INTRODUCTION
Tuberculosis is so common in Pakistan that clinicians quite rightly interpret any granulomatous histology as tuberculosis. Sarcoidosis is a multisystem disease which may mimic tuberculosis not only clinically but histologically as well. The fact that both the diseases can potentially affect any organ of the body complicates the matter even further. It is, therefore, prudent to keep the diagnosis of sarcoidosis at the back of one’s mind in cases not improving with anti-tuberculosis treatment.

CASE REPORT
A 38 years old woman, a mother of five healthy children, presented with three months history of marked, painless, retromandibular and submandibular areas of the neck, bilaterally (Figure 1a, b and c). She was systemically well. At another hospital, a fine needle aspiration biopsy from one of the swellings revealed granulomatous inflammation with a few salivary ductal structures. On the basis of the histology, she was started on antituberculosis regimen until about 6 weeks later when she developed a skin rash on her shins, diagnosed as erythema nodosum co-existent with xerostomia. Her ESR was 38 mm and Mantoux test was negative. There was no lacrimal gland swelling and corneal tear film was normal on slit lamp examination. A diagnosis of sarcoidosis affecting the major salivary glands was made. The salivary glandular swelling, subsided within two weeks of treatment with oral prednisolone.

ESR was 38 mm at the end of one hour. The full blood count, urinalysis, urea creatinine, liver functions, serum angiotensinconverting enzyme levels and serum calcium were within normal limits. A chest radiograph and electrocardiogram did not show any abnormal findings. A detailed history revealed marked dryness of mouth. There was no history of fever, weight loss, eye symptoms, respiratory or rheumatological symptoms. On examination, her mouth was extremely dry with shiny tongue (Figure 3). She had marked, bilateral symmetrical, non-tender swelling of parotids and submandibular glands but no lacrimal gland swelling and no lymphadenopathy. She had mild splenomegaly. The slit lamp examination of the eyes revealed a normal tear film on the cornea.

reveal any abnormality. An ultrasound of the abdomen confirmed mild splenomegaly. The Mantoux test with 10 tuberculin units was negative.

A diagnosis of sarcoidosis (Mikulicz syndrome), was therefore, made based upon bilaterally symmetrical swelling of major salivary glands, erythema nodosum, a granulomatous histology and a negative Mantoux test. The antituberculosis drugs were stopped and the patient was started on oral prednisolone 45 mg/day in three divided doses. The swelling almost subsided in two week’s time and dryness of the mouth improved as well. The prednisolone was tapered off over the next 8 weeks and the patient did not have recurrent problems over a three-month follow-up period.

DISCUSSION
The first ever case of bilateral painless swelling of parotids, submandibular and lacrimal glands was reported in 1888 by Johann Von Mikulicz-Radecki. In 1927, Schaffer introduced the term Mikulicz syndrome for cases secondary to sarcoidosis and lymphoproliferative disorders. The cases without a secondary cause were labeled as Mikulicz disease. The diagnosis of Mikulicz disease is based upon bilateral symmetrical swelling of lacrimal and one or both major parotid glands and exclusion of secondary causes of such glandular enlargement like sarcoidosis, viral infections and lymphoproliferative disorders. By this definition, the present case falls in the category of Mikulicz syndrome, secondary to sarcoidosis. In Sjogren’s syndrome, one may have swelling of the parotids and submandibular glands but the histology is not granulomatous. The Sjogren's syndrome is at times wrongly labeled as Mikulicz disease or Mikulicz syndrome in spite of granulomatous histology in the later two conditions in sharp contrast to non-granulomatous histology in the former. The differential diagnosis of symmetrical, bilateral, painless swelling of parotid and submandibular glands includes sarcoidosis (Mikulicz syndrome), Sjogren’s syndrome and lymphomatous infiltration. A granulomatous histology rules out Sjogren’s syndrome and lymphomatous process. A negative Mantoux test in an immunocompetent patient who did not respond to an adequate course of antituberculosis treatment, makes this diagnosis unlikely.

The Mikulicz syndrome is extremely rare and to the best of our knowledge, there is only one previous case report published in local literature. The lesson to learn from the present case is that while it is absolutely justified to think of common diseases first but whenever faced with atypical features, one must keep in mind the rare diagnoses, and take help from literature search, a practice which is almost always paying.

REFERENCES