P039 MUSCLE WASTING & WEAKNESS: A RARE PRESENTATION OF SARCOIDOSIS
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Background/Aims
Sarcoidosis is a rare multisystem disease characterised by the presence of noncaseating granulomas. It most commonly affects the lungs though can affect any other organ system. Rarely, it can manifest as an acute myopathy. We describe a case of a patient presenting with muscle weakness and constitutional symptoms who was eventually diagnosed with sarcoidosis.

Methods
A 48-year-old male with a background of lumbar spondylosis and BPH, presented with a 6-week history of progressive upper and lower limb weakness, myalgia and reduced mobility. He also described an 18-month history of progressive fatigue, drenching night sweats and...
10-kilogram weight loss. His symptoms meant he was unable to work as a firefighter. Examination demonstrated profound muscle wasting and reduced power in the proximal muscles of his upper and lower limbs. There was no evidence of rash, synovitis or lymphadenopathy. Blood tests showed a normocytic anaemia (Hb 100 g/L) and raised C-reactive peptide (180 mg/L) and erythrocyte sedimentation rate (100 mm/hour). The creatine kinase ranged between 20–42 units/litre. He had a weakly positive anti-nuclear antibody (1:80). The remaining autoantibody screen was negative including ENA, DSDNA, ANCA, rheumatoid factor and anti-CCP. Complement proteins were unremarkable. Furthermore, an extended myositis panel revealed no myositis-specific or myositis-associated antibodies. Serum calcium and angiotensin-converting enzyme (ACE) levels were normal. Blood cultures and virology screen including for HIV, hepatitis B, hepatitis C, CMV, EBV, COVID-19 and respiratory viruses were all negative. A chest radiograph was also unremarkable.

Results
He subsequently underwent electromyography which revealed generalised myopathy. An MRI of the lower limb proximal musculature showed evidence of muscle oedema worse on the right-side but no definitive evidence of myositis. A PET-CT followed revealing FDG-avid generalised lymphadenopathy and polyarticular uptake, but little uptake in the skeletal muscles. He underwent an external iliac lymph node core biopsy which demonstrated multiple noncaseating granulomas and lymphadenitis. Cultures for Tuberculosis were negative and there was no evidence of a lymphoproliferative disorder. A muscle biopsy was desired but not possible due to lack of availability because of the COVID-19 pandemic. The patient was diagnosed with sarcoidosis and commenced on three pulses of intravenous methylprednisolone followed by a weaning regimen of high-dose oral prednisolone and subcutaneous methotrexate. This resulted in a sustained improvement in his symptoms and normalisation of inflammatory markers.

Conclusion
Symptomatic myopathy is present in only 0.5-2.5% of sarcoidosis patients. This unique case highlights the heterogeneity of this disease and the vital role different diagnostic modalities play in achieving the correct diagnosis. It is also pertinent that the lymphadenopathy, found incidentally via imaging, led to the diagnosis. Although notoriously a diagnosis of exclusion, this case emphasises the importance of considering sarcoidosis even in the absence of respiratory symptoms, a raised ACE or hypercalcaemia.

Disclosure
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