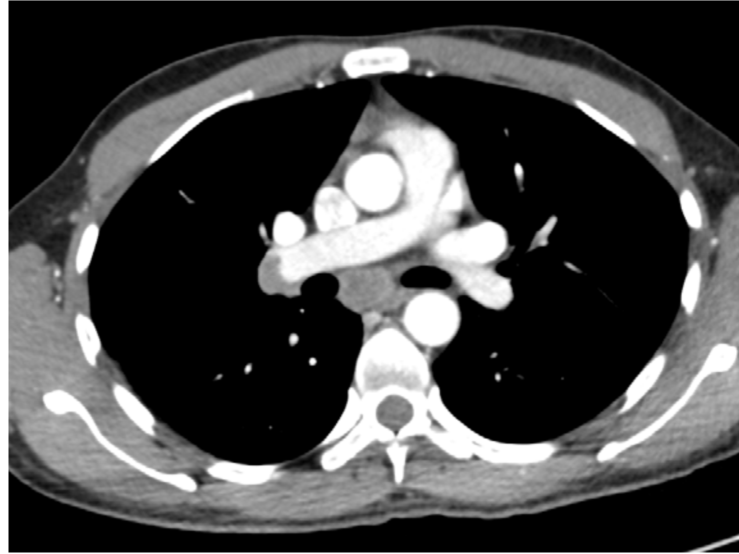
-GMS: Negative

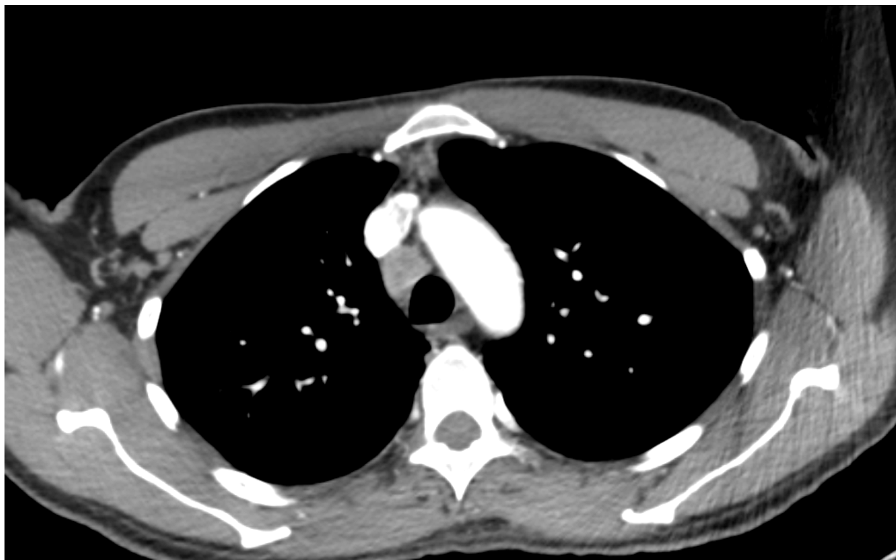
It is noted that the microbiology culture results are positive for Streptococcus viridans.

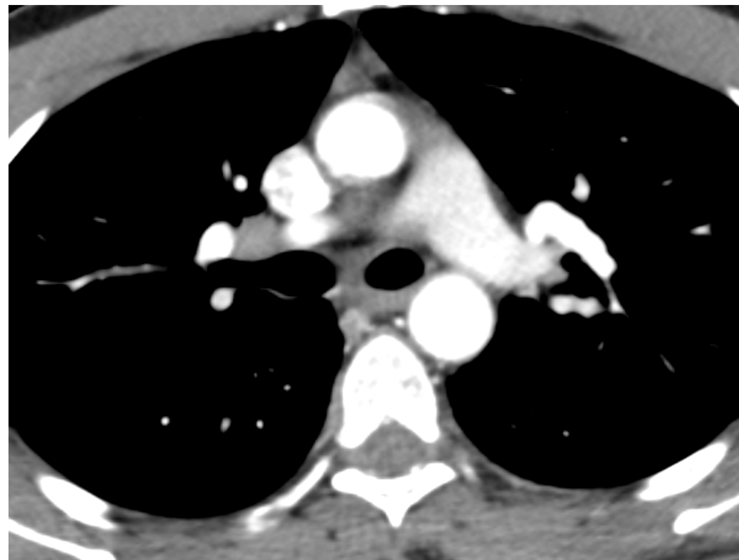
This represents an addendum to report additional findings, the diagnosis remains unchanged.

July 2021









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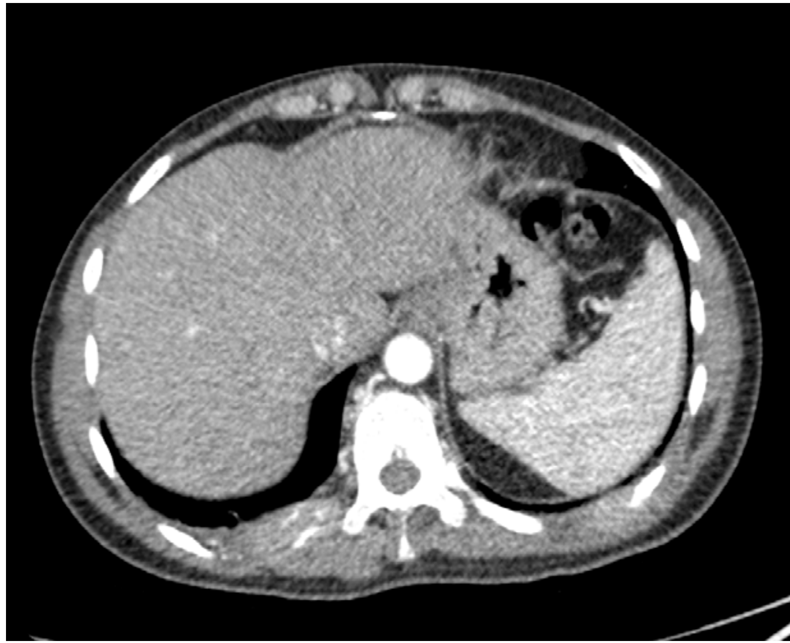
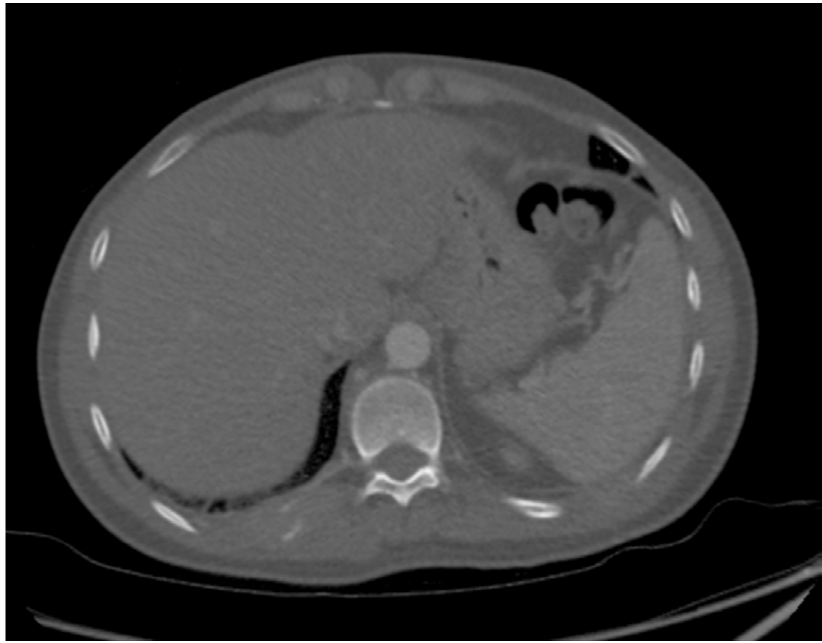
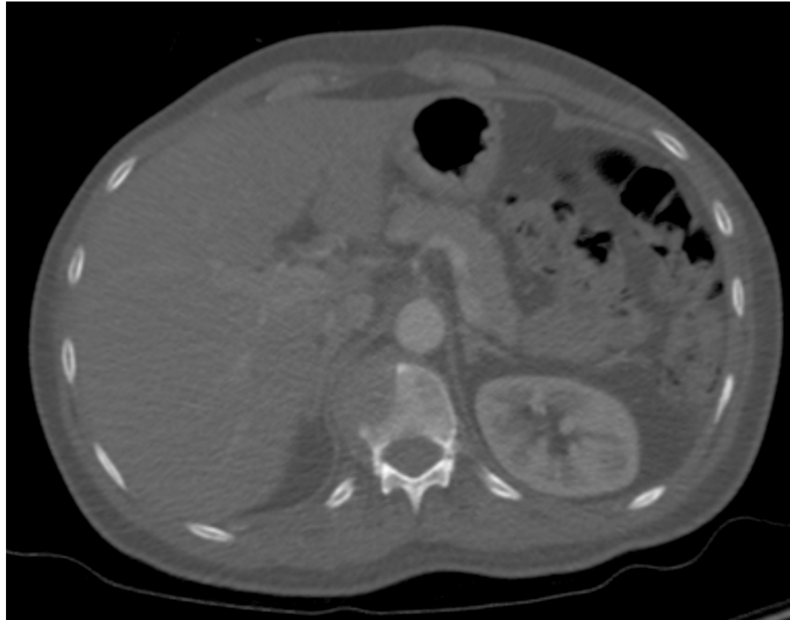
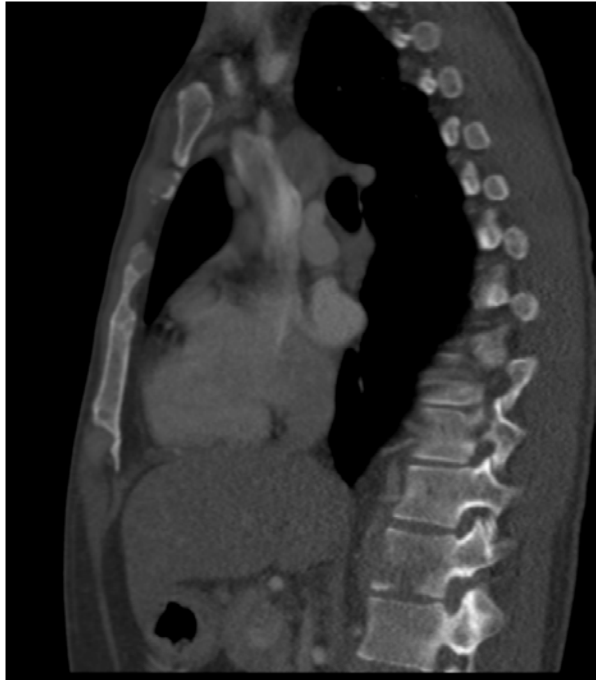
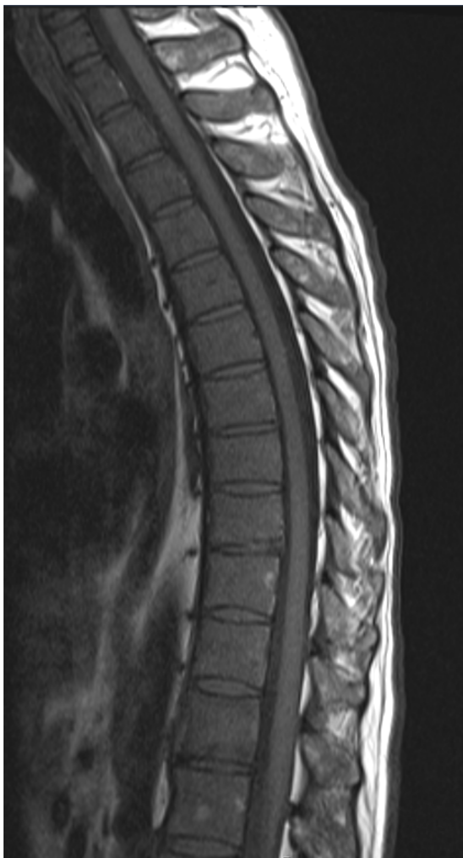
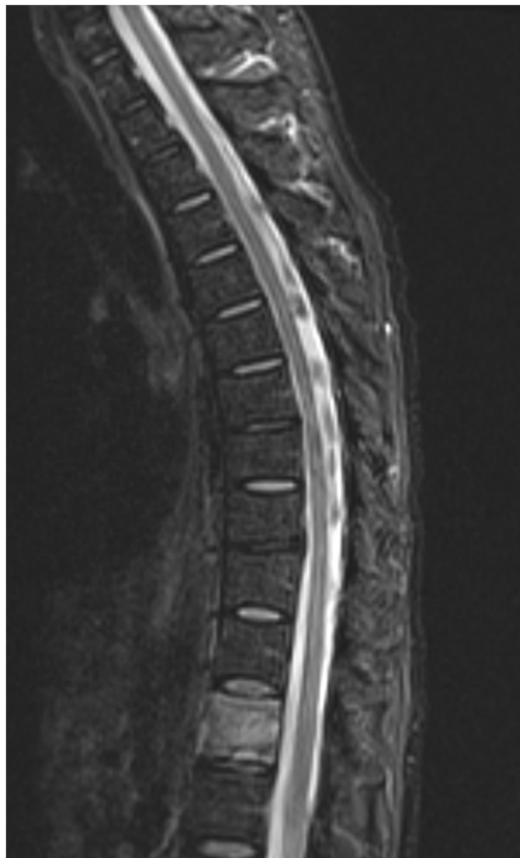
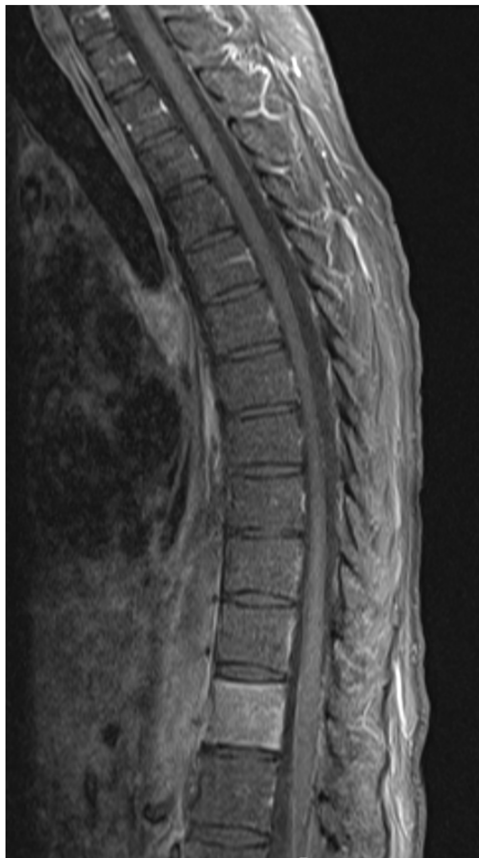
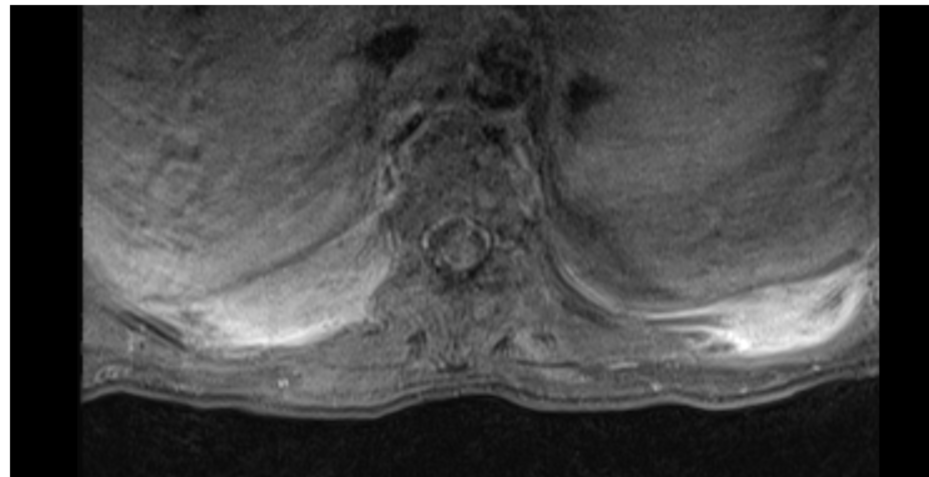
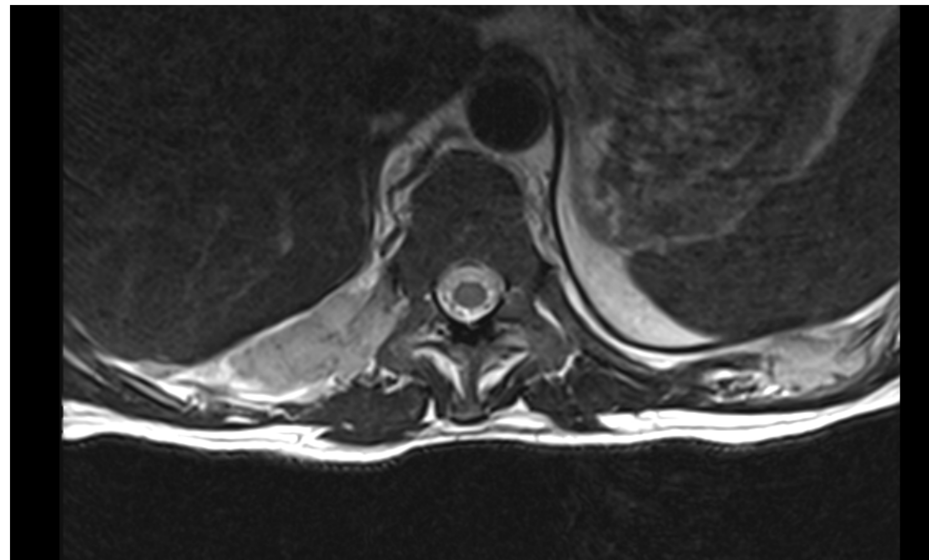




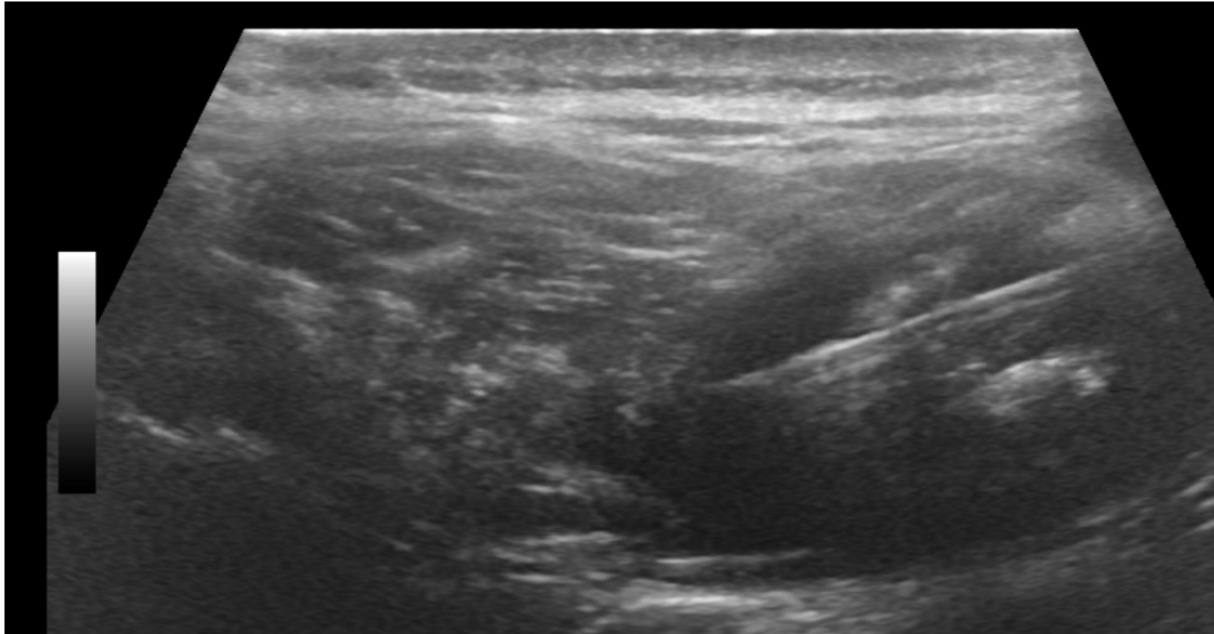




August 2021

US guided T11 rib biopsy.



Final Diagnosis

A. Bone, site not specified, biopsy:

-Granulomatous inflammation with palisading focal central microabscesses.
-No evidence of malignancy
-AFB, FITE, GMS and Warthin-Starry stains are negative for organisms.

Specimen Adequacy

Satisfactory for evaluation

General Categorization	Negative for malignancy

Diagnosis

Granulomatous Inflammation

Comments:

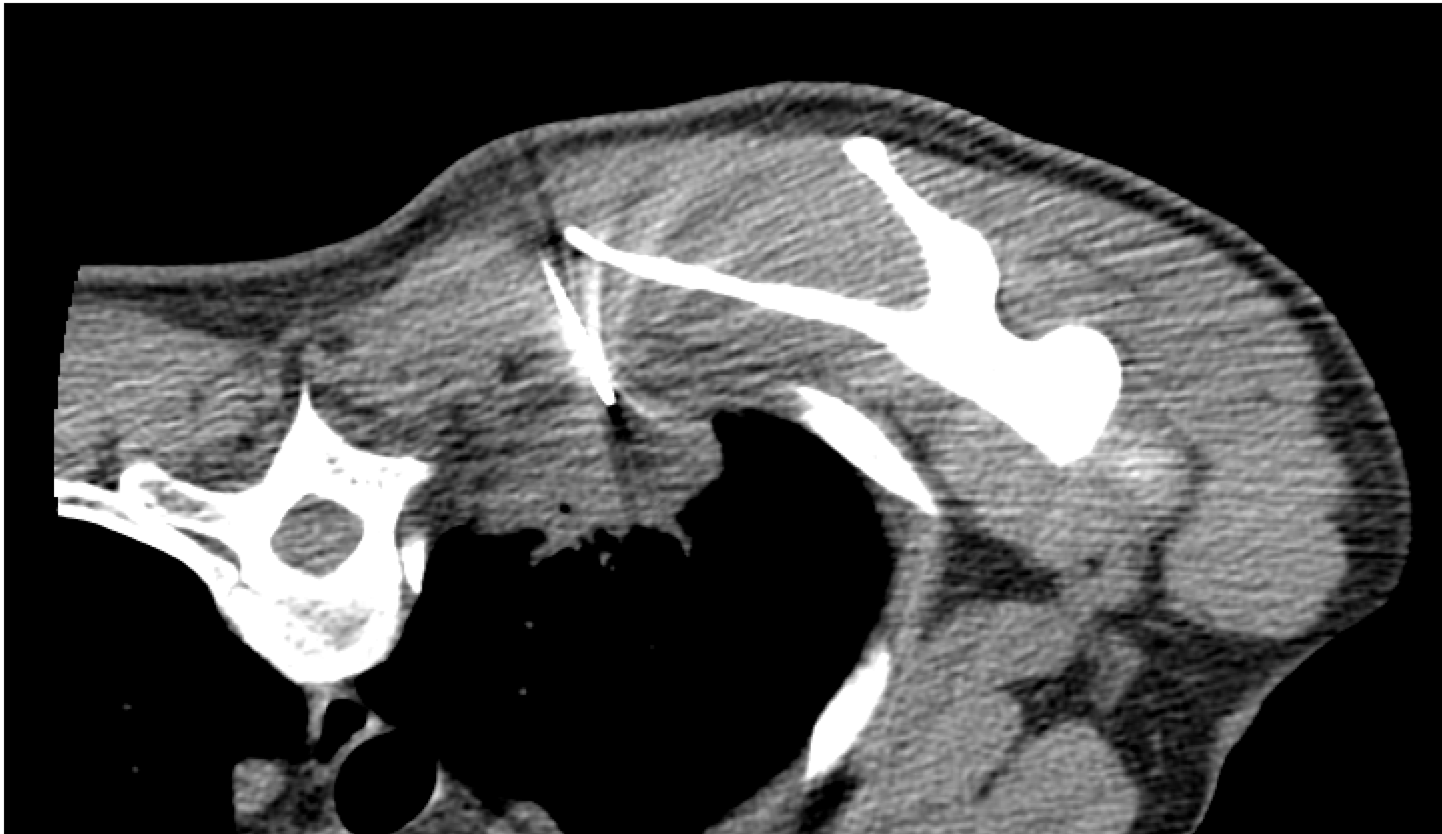
Cellular smear and cell blocks reveal lymphohistiocytic reaction and granulomas.
GMS: Negative
AFB: Negative

Results of Fite stain will be reported in an addendum.

Immunohistochemical stains:
CD68:Positive
S100: Negative
CD1a: Negative
Ae1/Ae3: Negative
CD45: Positive
CD3: Diffusely strong positive
CD20: Negative
PAX5: Negative
CD15: Negative
CD30: Negative

Diagnosis Comment

Biopsy consists of multiple palisading granulomas with focal central microabscesses. Surrounding inflammatory infiltrate consists primarily of lymphocytes , plasma cells and a few neutrophils and eosinophils.
All stains for acid-fast and fungal organisms are negative. Due to current treatment and low sensitivity of special stains, infectious organisms should not be ruled out. Differential diagnosis includes MTB, fungal organisms, cat-scratch disease. Correlation with microbiology cultures is recommended. Sarcoidosis should also be considered. There is no evidence of malignancy.

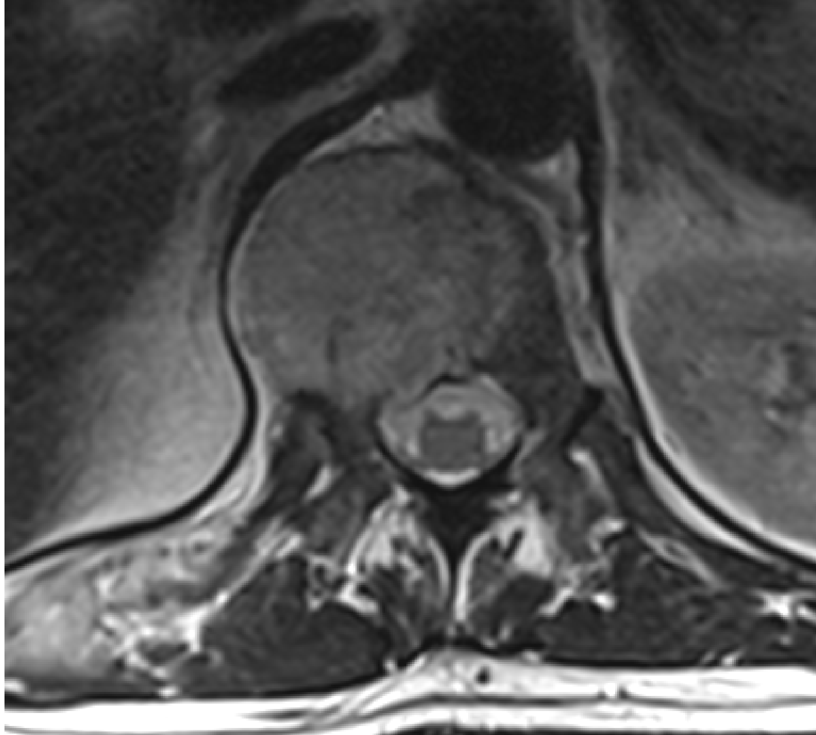


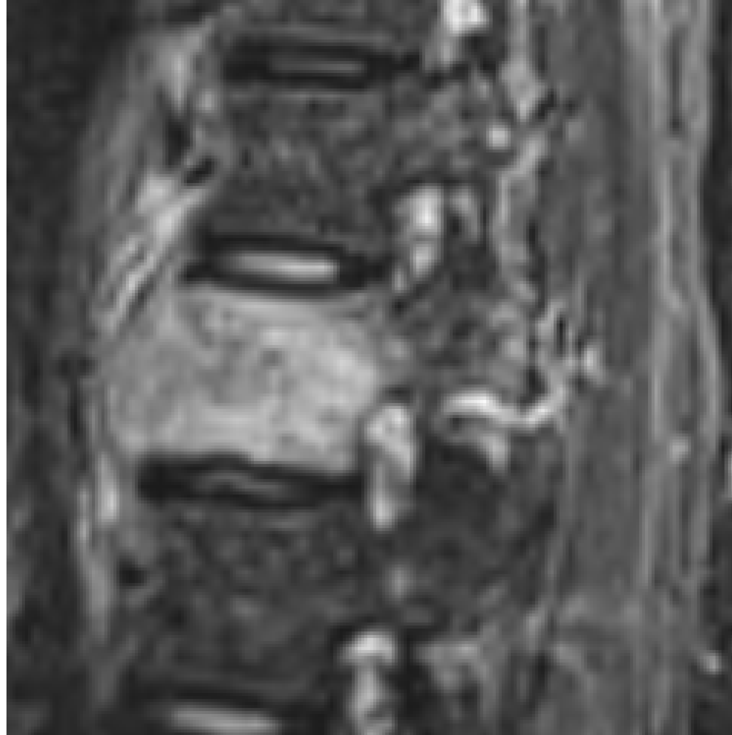
CT guided mass biopsy

Lung, right upper lobe biopsy
-Non-necrotizing granulomas suggestive of sarcoidosis.
-Focal areas of fibrosis and pneumocytes type II reactive hyperplasia, may suggest fibrosing phase of sarcoidosis.

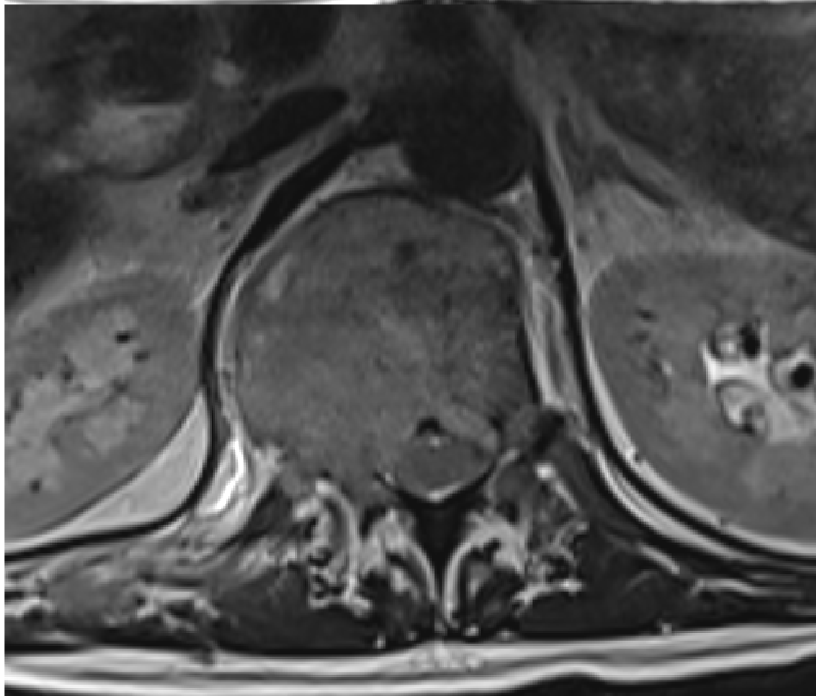
Literature review:

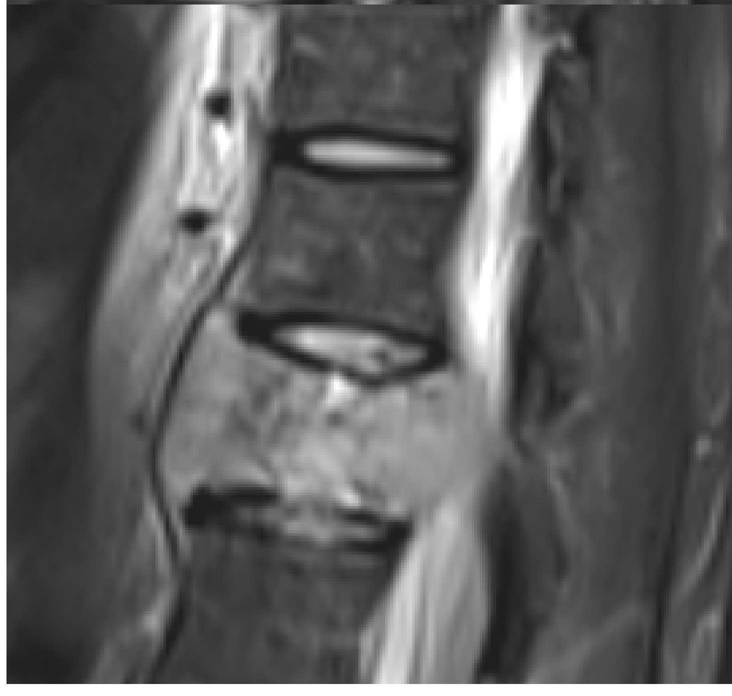
1. Lytic lesion of the sternum rare manifestation of sarcoidosis. TJ Oven Am J Med 1986 Feb
2. Sarcoidosis in 65-year-old woman presenting with a lung mass and pericardial effusion case report. Journal of medical case reports
3. Nodular sarcoidosis masquerading as cancer, clinical medicine insights





August





October

SUV range 12-20 (nodes, bone lesions and lung lesion)

July

October

October