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Neurosarcoidosis

Two interesting additional cases of hypothalamic-pituitary neurosarcoidosis have recently been described by Dr Smith and Dr Cullen.¹ According to the proposed criteria, the diagnosis of definite, probable or possible neurosarcoidosis can be performed by the careful evaluation of the patient. At present, the treatment of the disease mainly represents an intriguing and debated issue.

Corticosteroids are the treatment of choice. However, the occurrence of refractory neurosarcoidosis and, more often, the necessity to lower the long-term corticosteroid dose are relevant clinical problems. Both cytotoxic drugs (methotrexate, cladribine, azathioprine, chlorambucil, cyclophosphamide and ciclosporin) and immunomodulators (chloroquine, hydroxychloroquine and, more recently, infliximab) have been tested.^{2–5} Although some promising results have been achieved, no converging and definitive data on the safety and effectiveness of these therapeutic regimens have been reported so far. Also other treatment options have been considered: radiotherapy may be advisable when drugs fail,⁶ whereas the indication to neurosurgery looks likely to be exclusively limited to life-threatening situations or peculiar conditions, like hydrocephalus and compressive spinal lesions.

In our minds, the identification of effective and safe long-term treatment and the selection of the patients with a high risk of relapse will be the main goals in the future of neurosarcoidosis. For instance, new immunosuppressive

drugs, like mycophenolate mofetil, could be tested. Besides, a careful focus on the biological markers that might point out an increased risk of relapse or predict the possibility of poor responsiveness to corticosteroids may be necessary. Above all, prospective controlled studies will be needed in order to provide evidence-based indications for the management of neurosarcoidosis.

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