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CORRESPONDENCE

Relapsing necrotising sarcoid granulomatosis in a young patient

To the Editors:

The recent case of necrotising sarcoid granulomatosis described by ALIBERTI *et al.* [1] provides clinicians with an interesting insight into this rare condition. We would like to supplement the paucity of literature surrounding necrotising sarcoid granulomatosis and illustrate a case of our own. This was also in a young patient but did require treatment with oral corticosteroids at initial presentation and for a subsequent relapse.

A previously well 15-yr-old nonsmoking Caucasian female was referred to our chest clinic by her general practitioner with several months of pleuritic left-sided chest pain and fatigue. There was no past medical or family history of note, no relevant environmental exposures and the patient was receiving no regular medication. Clinical examination was unremarkable, and spirometry and laboratory parameters, including serum angiotensin-converting enzyme, were within normal limits. Chest radiography showed ill-defined consolidation at the left base and subsequent computed tomography showed multiple peripherally and pleurally based nodules throughout both lungs, but with no mediastinal lymphadenopathy. An open-lung biopsy revealed large aggregates of non-necrotising granulomatous inflammation around the bronchioles and in the pleura. Granulomatous vasculitis was also evident, leading to luminal narrowing and in some cases occlusion. Stains for fungi and acid–alcohol-fast bacilli were negative. Taken together, the findings were consistent with the diagnosis of necrotising sarcoid granulomatosis. In view of the patient's continuing chest pain and fatigue, oral prednisolone (30 $mg \cdot day^{-1}$) was started, and subsequently tapered and discontinued over the next 6 months with complete resolution of symptoms and chest radiograph changes. However, 3 months later, the patient developed further persistent chest pain with recurrence of ill-defined consolidation on chest radiography associated with a fall of 1 L in vital capacity. A further oral corticosteroid course was commenced, which was slowly tapered and discontinued over the next 17 months. At that point, the chest radiograph was normal and the patient asymptomatic. The patient remained well and was discharged from regular follow-up 1 yr later.

Our case complements the few documented cases of necrotising sarcoid granulomatosis occurring in young patients with pulmonary involvement alone [1–3]. Moreover, unlike the cases previously described [1–3], our patient did require oral corticosteroids at initial presentation and for a subsequent relapse. This provides further evidence that the condition is steroid-responsive and gives clinicians reason to be relatively optimistic when treatment is required in young symptomatic individuals.

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STATEMENT OF INTEREST
None declared.

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Angiotensin-converting enzyme genotype and C-reactive protein in patients with COPD

To the Editors:

In a recent issue of the *European Respiratory Journal*, MEYSMAN [1] suggested that in studies on the effects of angiotensin-converting enzyme (ACE) blockers in patients with chronic obstructive pulmonary disease (COPD), stratification for ACE gene polymorphism could potentially affect the outcomes under investigation. We have shown previously that the insertion (I)/deletion (D) polymorphism at intron 16 of the ACE gene is linked to pulmonary artery pressure (P_{pa}) in patients with