Initially considered as SS, but subsequent lip biopsy confirmed histological evidence of sarcoidosis in the presence of abnormal nailfold capillaroscopy and negative autoimmune profile. Sarcoidosis can be associated with various autoimmune diseases including systemic sclerosis, Hashimoto’s thyroiditis, systemic lupus erythematosus, rheumatoid arthritis, Sjögren’s syndrome and ankylosing spondylitis. The clinical presentation of the patient was consistent with sarcoidosis, which is a multisystem disease of unknown aetiology, known to exist worldwide with a variable prevalence of around 20 per 100,000 in the UK. It is characterized by the presence of multiple non-caseating granulomas, inflammation which may occur in any tissue in the body manifested as local symptoms with or without systemic features. Involvement of the salivary and lacrimal glands can result in xerostomia and xerophthalmia, respectively. Chronic sarcoid has an often subtle, insidious, progressive, and highly variable clinical course; it can be asymptomatic in a significant percentage of the cases. In addition to the clinical and radiological findings, the diagnosis of sarcoidosis should be based on the histological proof of non-caseating granulomas and ruling out other diseases that shares similar features. SS has many features in common with sarcoidosis; these may include sicca symptoms, arthralgia, myalgia, arthritis, erythematous rash, lymphadenopathy, peripheral neuropathy, fatigue and raised inflammatory markers. Moreover, positive rheumatoid factor, defective T suppressor cell regulation and HLA-DR3 are linked to both diseases. Pulmonary involvement in either of them may have similar clinical and radiographic manifestations, making it difficult for the clinician to distinguish between these diseases.

In terms of management, hydroxychloroquine may help the skin and joint manifestations in both diseases whereas more severe diseases may require treatment with glucocorticoids, methotrexate, and azathioprine. Nevertheless, prompt confirmation of the diagnosis is crucial provided the difference in response to medication, complications, outcome, and prognosis. Based on the clinical and lip biopsy findings, the above case was diagnosed with sarcoidosis. The case did not meet the criteria for the diagnosis of SS provided the negative results of Schirmer’s test, saliva flow test and autoimmune profile.

**Case report - Key learning points:** Raynaud’s phenomenon (secondary Raynaud’s) with positive capillaroscopy findings was an unusual early presenting feature of sarcoidosis in the above case. There was one case report of similar presentation published in 2011. However, literature did not reveal specific information about abnormal nailfold capillaroscopy results in sarcoidosis. Dry eyes and dry mouth may occur in sarcoidosis mimicking the presentation of primary SS. In addition, true coexistence of sarcoidosis and SS has also been defined based on the histopathologic examination of the exocrine glands. Diagnostic criteria need to be applied for patients with suspected overlap of the two diseases.

**Sjögren’s Syndrome and Its Mimics**

**O10 A Case of Sarcoidosis Mimicking Sjögren’s Syndrome along with Abnormal Nailfold Capillaroscopy**

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**Case report - Introduction:** Sicca symptoms and Raynaud’s disease are amongst the common presentation of Sjögren’s syndrome (SS) which has an estimated prevalence of 1%. We are reporting a case that was
Clinicians will need to be vigilant and perform appropriate investigations for overlapping rheumatic conditions with sarcoidosis. Lip biopsy remains a crucial investigation for cases referred with sicca features, not only to establish the diagnosis of SS but also to exclude associated lymphoma or sarcoidosis.