Journal of Rheumatic Diseases
Vol. 19, No. 5, October 2012
http://dx.doi.org/10.4078/jrd.2012.19.5.302

□ Clinical Image □

Multiple Arterial Aneurysms in Behcet's Disease

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Case Report

Patient: 58-year-old female

Chief complaint: Pulsatile swelling on the posterior aspect of left knee for 3 years.

Physical examination: At admission, blood pressure of 115/85 mm Hg, body temperature of 36.8°C, pulse of 67/min and respiratory rate of 19/min were checked. On presentation, physical examination revealed an about 4×7 cm-sized, non-tender, pulsating mass on the left popliteal area. Pathergy test performed using a 20-gauge needle was positive.

Past medical history: She had recurrent oral and genital ulcers for 7 years.

Laboratory tests: Laboratory test revealed white blood cell (WBC) of 8.1 10^3/mL, Hb of 12.8 g/dL and platelet of 18.3× 10^3/mL. A high erythrocyte sedimentation rate of 58 mm/hr (normal ＜20/mm/hr), C-reactive protein of 132.47 mg/L (normal ＜5 mg/L) and positive HLA-B51 were noted. Blood chemistries, autoantibodies and tests for viral infections were within normal limit or all negative.

Radiologic findings: Computed tomography (CT) angiogram (Panel) revealed aneurysmal dilatation of aortic arch, infrarenal aorta, both common femoral and popliteal arteries (white arrows), and thrombosis in the left popliteal vein (white arrow) on CT scan of left lower extremity (Figure 1).

Diagnosis and treatment: A diagnosis of Behcet's disease with arterial and venous complications was made with characteristic clinical symptoms, including recurrent oral and genital ulcers ischemic pain and positive Pathergy test. She denied to operative treatment and has been treating with glucocorticoid, colchicines, anti-platelet drug and azathioprine.

Discussion

We here present an unusual case of a Behcet's disease with multiple arterial aneurysms and deep venous thrombosis. Behcet's disease is an inflammatory disorder of unknown cause, characterized by recurrent oral ulcers, genital ulcers,

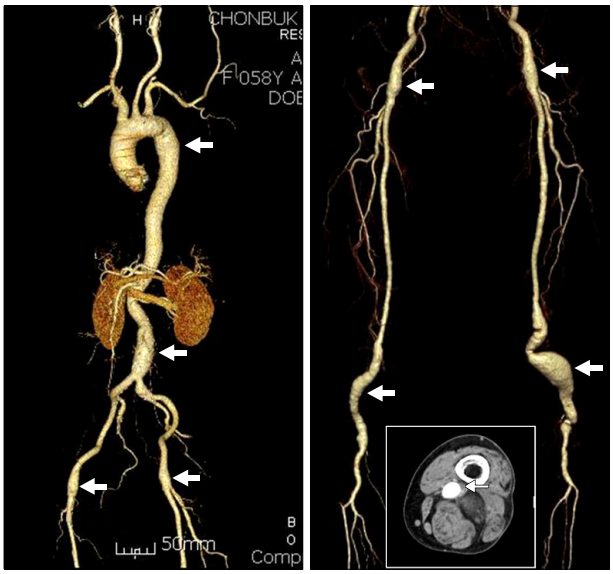

Figure 1. Multiple arterial aneurysmal dilatations on computed tomography angiogram. There were aneurysms on the aortic arch, infrarenal aorta, both common femoral and popliteal arteries (white arrows), and thrombosis in the left popliteal vein (white arrow) on the CT scan of lower extremity.

＜Received : June 21, 2012, Revised : July 10, 2012, Accepted : August 14, 2012＞
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pISSN: 2093-940X, eISSN: 2233-4718
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uveitis, positive Pathergy test and cutaneous and vascular lesions (1). Vasculitis accounts for most of the pathologic processes in Behcet's disease and can affect both veins and arteries of any sizes (2).

The arterial lesions of Behcet's disease (vasculo-Behcet's disease) include aneurysms, stenosis, and occlusions. The artery most often affected is the aorta followed by the pulmonary arteries, femoral artery, subclavian artery, and popliteal artery. In most reports, arterial lesions are isolated; rarely, they can be multiple and frequently coexist with venous thrombosis (3). The arterial inflammation is acute and destructive to the vessel wall and results in rapid formation of aneurysms with an increased incidence of rupture and bleeding. Acute arterial involvement in Behcet's disease should be regarded as a medical emergency and should be treated with pulsed intravenous corticosteroids and cyclophosphamide followed by maintenance oral corticosteroids (4). Systemic arterial aneurysms in Behcet's disease should be surgically corrected because of the risk of aneurismal rupture. Thus, early diagnosis and early institution of immunosuppressive therapy and surgical correction will help in preventing formation and progression of this life threatening complication.

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