Behcet’s Disease Dilemma!

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Sir,

The latest issue of May 2016 of JAPI has reported an interesting case of Behcet’s disease, suspected clinically and confirmed with other features from the ISG criteria. The ISG criteria for Behcet’s, created in 1990, have excellent specificity, but lack sensitivity. The International Criteria for Behcet’s Disease (ICBD) was created in 2006, as replacement to ISG. However, we feel that it would be appropriate to highlight additional medical literature about the diagnosis of Behcet’s disease at this juncture.

To date, Behcet’s Disease remains a clinical diagnosis based on its disease manifestations. There is no relevant biological test for diagnosis. For this reason different classification criteria were created for the identification of Behcet’s Disease for the past nine decades.

This case report with short acute illness with oral ulcers of 4–5 days and apparently medical history did not support recurrent episodes or chronicity. The clinical photograph of genital ulcers is perhaps not on current presentation. International study group criteria in 2003 were improved by ICBD for earlier diagnosis and treatment.

All criteria have in common the fact that they give significant weight to recurrent oral ulceration. However, recurrent oral ulceration is not an uncommon complaint and differentiating it from the recurrent oral ulceration of Behcet’s Disease can be a challenge.2

In the new International Criteria for Behcet’s Disease (ICBD), a pathergy test was optional, as this takes into account the declining sensitivity and increasing specificity of pathergy test.3

The reported higher sensitivity of the ICBD will allow for earlier recognition, earlier diagnosis, and earlier treatment.4

Gastrointestinal manifestations can be seen in 7–29% of patients. They are produced by ulcers anywhere in the gastrointestinal tract. It is difficult to differentiate Behcet’s Disease from inflammatory bowel disease because of the similarity in intestinal and extra-intestinal symptoms. Nevertheless, presence of granulomata can be used to exclude Behcet’s Disease.

The frequency of finding granulomas in CD varies between 15% and 85%, but is rarely higher than 50–60%. The results depend highly on tissue sampling (number of biopsies, number of sections examined, endoscopic or surgical samples). For surgical samples the frequency varies between 15–82% and for endoscopic samples between 3–56%.5,6

**Viewpoint**

In the absence of indisputable evidence to support Behcet’s disease the differentials could have been Crohn’s disease or other autoimmune or ulcerative lesions of unknown aetiology. The biopsies taken from colon may not specifically be supporting the diagnosis of Behcet’s disease alone. Biopsies from multiple sites and more in numbers could have helped to identify other specific features of similar diseases. Behcet’s disease/syndrome is diagnosed clinically, and tissue evaluation is supportive.6 In a study of 48 patients with Behcet disease and 47 healthy controls, serum levels of calprotectin were significantly elevated in the Behcet disease group.7

**References**