CORRESPONDENCE

The Diagnosis, Differential Diagnosis, and Treatment of Sarcoidosis

by Antje Prasse in issue 33–34/2016

Causes of Depression in Sarcoidosis

Many thanks for this great review article (1). I am a general practitioner who runs a sarcoidosis clinic, and as such I missed the psychosomatic aspect. This is relevant because almost all of my sarcoidosis patients experience depression. Little of relevance is to be found in the literature. An older article (2) from Göttingen offers the conclusion that sarcoidosis patients are "mostly in a chronic situation of conflict or overload" and that they can be "described as workaholic in some cases." The study included very few patients, and participants had completed and returned an extremely comprehensive questionnaire. My conclusion is that it was particularly conscientious and helpful patients that were studied in this setting.

My own impression is that depression in sarcoidosis is based on four factors. Firstly, biochemistry: inflammation affects psychological and cognitive functions, as is the case in many autoimmune conditions and interferon therapy. Mediators of inflammation will cause depression quasi-physiologically. Secondly, the leaden fatigue hampers everyday coping and social contacts. Thirdly, sarcoidosis often develops at a young age and takes a chronic and burdensome course, and its treatment may trigger adverse effects—all of which cause worry and anxiety. Fourthly, even small doses of steroids can trigger depression or make it worse.

One further points: In my patients, I measure both vitamin D concentrations: 25-hydroxyvitamin D and 1.25-hydroxyvitamin D, and in the ratio of the two I see a parameter of activity that is often more sensitive than angiotensin-converting enzyme and the soluble interleukin-2 receptor. Furthermore, some sarcoidosis patients have evident vitamin D deficiency, and an indication for substitution exists. DOI: 10.3238/arztebl.2017.0120a

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Dr. med. Uta Groger
Ärztin für Allgemeinmedizin, Bielefeld
groger.bielefeld@t-online.de

Topical Therapeutic Options Should Be Given Preference

Professor Prasse rightly emphasizes in her CME article (1) that in Caucasian people, the skin is affected by sarcoidosis in about 15% of cases. Some disease courses actually affect the skin only, and, according to more recent epidemiological data, these are not rare (2).

As there is thus far no treatment that has gained specific approval for sarcoidosis, and as the systemic therapies named in the article may cause serious adverse effects, we need to remember that for the treatment of cutaneous sarcoidosis alone, topical therapeutic options are available that have potentially fewer side effects. This is also true for phototherapeutic approaches, such as laser therapy, photodynamic therapy, topical PUVA therapy, and UV-A1 phototherapy. The latter was also mentioned in the German Dermatological Society's recently published S1 guideline on UV phototherapy and photochemotherapy (3). In exclusively cutaneous forms of sarcoidosis, these therapeutic options should be used preferentially, in the sense of "Do No Harm," even though their evidence level—similar to that of other therapeutic approaches in sarcoidosis—may be less than satisfactory. DOI: 10.3238/arztebl.2017.0120b

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Prof. Dr. med. Peter Elsner
Dr. med. Steven Goetze
Hautklinik, Universitätsklinikum Jena
elsner@derma-jena.de

In Reply:

As our colleagues explained in detail, the topical treatment of cutaneous sarcoidosis constitutes a valuable therapeutic principle that complements systemic immunosuppression. Especially in isolated skin lesions that do not cause major impairment to the patient, it should be the primary therapeutic approach. The reminder of the psychosomatic component of the disease, which affects many patients with sarcoidosis, and the disproportionally high rates of associated depression is also important and appropriate. As Dr. Groger explained, there are hardly any scientific studies of this topic, and the association with sarcoidosis is largely not understood. I do, however, find the idea of vitamin D substitution as a possible therapeutic option problematic. Many patients with sarcoidosis tend to have hypercalcemia, which is affected by their diet, exposure to sunlight, and variations in the inflammatory activity of the sarcoidosis. A large proportion of patients subsequently develop kidney stones over the course of their disease. Even if the vitamin D concentration was found to be low in a sarcoid patient, regular monitoring of the calcium concentration is required once vitamin D substitution has been initiated. In this context it is worth to mention that the pathophysiological role of vitamin D in sarcoidosis is largely unknown. DOI: 10.3238/arztebl.2017.0120c

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Prof. Dr. med. Antje Prasse
Medizinische Hochschule Hannover, Abteilung für Pneumologie
Carl-Neuberg-Straße 1, 30625 Hannover
Prasse.Antje@mh-hannover.de

Conflict of interest statement
The authors of all contributions declare that no conflict of interest exists.