A 62 year old female was diagnosed with pT3b melanoma in 2012 following the excision of a 2.1mm mole on her back. Two months later she underwent a wider excision and sentinel lymph node biopsy which found a 0.5mm deposit. In 2014 a small pigmented lesion on her back was excised which was confirmed to be BRAF positive intranodal malignant melanoma metastasis, staging T3N1M0. The patient was commenced on Pembrolizumab in February 2016 due to recurrent local disease. Three months later PET showed FDG avid lymphadenopathy in the central mediastinum and lung hilar regions (Fig. 1). This was histologically confirmed as sarcoid. A nodule on the right elbow was also biopsied and confirmed to be sarcoid on histopathology (Fig. 2.) The patient was commenced on a reducing regime of Prednisolone to manage the sarcoidosis. A repeat CT in February 2017 showed resolution of the right hilar lymphadenopathy and shrinkage of the mediastinal lymph nodes consistent with improvement in the sarcoidosis.

A 45 year old male was diagnosed with melanoma in 2014 following the excision of a 4cm mole on the sole of his left foot in July 2015. He subsequently underwent a wide local excision and a sentinel node biopsy in his left groin which was positive. This was followed by completion clearance of the left inguinal lymph nodes with no further metastatic disease identified, disease staged as pT3bN1M0. The following year the patient noted multiple lesions on his left leg which were confirmed to be metastatic melanoma on biopsy, there was no evidence of visceral metastases on CT. The patient subsequently underwent radiotherapy and then in March 2016 was commenced on Pembrolizumab. PET CT in November 2016 demonstrated bilateral hilar lymphadenopathy, but no overt evidence of melanoma spread (Fig. 3.) EBUS guided PNA of sub carinal and right hilar lymph nodes identified granulomatous inflammation consistent with sarcoidosis. He remained asymptomatic from a respiratory point of view.

A 47 year old male was diagnosed with melanoma of unknown primary in July 2013 after an excision biopsy of a left groin lump. A right groin dissection three months later confirmed BRAF positive metastatic melanoma T4N2M0. PET CT in December 2014 confirmed recurrent disease leading to further surgery. A further PET CT post operatively in February 2015 indicated a solitary avid lymph node. The patient subsequently underwent radiotherapy and PET CT in October 2015 showed metabolically active disease in the left para aortic region. The patient was commenced on Pembrolizumab therapy. Internal CT imaging showed a good response to treatment however, in December 2016 CT imaging showed bilateral hilar and mediastinal lymphadenopathy, strongly suggestive of sarcoidosis (Fig. 5.) The patient remained asymptomatic from a respiratory perspective. Serum ACE level was 10B. EBUS in January 2017 confirmed granulomatous inflammation suggestive of sarcoidosis.