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LEARNING POINTS

- The importance of taking a thorough history cannot be underestimated.
- Drug interactions account for 1 in 16 hospital admissions and 4% of the hospital bed capacity. A medication history is important as adverse drug reactions are a considerable burden on the NHS.
- This case highlights the importance of using the ward pharmacist and Egton Medical Information System (EMIS) to get the full picture.
- Monitoring clinical response after removing the offending medication is essential, but don't forget why the medication was started in the first place – the recurrence of the patient's restless legs syndrome required the use of an alternative medication.
- Report adverse drug reactions using the Yellow Card Scheme.

IMAGES IN MEDICINE

A common autoimmune disease with rare organ involvement

A 32-year-old woman presented with a 5-week history of vomiting, upper abdominal pain radiating through to the back and weight loss. Physical examination revealed epigastric tenderness. Abdominal computed tomography showed a mass involving the head of the pancreas (*Figure 1*). Endoscopic ultrasound showed a hypochoic pancreas with multiple peripancreatic nodes. At laparotomy the findings were of ascites, peritoneal seedlings, pancreatic mass and venous collaterals suggesting portal hypertension. Pancreatic and lymph node histology was consistent with systemic sarcoidosis (*Figure 2*). A chest radiograph showed bilateral hilar adenopathy. At bronchoscopy an endobronchial

cobblestone appearance was observed, consistent with sarcoidosis.

The patient was started on prednisolone 40mg/day and improved clinically. The ascites, which were thought to be secondary to sarcoidosis, resolved with furosemide. Follow up computed tomography after 1 month on a reducing dose of prednisolone (5 mg per week) showed a resolving pancreatic mass.

Sarcoidosis, a systemic granulomatous disease of unknown aetiology, affects mostly young adults. It may mimic malignancy, with pancreatic involvement being present in only 1–5% (Delgado-Bolton et al, 2011; Tsintsadze et al, 2011).

Two thirds of patients with pancreatic sarcoidosis have abdominal pain, and three

quarters have bilateral hilar adenopathy. Thus, abdominal pain in a patient with bilateral hilar adenopathy should lead the clinician to think of pancreatic sarcoidosis (Wijkstrom et al, 2010). **BJHM**

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Dr Judith Storm is Registrar in the Department of Pharmacology and Therapeutics, Belfast City Hospital, Belfast BT9 7AB, **Mr Mark Taylor** is Consultant in the Department of Surgery, Mater Hospital, Belfast, **Dr Michael Mitchell** is Consultant in the Department of Gastroenterology, **Dr Maurice Loughrey** is Consultant in the Department of Pathology, and **Dr Inder Mainie** is Consultant in the Department of Gastroenterology, Belfast City Hospital, Belfast

Correspondence to: Dr J Storm (judithstorm@hotmail.co.uk)

Figure 1. Abdominal computed tomography showing mass involving the head of the pancreas (arrow), enlarged peripancreatic lymph nodes and portal vein compromise with evidence of left-sided portal hypertension and gastric varices.



Figure 2. Peripancreatic soft tissue biopsy demonstrating multiple non-caseating granulomata within adipose tissue. High power (inset) shows classical aggregates of epithelioid histiocytes with scattered lymphocytes and no necrosis, features consistent with sarcoidosis.

