NEUROSARCOIDOSIS AND FEMORAL NEUROPATHY

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Sarcoidosis is a multisystem granulomatous disorder that can produce clinically apparent neurological symptoms in up to 10% of patients. Neurological manifestations, termed neurosarcoidosis typically develop in the presence of other organ system involvement, primarily pulmonary. While cranial neuropathies are well established as the most common neurologic manifestation of the disease, peripheral involvement may also develop in a smaller subset of patients. The diagnosis of sarcoid involvement of the neurologic system is aided with a previous diagnosis of the disease; absence of such a history makes the clinical diagnosis of the disease challenging.

We discuss here a 47 year old fireman who presents to the Orthopaedic clinic one month after stepping into a hole, twisting his knee, with subsequent left knee effusions, recurrent giving way, left leg weakness and pain. He arrived to the office with an MRI that was without significant pathology.

Physical examination, however, suggested significant left quadriceps weakness, lateral joint line tenderness, and positive lateral McMurray’s. Ligamentous exam was intact and passive knee range of motion was full and symmetric. Most interesting is that the patient was unable to independently lift his left lower extremity against gravity off the examination table nor extend his knee. He had some low back pain with a mildly positive straight leg raise. No bowel nor bladder compromise.

Due to such profound weakness in the thigh musculature, an MRI of the LS spine and EMG of the left lower extremity was obtained. The MRI and further work up suggested sarcoid involvement of the spine at multiple levels including cervical, thoracic, and lumbar. A biopsy confirmed the diagnosis of neurosarcoidosis. The patient has been treated with Prednisone and physical therapy. He is making steady but slow improvement over 6 months of follow up with some return of left thigh muscle function.

An extremely uncommon presentation of sarcoidosis as neurosarcoidosis was illustrated in this case subsequent to a common traumatic event. Severe extremity weakness inconsistent with the insulting event suggested further work up. This case urges the clinician to obtain a careful history and perform a thorough physical examination in the pursuit of a diagnosis consistent with a patient’s clinical presentation.