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Behçet's Disease and Familial Mediterranean Fever

Guest editors

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Letters to the Editor

Multiple venous thrombosis in a patient with Behçet's disease and protein C deficiency

Sirs,

In 1997 a 27-year old woman was diagnosed Behçet's disease based upon recurrent erythema nodosum, bilateral gonarthrits, oral ulcerations, elevated ESR and C-reactive protein, increased neutrophil migration *in vivo*. Rheumatoid factor and antinuclear antibodies were negative. Moreover, the patient presented distension of the abdominal wall veins. Multiple venous thrombosis were demonstrated by echocardiography, computed tomography of thorax and abdomen, phlebography and Doppler study of lower limbs with involvement of femoral and external iliac veins of both sides, inferior vena cava, suprahepatic veins and right atrium. The obstruction of the inferior vena cava led to collaterals. The CT image (Fig. 1) shows the presence of multiple collateral vessels while the inferior vena cava is not evident.

A screening about clotting process showed protein C deficiency by functional assay (55%). We think that the multiple venous thrombosis are due to the concomitant presence of Behçet's disease and protein C deficiency that both provoke hypercoagulable state.

Rarely isolated cases of arterial or venous thrombosis have been reported in patients affected by Behçet's disease associated with protein C deficiency (1, 2); nevertheless some studies addressed to evaluate the presence of thrombophilic factors in Behçet's disease have not found decreased protein C level or other coagulation inhibitor abnormality (3-5).

Our patient has been given warfarin and colchicine, obtaining a satisfactory control of the activity of Behçet's disease, with no further thrombotic events.

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Bilateral uveitis in a 7-year-old patient with familial Mediterranean fever. An extremely rare complication

Sirs,

Familial Mediterranean Fever (FMF) is an inherited disorder characterized by recurrent self-limited episodes of fever accompanied by peritonitis, pleuritis or sinusitis which occurs predominantly in non-Ashkenazi Jews, Armenians, Arabs, and Turks (1-3). The frequency of FMF in the most commonly involved ethnic groups varies between 1/256 and 1/1075 (4-6). The most common mutation is M694V although at least 20 mutations have been identified (4-6). Diagnosis is based on a history of typical acute attacks, ethnic background, and frequently a notable family history (7). Colchicine is the drug of choice. A trial of colchicine may also help in the differential diagnosis with other periodic fever syndromes. The main ocular involvement in FMF is retinal changes, which resemble colloid bodies (8). Uveitis in these patients has not been defined previously. We here present an unusual pediatric case with FMF associated with bilateral uveitis.

A 3-year-old girl was admitted to Hacettepe University Faculty of Medicine due to recurrent abdominal pain with fever and arthralgia of 1 year duration. There was a family history of FMF without consanguinity between parents. Physical examination was normal with a blood pressure of 90/40 mmHg. Diagnosis of FMF was made according to Tel Hashomer criteria (9) and was supported by laboratory findings which were as follows: hemoglobin, 12.4 gr/dl; hematocrit, 37%; WBC, 6400/mm³; platelets, 412,000/mm³; erythrocyte sedimentation rate, 46 mm/h; fibrinogen, 412 mg/dl (normal 417-430 mg/dl); C-reactive protein, 36 mg/dl (normal 0-0.8 mg/dl). Urinalysis showed no protein, 1034 specific gravity and 2 WBC/high-power-field in microscopy. Transaminases and renal function tests were within normal limits. Serology of hepatitis B and antinuclear antibody (ANA) were negative. HLA-B5 and HLA-B27 were also negative. Abdominal ultrasonography was normal. Sacroiliac magnetic resonance imaging showed no sacroiliitis. Homozygous M694V mutation was found in DNA analysis. Colchicine therapy was started 0.5mg, bid initially, however the patient was lost to follow up for four years until left anterior uveitis was diagnosed at a local hospital due to loss of vision in her left eye. During this period there had been abdominal pain and arthralgia every two

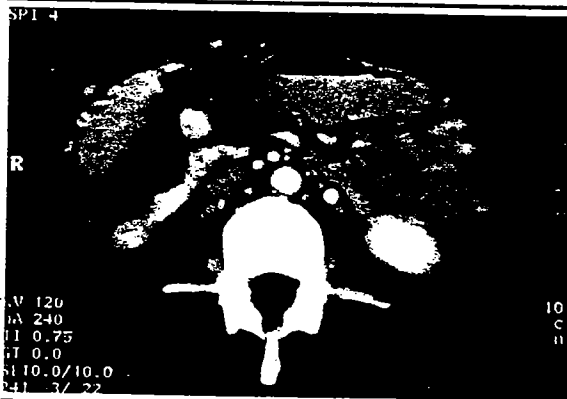


Fig. 1. The abdomen CT image shows multiple collateral vessels; the inferior vena cava is not evident.



Fig. 1. Anterior uveitis. Biomicroscopic evaluation revealed conjunctival injection and many (+4) cells in the anterior chamber.

months. Four months after development of left uveitis, right anterior uveitis was also diagnosed (Fig. 1). She was treated with topical prednisolone sodium phosphate 1% three times daily and oral methyl prednisolone. The patient's visual acuity on initial examination was 20/20 OD, and 80/200 OS. Biomicroscopic evaluation revealed conjunctival injection and intense (+4) cells in the anterior chamber of the right eye. Keratic precipitates on the corneal endothelium, few (+1) cells in the anterior chamber and seclusio pupillae was revealed in the left eye. Dilated fundoscopic examination revealed no inflammatory activity in the vitreous and no fundal abnormalities existed. Fundic details of the left eye were not well identified and B-scan ultrasonography showed no intraocular abnormalities. The patient was started on hourly dexamethasone (1mg/ml) drops OD, 8 times daily OS, cyclopentolate HCl 1% three times daily OU and dexamethasone alcohol 0.1% ointment at night. Three days later the biomicroscopic examination of the right eye revealed a moderate (+2) number of cells in the anterior chamber. The patient was instructed to use dexamethasone (1mg/ml) drops in a tapering manner and cyclopentolate HCl 1% three times daily OU. In her follow up, her left eye was operated on for facoemulsification and intraocular lens implantation. She has been free of FMF attacks for 1 year, however uveitis has not yet resolved.

FMF is characterized by brief attacks of fever and pain. Serous membranes are the main target of the disease. We here present a patient with bilateral anterior uveitis which is an unusual finding of FMF. Juvenile chronic arthritis was excluded according to ACR criteria (10). Juvenile spondyloarthropathies were not considered in the differential diagnosis because there was no enthesopathy, urethritis, diarrhea or psoriasis in her previous, current or family his-

tory and no sacroiliitis was demonstrated in her sacroiliac MRI, in addition to the absence of HLA-B27 antigen. In recent years, FMF with Behcet's disease (BD) in the same individual was defined (11). However, in this patient complete or incomplete Behcet's disease was also ruled out according to the International Study Group for BD due to the absence of recurrent aphthous stomatitis, genital ulceration, pathergy or skin involvement characterized usually by erythema nodosum and pustular rash and by the absence of the HLA-B5 antigen. The patient was diagnosed as having FMF due to the presence of a history of typical FMF attacks and homozygous M694V mutation. In addition, after colchicine was started at a dose of 1 mg/d, her attacks subsided and acute phase reactants became normal. Eye involvement in FMF has been described rarely in the literature but there were no pediatric patients reported. After Michaelson *et al.* first described fundal changes in recurrent polyserositis, Yazici *et al.* reported eye involvement in a patient with FMF (8,12). Later Scharf *et al.* and Hirsh *et al.* also reported their findings (13,14). In our series of over 600 children, this was the first case with uveitis.

In conclusion, uveitis is rarely seen in FMF. This complication should be considered when some eye problems are observed in a patient with FMF.

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