CLINICAL VIGNETTE

A Common Lesion with a Mistaken Identity

Charmi Shah, MD

Brief Summary

A 35-year old female with history of herpes simplex virus 1 (HSV1) presented with genital lesion. The lesion was suspicious for HSV and she was prescribed valacyclovir and a culture was obtained. The PCR was subsequently returned negative for HSV1/2. Her past medical history includes polycystic ovary syndrome (PCOS) on birth control pills and hyperprolactinemia.

To evaluate hyperprolactinemia, an MRI of the pituitary gland was obtained which revealed no discrete pituitary lesion, but noted an incidental new filling defect in right sigmoid sinus extending to the cranial most aspect of the right cervical intra jugular vein consistent with thrombus. She was directed to the emergency room where a hypercoagulable evaluation revealed an elevated protein C clottable activity with cardiolipin anticoagulant and a protein S levels within a normal range. Patient was started on apixaban to follow up with neurology and hematology.

A month later, repeat MRI revealed the nonocclusive thrombus which was stable and non-hemorrhagic. Hematology/Oncology evaluation included normal bet2 GP, but intermediately elevated cardiolipin IgM antibody. Subsequent testing did not suggest a hypercoagulable state and Protein C clottable activity normalized.

Patient presented to her PCP with a vaginal lesion which was diagnosed as folliculitis. A month later another vaginal lesion developed with negative HSV PCR which did not respond to antiviral therapy. She was referred to dermatology for biopsy after three more episodes of vaginal lesions that failed to respond to anti-viral therapy. Initial biopsy was inconclusive.

Patient was started on prophylactic valacyclovir, but continues to have recurrent vaginal lesions. A repeat biopsy during an active outbreak led to the diagnosis of bullous dermatitis and raised concern for possible Behçet's syndrome. Rheumatology consultation confirmed Behçet's syndrome.

The patient was started on colchicine which improved symptoms. To date, she has not had any more vaginal lesion outbreaks. She remains on anticoagulation for the thrombus.

Discussion

Behcet's syndrome (also known as Silk Road Disease)[1] is a rare disorder found mainly in Mediterranean, Middle East, and Far East populations. Behcet's syndrome symptoms usually begin around ages 20 to 30. While there is no definitive test to diagnose, Behcet's syndrome should be considered in individuals who have recurrent oral lesions with a compilation of systemic symptoms. Symptoms that should raise suspicion include ocular disease, especially hypopyon, panuveitis or retinal disease; vascular disease, particularly Budd-Chiari syndrome and cerebral venous thrombosis; and patients with pathergy manifesations.[2] The syndrome typically runs a relapsing-remitting course and therefore can be difficult to diagnose. Experts currently recommend diagnoses based on the International Study group (ISG) criteria.[3]

The syndrome is believed to be due to vasculitis and may involve all sizes of blood vessels. Treatment is aimed to decrease inflammation and prevent organ damage. Evaluation often requires a multidisciplinary team and treatment is individualized based on involved organ systems. For suppression of genital ulcers, colchicine 1-2mg/day in divided doses is recommended. Apremilast has also been shown to be effective with preventing ulcers. While no superiority studies were identified, the preference is generally a trial of colchicine due to its rapid onset, lower cost and overall better tolerability.[4-6]

Refractory cases may require oral prednisone, azathioprine or immunomodulators, especially when extensive organ involvement is identified.[7] Duration of treatment also varies based on organ systems involved and severity of symptoms. Typically, some form of immunosuppressive therapy is continued for 18-24 months.[8]

Prognosis varies based on age, gender and organs involved. For patients with predominantly mucocutaneous and arthritic manifestations, the disease burden improves with time and many patients become asymptomatic.[9] The greatest morbidity and mortality comes from neurologic, ocular, and large-vessel arterial or venous disease.[10-12] Survival appears to have improved over the years, possibly as the result of earlier recognition and treatment using glucocorticoids and other immunosuppressive agents.

Conclusion

Evaluation of rashes and genital lesions are common in the primary care setting. HSV is a common cause of many of these lesions, whereas Behçet's syndrome is very rare and has no definitive diagnostic test. It is diagnosed clinically and best characterized in the context of recurrent aphthous ulcerations along with characteristic systemic manifestations such as genital ulcers, folliculitis, ocular disease, pulmonary artery aneurysms and vascular disease. It is important to broaden the differential and re-evaluate when a condition does not follow its expected course.

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