SARCOIDOSIS IN THE TROPICS
(*A "Symposium by Correspondence"*)

In an article entitled Sarcoidosis and Leprosy, in the *Journal of Tropical Medicine and Hygiene* (abstract in this issue), D. G. James and W. H. Jopling said in effect that there is evidence that sarcoidosis is relatively common in colored races, and that consequently it is of particular interest in the tropics. The article proceeds to discuss the condition with relation to leprosy, with emphasis on skin lesions.

Since we had not personally seen a recognized case of sarcoidosis in our many years in the Philippines, which is decidedly in the tropics, the validity of that introductory statement seemed to us of dubious validity. A circular inquiry about the matter was therefore sent to a number of leprologists in different countries. First in mind was the matter of skin lesions which could be confused with tuberculoid leprosy, such lesions being what would come to the attention of leprologists and dermatologists; cases with nothing but pulmonary lesions would be in another field. The replies constitute a "symposium" in the Correspondence section of this issue.

By chance, while the answers to this inquiry were coming in, there was received among our exchanges the comprehensive Proceedings of an International Conference on Sarcoidosis which was held in Washington, D. C., in June 1960. These proceedings are Part 2 of the November 1961 issue of *The American Review of Respiratory Diseases.*

Apart from the data on prevalence and distribution,[1] the most in-

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[1]Data from the reports on sarcoidosis in Latin America by Purriel and Navarette, and in South Africa by van Lingen, will be mentioned in connection with certain of the contributions to the symposium.

teresting feature of these proceedings, in the present connection, is the fact that the report of the Medical Group appointed by the meeting defined sarcoidosis as a *systemic* granulomatous disease in which numerous organs may be involved—but *without specific mention of the skin* (italics ours). It is said that the characteristic histologic appearance of epithelioid tubercles is not pathognomonic, but there is no mention of tuberculoid leprosy among the numerous conditions that must be excluded. It seems strange, on the other hand, that among the conditions to be excluded are "local sarcoid reactions."

In the discussion a dermatologist (O. Horowitz, of Copenhagen) questioned the exclusion of cases with "local sarcoid reaction." It was said in reply that to classify the disease as sarcoidosis one "must demonstrate systemic involvement and not just a single isolated lesion."

Other discussants, with helpful intent, pointed out that what the committee was trying to exclude are the local reactions to tattoos, scars, foreign-body granulomas and such things unrelated to systemic disease; also local reactions secondary to a carcinoma; or a peptic ulcer in which sarcoid tissue is found—which last seems rather far afield!

Another dermatologist (W. B. Shelley, of Philadelphia) held that sarcoid lesions do occur in the skin when they may not be evident elsewhere—after all, sarcoidosis was first recognized in the skin—and that the definition should not rule out the cutaneous disease. However, another speaker (D. G. James, of London), felt that they were talking about an "extremely small segment" of cases, which should not be allowed to bog down an important international description. This description is "going to go out to North Africa, where a patient may have a local area of leprosy on the finger;" no single pimple on the skin should be allowed "to escape from your exclusion clauses."

At the end the description was not modified. And so it seems that we have two schools of thought. One of them, the majority, are clinicians who do not recognize sarcoidosis except on the basis of visceral lesions, notably x-ray changes in chest films. The other, a minority consisting of dermatologists, would recognize cases with skin lesions of truly sarcoid nature, not confused with any of the extraneous conditions talked about at the conference.

No such distinction was in mind when the question of the present symposium was asked. This should be borne in mind in considering the answers, which are reviewed here briefly.

To begin with the Philippines, where the question was raised, the experience of Rodriguez among Filipino patients does not support the questioned thesis so far as cases with skin lesions are concerned; sarcoid cases have not been encountered. Farther east in the Pacific region, sarcoidosis is, according to Arnold, definitely not seen among the multiracial permanent residents of Hawaii, although on islands on the opposite side of the equator is does occur in New Zealand.

In India, Dharmendra, now at Chingleput, concludes that sarcoidosis is "not frequent" in that country; so infrequent, in fact, that Wardekar, at Wardha, is unable to contribute anything on the subject. Mukerjee, in Calcutta, reports that the condition is not seen in the clinics there. He goes on to cite an unsupported textbook statement that the disease is found in 0.1 per cent "in tropical practice," and he also mentions an article in which a single case was reported.

The situation in tropical Africa would seem to be not very different from that in

India, but very different from that among Americans of African affiliations. From Uganda, Kinnear Brown, who spends much of his time on safari seeking out leprosy cases, reports that he has not seen a sarcoidosis case there (or, previously, in Nigeria) although recently when in England he made a special effort to familiarize himself with the condition. Shaper, from a general hospital in Uganda, is thoroughly and insistently noncommittal. On making inquiries among his colleagues, the effort with the clinicians and the pediatrician was unproductive. However, the radiologist and the pathologists said they had repeatedly made tentative or alternative diagnoses of sarcoidosis, but they were unwilling to say that any of them had ever been confirmed.

Stanley G. Browne, in Eastern Nigeria, had not diagnosed a single case during his 26 years experience there and in the Belgian Congo, although it was possible—but unlikely—that some cases may have been misdiagnosed either way. He discusses leprosy cases of interest in this connection.

In South Africa, not tropical, the situation seems to be somewhat different, although one contributor, Marshall, of Cape Town, had seen only one case of sarcoidosis himself. Kooij, also of Cape Town, had seen 3 definite and 5 possible cases, all in colored patients, in the past three years. Reporting at the Washington conference, van Lingen had found only 5 cases reported in the South African literature, 3 of them in Africans, but a special inquiry in the five teaching hospitals had revealed totals of 18 cases in whites and 30 in Africans—the former the more numerous in proportion to population.

Passing now to tropical South America, it is clear that the disease is present, but infrequent to rare. From Venezuela, Convit describes the 2 cases with skin lesions in his dermatology clinic at the Vargas Hospital, and tells of others without skin lesions seen by the medical department of that institution. All were in mixed-blood colored people. From Brazil (where Purriel and Navarette had learned of 63 cases), Alonso tells of the infrequency of the condition in practice, and relates Rabello's opinion that cases involving the lungs and lymph nodes are more frequent than cutaneous cases. He was unable, because "the sample was too small," to venture an opinion as to whether or not the disease was more frequent among colored people than among whites.

The situation in the United States would seem, from this *uberblich,* to be unique, with a material total prevalence of sarcoidosis in parts of the country, and a marked predominance in the Negro race—which probably gave James and Jopling the idea upon which their article was based. The contribution of Johnwick is strictly from the point of view of the leprologist at Carville, where apparently cases of cutaneous sarcoid do not get admitted with the mistaken diagnosis of tuberculoid leprosy.

Finally returning to the Orient, Kitamura, from Japan, points out that sarcoidosis has been recognized as such only in recent years, since 1945 in significant fact, and that recently some 400 probable cases have been gathered by questionnaire. Here would seem to be the only country where studies of a relationship between sarcoidosis and leprosy could logically be undertaken—if any such study should seem worth while.

The question that was the basis of the inquiry represented here has been very thoroughly answered in the negative, and in the doing some points of interest have been brought out. The most interesting is the very marked contrast of experience of Negroes in the United States and in Africa. There is a question for which no answer seems in sight. One contributor, Kooij, holds for a mycobacterial causation of sarcoidosis—*M. tuberculosis, M. leprae,* etc. Both of those infections are so prevalent in Africa, to say nothing of other tropical countries, that one would expect to find plenty of cases of sarcoidosis if there were any causal relationship.—H. W. WADE