SHORT REPORTS

Sarcoidosis presenting as gingivitis

Sarcoidosis is a systemic granulomatous disease of unknown cause that may affect any tissue in the body. In the head and neck the most common signs, together with widespread systemic disease, are cervical lymphadenopathy and swelling of the parotid glands.¹ Gingival symptoms at any stage are rare,² and patients who have them usually present with other clinical features of the disease³ or with gross gingival hyperplasia.^{4,5} We describe a patient whose sole presenting complaint was persistent soreness and ulceration of the gums and who was subsequently found to have systemic sarcoidosis.

Case report

A 34 year old man was referred by his dentist with a two month history of soreness and ulceration of the gums; he had no other symptoms. There had been no improvement after scaling and courses of metronidazole and penicillin. He was taking no drugs although he had taken phenytoin and phenobarbitone for childhood epilepsy until he was 18. He had no history of allergy. No abnormality was found on general physical examination; in particular there was no lymphadenopathy or visceromegaly. On examination of his mouth the attached gums looked granulomatous with superficial ulceration and bled readily when probed.

Granulomatous appearance of attached gums on presentation and initial chest radiograph.

Histological examination of a gingival biopsy specimen showed a granulomatous chronic inflammatory infiltrate with numerous giant cells, many associated with birefringent material. No central caseation was seen, and Ziehl-Neelsen staining showed no acid fast bacilli. These findings were consistent with a diagnosis of sarcoidosis or Crohn's disease. A chest radiograph showed enlarged bilateral hilar and right paratracheal shadows consistent with adenopathy, and a Kveim test was reported positive. The full blood count; serum urea, electrolyte and calcium concentrations; and simple respiratory function values were all within normal ranges. Sarcoidosis was diagnosed.

After discussion with a physician the patient was reviewed regularly. After four months the gingival lesions had become less florid and serial chest radiographs showed reduced hilar shadowing. After nine months the oral and radiological signs had resolved. The patient remained well three years after presentation.

Comment

Sarcoidosis may include oral symptoms and clinically normal oral tissues may provide histological evidence of systemic sarcoidosis. It is rare, however, for oral symptoms alone to lead to the diagnosis.^{1,2} Persistently sore, ulcerated gums that do not respond to local treatment and antimicrobial drugs suggest an underlying systemic disorder. The possibilities include erosive lichen planus, mucous membrane pemphigoid, Wegener's granulomatosis, blood dyscrasias, and Crohn's disease. This report of gingival symptoms as the sole clinical sign of the underlying disease confirms the place of sarcoidosis among the differential diagnoses.

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- 2 Altman K, Robinson PD. Sarcoidosis with oral involvement. *Br Dent J* 1984;157:310-1.
- 3 Woodward RTM. Lofgrens syndrome. *Br Dent J* 1983;154:143-4.
- 4 Watts KD. Sarcoid of the gingivae: a case report. *British Journal of Oral Surgery* 1968;6:108-13.
- 5 Sloan PJM, O'Neil TCA, Smith CJ, Holdsworth CD. Multisystem sarcoid presenting with gingival hyperplasia. *British Journal of Oral Surgery* 1983;21:31-5.

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Long term follow-up of factitious anaemia

In Münchhausen's syndrome,¹ or chronic factitious disorder with physical symptoms,² some patients' factitious anaemia is due to self induced bleeding,³ which is difficult to diagnose.³ We report the long term follow up of four such patients.

Case reports

Case 1—This woman was a laboratory technician who had had iron deficiency anaemia with amenorrhoea and mild anorexia nervosa when aged 24. The anaemia's cause had not been established at first, but, eventually, devices for phlebotomy were discovered among her personal belongings and antecubital venepuncture sites found. She never admitted to bleeding herself. She has tolerated severe chronic anaemia, with a haemoglobin concentration usually below 50 g/l for 11 years, being able to swim and ski regularly and work part time. A long trial of psychotherapy for her borderline personality disorder was unsuccessful.

Case 2—This woman was 28 when iron deficiency anaemia and hypokalaemia were diagnosed but unexplained. In discussions she admitted to drawing blood from her antecubital veins daily or weekly and to taking diuretics and laxatives; she eventually developed anorexia nervosa. She had had severe emotional problems since puberty, including deep depression, anxiety, promiscuity, and drug abuse. She had regular psychotherapy but never stopped bleeding herself; her anorexia nervosa and bulimia also did not improve. In seven years of follow up her haemoglobin concentration was usually 40-80 g/l. She worked temporarily in a general practitioner's surgery but not recently. A borderline personality with autodestructive and antisocial behaviour was diagnosed.

Case 3—This patient was a student nurse of 21 when she was found to be anaemic and have fresh puncture sites in the antecubital fossae. As she tolerated haemoglobin concentrations of 50-60 g/l with few symptoms her anaemia was presumed to be long standing. The cause remained unknown until she admitted to bleeding herself. Later she began to take heroin; she left nursing and was lost to follow up. A psychiatrist treating her for opiate withdrawal described her as very introverted and diagnosed a severe borderline neurosis. Six years after factitious anaemia had been diagnosed she agreed to see one of us again. She was working and looked anaemic, but she refused to say whether she was still bleeding herself and to be examined or have a blood sample taken.

Case 4—This patient was 23 when she was admitted to hospital with iron deficiency anaemia. Extensive investigations failed to find the cause until she admitted to bleeding herself. After reluctantly accepting psychiatric help she stopped bleeding herself for six months but then relapsed. She was physically and professionally active while being chronically anaemic with a haemoglobin concentration of 45-60 g/l. At school she had looked anorectic (and still did), was