OBSERVATION

Sarcoidosis Associated With Pegylated Interferon Alfa and Ribavirin Treatment for Chronic Hepatitis C

A Case Report and Review of the Literature

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Background: At least 2.7 million Americans are infected with chronic hepatitis C. An increasing number are treated with interferon alfa plus ribavirin regimens. Not surprisingly, this immune stimulation is associated with the development of autoimmune and cutaneous diseases. Several cases of sarcoidosis have been reported with hepatitis C treatment, most recently in association with pegylated interferon alfa plus ribavirin. Systemic manifestations of sarcoidosis are usually treated with oral steroids, which unfortunately often increase the hepatitis C viral load. Thus, it is important to ascertain whether systemic corticosteroids are required to treat interferon alfa–associated sarcoidosis.

Observations: We report the third case of cutaneous sarcoidosis in association with pegylated interferon alfa plus ribavirin treatment. Our patient had both cutaneous and pulmonary involvement, which has been spontaneously resolving since his treatment regimen was completed. In addition, we review the 12 previously reported cases of cutaneous sarcoidosis that occurred in patients undergoing hepatitis C treatment with interferon alfa.

Conclusions: As the number of patients being treated with interferon alfa and ribavirin for hepatitis C increases, it is essential that dermatologists recognize the association of this treatment with sarcoidosis, because skin lesions may provide the first clue to diagnosis. Development of sarcoidosis may relate to hepatitis C as a possible antigenic trigger in the presence of an enhanced helper T cells type 1 response from treatment. Sarcoidosis with skin lesions in patients undergoing hepatitis C treatment often follows a benign course, and interferon alfa therapy may sometimes be continued with resolution of sarcoidosis occurring spontaneously or within a few months of completing treatment. Cautious use of systemic corticosteroids is warranted given their adverse effects on hepatitis C viral loads.

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REPORT OF A CASE

A 63-year-old Hispanic man with no previous history of sarcoidosis received peginterferon alfa-2a, 135 µg injected subcutaneously once weekly, and ribavirin, 400 mg orally twice daily, for chronic hepatitis C (genotype 2) infection. He was previously untreated and responded well, with an undetectable viral load and improvement in liver function tests at 24 weeks of treatment. Six months after therapy was instituted, he noted the gradual and progressive appearance of asymptomatic skin lesions on his forehead, scalp, and extremities. At the same time, his review of systems was notable for an occasional cough productive of clear sputum. He had no other pulmonary symptoms and was able to hike several miles and play racquetball regularly.

Four months after noting the first skin lesions, the patient presented to the San Francisco Veterans Affairs Dermatology Clinic (San Francisco, Calif), with multiple violaceous dermal papules that coalesced into plaques on his right knee and the bilateral aspects of his elbows.

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In sarcoidosis, there appears to be a predominance of helper T cells type 1 (Th1) immune response with CD4+ T cells in affected lungs, producing large amounts of interferon gamma and interleukin (IL) 2. Local macrophages are also activated and produce IL-1, IL-12, and interferon gamma. Helper T cells type 2 (Th2) lymphocytes are relatively inactive in the granulomas, and there are proportionately low levels of Th2-associated cytokines. Interferon alfa is successful in treating infectious diseases because of its immunomodulating effects. In vitro, interferon alfa causes T cells to produce large amounts of interferon gamma and limited amounts of IL-4 and IL-5, suggesting that interferon alfa favors the development and enhancement of Th1-mediated responses. This enhancement of interferon alfa activity seems to be the reason for its immunosuppressive effects in the treatment of sarcoidosis.
African American, and our patient was Hispanic. Hepatitis C viral genotype 1a occurred in 3 patients, with genotypes 3a and 2 specified in 2 others.

Nine of the cases occurred in patients who received a combination treatment of interferon alfa or pegylated interferon alfa and ribavirin. In 3 of these cases, patients had previously been treated with interferon alfa only without any manifestations of sarcoidosis. This suggests that the combination of interferon alfa and ribavirin further modifies or enhances the immune response in a way that predisposes the patient to sarcoidosis. Although the exact mechanism of ribavirin in treating hepatitis C is unknown, a recent study suggested that it also enhances T<sub>IM</sub>1 responses when applied to T cells in vitro. This may explain why combination therapy with interferon alfa and ribavirin is more efficacious in treating hepatitis C virus and why it also may further predispose patients to sarcoidosis and other autoimmune diseases. No cases of sarcoidosis that occurred with ribavirin-only treatment have been reported.

Most patients with interferon alfa–associated sarcoidosis had resolution of their disease without immunosuppressive treatment. In several cases, interferon alfa treatment was discontinued because of either sarcoidosis or hepatitis nonresponder status. Subsequent resolution of sarcoidosis within months was the rule. In 4 of the cases, the treatment regimen was not modified and the sarcoidal manifestations included cutaneous lesions.

Details of these cases are summarized in the Table.

Six patients had only cutaneous involvement. One patient had cutaneous plus liver involvement discovered on an incidental protocol biopsy specimen. Many patients, including our case, had negative ocular examination results. All but 1 had an elevated angiotensin-converting enzyme level. Only 1 patient had a previous possible history of sarcoidosis. The mean time to onset of disease from the start of interferon alfa treatment was 4 months. Of note, responder status to treatment was essentially equal in those cases in which it was specified (4 responders vs 5 nonresponders) and did not correlate with the mean time to onset. Men and women were equally affected. In the 5 cases in which race was specified, 3 patients were white, 1 was

<table>
<thead>
<tr>
<th>Source</th>
<th>Age, y/</th>
<th>Sex</th>
<th>Prior Treatment</th>
<th>Interferon Alfa Only</th>
<th>Onset, mo</th>
<th>Findings</th>
<th>ACE Level, U/L</th>
<th>Treatment</th>
<th>Follow-up and Resolution</th>
<th>Responder Status</th>
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</thead>
<tbody>
<tr>
<td>Hoffmann et al, 1998</td>
<td>39/M</td>
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<td>Interferon alfa</td>
<td>No</td>
<td>5</td>
<td>C, P</td>
<td>88</td>
<td>Discontinued</td>
<td>5-mo Resolution</td>
<td>R</td>
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<td></td>
<td>Interferon alfa</td>
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<td>4</td>
<td>C</td>
<td>108</td>
<td>Discontinued; decreased interferon alfa; topical corticosteroids</td>
<td>Clinical improvement</td>
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<tr>
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<td></td>
<td>Interferon alfa</td>
<td>No</td>
<td>3</td>
<td>C</td>
<td>56</td>
<td>Discontinued; oral corticosteroids</td>
<td>2-mo Resolution</td>
<td>NR</td>
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<td>Pèrez-Alvarez et al, 2002</td>
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<td></td>
<td>Interferon alfa, ribavirin, amantadine</td>
<td>No</td>
<td>3</td>
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<td>108</td>
<td>Discontinued; oral corticosteroids</td>
<td>3-mo Resolution</td>
<td>NR</td>
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<td>Interferon alfa, ribavirin</td>
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<td>94</td>
<td>Discontinued; oral corticosteroids</td>
<td>6-mo Resolution</td>
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<td></td>
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<td>C, P</td>
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<td>No change in treatment</td>
<td>4-mo Resolution</td>
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<td>No</td>
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<td>Discontinued, oral corticosteroids</td>
<td>1-y Resolution</td>
<td>NS</td>
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<td>4</td>
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<td>Discontinued</td>
<td>5-mo Resolution</td>
<td>NR</td>
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<td>5</td>
<td>C</td>
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<td>Discontinued</td>
<td>3-mo Resolution</td>
<td>NR</td>
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<td>Peginterferon alfa, ribavirin</td>
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<td>C, P</td>
<td>96</td>
<td>No change in treatment</td>
<td>2.5-mo Resolution after treatment completion</td>
<td>R</td>
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</tbody>
</table>

Abbreviations: ACE, angiotensin-converting enzyme; C, cutaneous sarcoidosis; L, hepatic sarcoidosis; NA, not available; NR, treatment nonresponder; NS, treatment response not specified; P, pulmonary sarcoidosis; R, treatment responder.
inary involvement that resolved after his interferon alfa treatment was completed, he did not experience significant pulmonary compromise and continued his daily activities, including hiking and racquetball.

Sarcoidosis with skin lesions that occurs in patients undergoing interferon alfa treatment for hepatitis C often follows a benign course, and hepatitis treatment may possibly be continued with close monitoring for systemic problems such as pulmonary compromise. On the basis of the reported cases, interferon alfa–associated sarcoidosis with cutaneous involvement can be expected to resolve within approximately 6 months of treatment discontinuation, if not sooner. Several cases resolved spontaneously despite the continuation of interferon alfa and ribavirin treatment. Steroids, which are the main treatment for systemic sarcoidosis, increase the hepatitis C viral load both in vitro and in vivo.20 Physicians should thus exert caution in treating interferon alfa–associated sarcoidosis with systemic corticosteroids.

Our case is the third reported case of cutaneous sarcoidosis that occurred with peginterferon alfa and ribavirin treatment. As more patients are treated with this regimen because of greater efficacy and convenience of administration, predisposition to sarcoidosis will likely prove to be an increasingly recognized adverse effect. As in other cases of sarcoidosis, the skin is a commonly affected organ. Because symptoms of sarcoidosis such as fever, fatigue, and anorexia are often nonspecific and similar to the frequent adverse effects associated with hepatitis C treatment, the dermatologic examination can often provide helpful diagnostic clues and skin biopsy can yield rapid diagnosis.

Dermatologists and other physicians should be aware of the enhanced potential for cutaneous and systemic sarcoidosis in patients undergoing interferon alfa treatment for hepatitis C. In cases with skin lesions, interferon alfa treatment may sometimes be continued and oral corticosteroids should be used judiciously in what is often a mild sarcoidal disease course. Further investigation into the possible association of hepatitis C as an antigenic trigger coupled with enhanced T<sub>H</sub>1 immunoresponses related to interferon alfa treatment may contribute to understanding the etiology and pathogenesis of what remains a mysterious disease.

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REFERENCES