Coronary artery ectasia in a patient with Behçet’s disease

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Case Report. A 36-year-old female, diagnosed with Behçet disease since she was 30 years old, with recurrent oral aphthae, genital ulcer, and iridocyclitis, developed angina pectoris. She had class II (Canadian Cardiovascular Society) angina. The Behçet’s disease had been controlled with colchicine (1.5 mg/day) and corticosteroid (2 mg/day). On physical examination, she was afebrile, pulse rate was 76 per minute and blood pressure was 120/80 mm Hg. Cardiovascular system examination was normal. Her chest x-ray, liver, and kidney function tests were normal. C reactive protein concentration was raised; antinuclear antibody and anti-DNA tests were negative. Her human leucocyte antigen-B5 and pathergy tests were positive. Electrocardiogram demonstrated ST-T changes in the anterior derivations. Normal anterior wall motion was shown on transthoracic echocardiogram. Coronary angiography showed ectasia of the coronary artery (20 mm x 8 mm), proximally including the left anterior descending artery and circumflex coronary artery, beginning from the ending of the left main coronary artery (Figure 1). She was not considered a candidate for surgery, and was discharged on corticosteroids, colchicine and antiaggregant treatment.

Discussion. Arterial lesions of Behçet’s disease may present as an occlusive disease, an ectasia, or a combination of the occlusive lesion and aneurysm. The prevalence of coronary involvement in Behçet’s disease is 0.5%. Coronary aneurysms are more frequent than stenotic lesions. Aneurysms are believed to occur due to weakened adventitia secondary to lymphocyte infiltration to the vasa vasorum. Aneurysms have poorer prognosis than occlusive disease in Behçet’s disease because of the risk of rupture. The aneurysms most often involved are the aorta, and pulmonary arteries, followed by femoral, subclavian, and common carotid arteries. Involvement of the coronary arteries is very rare. Behçet’s disease continues with remissions and attacks. There is still no definite medical treatment. Frequent monitoring of the inflammatory markers, including C-reactive protein and white blood cells, are essential for the management of Behçet’s disease. The most common approach is the use of immunosuppressive agents. These include...
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Corticosteroids, cytotoxic agents, and cyclosporine. The dose of corticosteroid must be adjusted appropriately.

In conclusion, young patients presenting with any type of arterial ectasia should also be investigated for Behçet’s disease, among other etiologies.

References


Case Reports

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