GI and Hepatic Sarcoidosis

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Sarcoidosis is a systemic granulomatous disease of unknown etiology, characterized by the formation of noncaseating granulomas. The stomach is the most commonly involved portion of the GI tract, but sarcoidosis of the esophagus, appendix, colon, rectum, pancreas, and peritoneum have also been described.

Gastric involvement with sarcoidosis is typically manifest as peptic ulceration or narrowing of the gastric lumen due to granulomatous inflammation and associated fibrosis of the gastric wall. Patients usually experience dull, burning, or cramping abdominal pain; nausea and vomiting occur when gastric outlet obstruction is present.

The differential diagnosis of noncaseating granulomata involving the stomach, small bowel, or colon includes sarcoidosis, Whipple’s disease, Crohn’s disease, and infection with Mycobacterium tuberculosis, Histoplasmosis capsulatum, or Treponema pallidum.

The diagnosis of sarcoidosis of the stomach or intestine is based on the presence of noncaseating granulomas on biopsy, evidence of sarcoidosis involving extraabdominal organs, negative stains and cultures from gastrointestinal biopsy specimens, and exclusion of sarcoid-like reactions to malignancy or foreign bodies.

Sarcoidosis is rarely reported in association with either Crohn's disease or ulcerative colitis, and the concurrence is rare enough to suggest that the two diseases are independent.

The liver is almost always involved in patients with gastrointestinal sarcoidosis, but may be affected in the absence of other gastrointestinal involvement. The diagnosis and treatment of hepatic sarcoidosis are discussed separately.

Asymptomatic patients are typically monitored without initiation of active therapy. For symptomatic patients with substantial organ involvement, we typically initiate therapy with prednisone ۰.۵ mg/kg per day (eg, approximately ۳۰ to ۴۰ mg daily). This dose is continued for six to eight weeks until a response to therapy is noted and then gradually tapered, over a period of approximately six months, to a maintenance dose of ۱۰ to ۱۵ mg daily.

Disease activity is monitored clinically and radiographically. The role of serum angiotensin converting enzyme levels in monitoring gastrointestinal sarcoidosis is not known, but appears to be limited. Repeat endoscopy is performed when the response to therapy remains unclear, particularly when intensification of therapy is being considered for persistent symptoms.

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