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TREATMENT OF BEHCET'S DISEASE

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A case of Behcet's disease treated initially with corticosteroids to which dapsone was added subsequently and being kept in remission with dapsone alone is presented. High maintenance dose of corticosteroids necessitated the substitution with dapsone.

Key Words : Behcet's disease, Corticosteroids, Dapsone

Introduction

Behcet's disease is diagnosed mainly on clinical grounds. The major criteria for diagnosis are oral and genital ulcers, neuroocular and dermatological signs. The minor criteria consist of proteinuria and haematuria, thrombophlebitis, aneurysms and arthralgias. Three major or two major and one minor criteria are necessary for diagnosis.[1]

Behcet's disease is reported infrequently from India. Majority of the cases have been reported from Japan, Korea, China and the Middle East.[2]

Drugs like colchicine, cyclophosphamide, chlorambucil, corticosteroids, azathioprine, levamisole, acyclovir and cyclosporin have been tried in the treatment with variable results.[1] Dapsone was used and found to give good results.[3,4] We are reporting a case treated with corticosteroids and dapsone with excellent results.

Case Report

A 48-year-old female reported to Goa Medical College with intermittent, moderate grade fever of 1½ months duration, crops of painful erosions and ulceration on the hard palate, buccal mucosa and vulva of 15 days duration and skin eruptions of 8 days duration. The mucous membrane erosions and ulcers varied in size from 0.5 to 1 cm having greyish white slough in the floor with an erythematous halo in some of them. Patient had scanty, generalised skin eruptions consisting of discrete or grouped, erythematous papules, vesicles and pustules. There was no involvement of the eye. Systemic examination was within normal limits.

Investigations revealed a haemoglobin of 12 gm%, total leucocyte count was 10,700/cumm. The differential count showed neutrophils 90%, lymphocytes 9% and eosinophils 1%. The ESR was 49 mm/1st hour. The liver function and kidney function tests were within normal limits. X-ray of the chest did not reveal any abnormality. We noticed pustules at injection sites which denoted pathergy.

The condition was controlled with 60 mg of prednisolone (1 mg/kg). However attempts to reduce the dose of prednisolone led to flare up of skin and mucous membrane lesions. On adding dapsone 100 mg twice a day the disease was controlled and prednisolone could be slowly tapered and withdrawn in a span of 4 months. A maintenance dose of 50 mg of dapsone per day kept her symptom free for further 6

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months. Withdrawal of dapsone on her own 2 months ago led to a relapse, necessitating reintroduction of dapsone in a dose of 100 mg per day. Patient is well under control for last 1½ months and is being followed up.

Discussion

The diagnosis of Behcet's disease in our case was based on the presence of 3 major criteria-oral ulcers, genital ulcers and skin lesions. Pathergy, a characteristic finding in Behcet's disease, further confirmed our diagnosis. In the initial stages the condition was brought under control with corticosteroids however high maintainance doses were required. With the addition of dapsone, corticosteroids could be completely withdrawn and the patient remained symptom free. The withdrawal of dapsone resulting in a relapse and the reintroduction controlling the condition suggested the active role of dapsone in Behcet's disease.

Dapsone is an easily available, cheap and comparatively safe drug. Sharquie,[3] and Convit et al[4] have found good results using dapsone in Behcet's diaease. It merits further trials and may become the drug of choice for Behcet's disease.

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