To the Editor:

The use of anti-tumor necrosis factor-\(\alpha\) (anti-TNF-\(\alpha\)) agents is validated in refractory rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, Crohn’s disease, and ulcerative colitis. Although very effective in breaking down granulomatous inflammation typically involved in sarcoidosis, anti-TNF-\(\alpha\) agents significantly reduce the host granulomatous defence mechanisms that normally contain pathogens such as mycobacteria and fungi. We describe a case of disseminated cryptococcosis in a patient with refractory systemic sarcoidosis, in whom complete resolution followed discontinuation of anti-TNF-\(\alpha\) drug and antifungal therapy.

A 42-year-old man was referred to our internal medicine department with a 2-year history of unexplained left-ear deafness and lymphocytic meningitis. Clinical examination was normal except for left-ear deafness. Gadolinium-enhanced magnetic resonance imaging (MRI) showed multiple solid enhancing lesions involving the left internal acoustic canal and the left frontal lobe. Cerebrospinal fluid (CSF) analysis revealed lymphocytosis (85/mm\(^3\)), elevated CSF protein (1.24 g/l), and low glucose CSF concentrations (1.4 mmol/l). Viral, bacterial, and fungal cultures were negative. Thoracic computed tomography (CT) scan showed multiple bilateral hilar and mediastinal lymphadenopathies, with no parenchymal involvement. PPD tuberculosis skin test (10 IU) was positive (7 mm). Serum angiotensin-converting enzyme level was normal and HIV test was negative. The bronchoalveolar lavage interpretation formula and CD4/CD8 ratio were suggestive of sarcoidosis. Histopathological examination of multiple bronchial biopsies revealed noncaseating epithelioid granulomas with a few giant cells. No acid-fast bacilli were identified and cultures were negative.

Treatment with prednisone was initiated at 60 mg/day, then tapered to 35 mg/day over 11 months. At this time, the patient complained of headaches. Clinical examination showed severe bilateral visual acuity loss. Ophthalmologic examination revealed a bilateral papillary edema. No acid-fast bacilli were identified and cultures were negative. Treatment with prednisone was initiated at 60 mg/day, then tapered to 35 mg/day over 11 months. At this time, the patient complained of headaches. Clinical examination showed severe bilateral visual acuity loss. Ophthalmologic examination revealed a bilateral papillary edema. Histopathological examination of multiple bronchial biopsies revealed noncaseating epithelioid granulomas with a few giant cells. No acid-fast bacilli were identified and cultures were negative.

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