

Practical Guideline for General Practitioners (GP) to Approach to the Patients Suspected to have Behcet's Disease

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Letter to Editor

Behcet's Disease (BD) is a chronic inflammatory multisystem disease belongs to the Vasculitides with small, medium and large sized vessel involvement [1, 2]. This disorder is characterized by oral aphthosis, genital aphthosis, ocular inflammation, skin lesions, vascular involvement, positive Pathergy test and HLA-B51 positivity [3].

There are six key items for approaching towards Behcet's Disease (BD) including:

- Oral Aphthosis
 - Genital Aphthosis
 - Dermal Aphthosis
 - Erythema Nodosum
 - Pseudofolliculitis and/or Pustular lesions in skin
 - Eye inflammation; ocular pain and/or ocular redness and/or blurred vision and/or the floaters in visual field.
- In the presence of oral aphthosis only in a patient he/she has to be referred to a Rheumatologist by GP when there is an indication for evaluation of it (for more information, please look at my presentation regarding approach to oral aphthosis via https://www.researchgate.net/publication/307605807_Approach_to_Oral_Aphthosis).
- In the presence of each items of genital aphthosis or dermal aphthosis or erythema nodosum in a patient he/she has to be referred to a Rheumatologist by GP too.

- In the presence of pseudofolliculitis and/or pustular lesions without any other items in a patient; he/she has to be referred to a Dermatologist by GP.
- In the presence of ocular pain and/or ocular redness and/or blurred vision and/or the floaters in visual field without any other items in a patient; he/she has to be referred to an ophthalmologist by GP.
- If there are at least 2 items of the above mentioned in a patient; he/she has to be referred to a Rheumatologist by GP.
- If there is not any item of the above mentioned, the GP should forget about BD for the time being.

In the case of pseudofolliculitis and/or pustular lesions without any other items the patient has to be evaluated, managed and followed by Dermatologist with or without the cooperation of an infectious disease specialist. When each one of other above items could be appeared along with pseudofolliculitis and/or pustular lesions, then the case has to be introduced to a Rheumatologist by Dermatologist.

When scleritis and/or uveitis and/or retinal vasculitis could be detected in the patient referred to ophthalmologist, then he/she has to be introduced to a Rheumatologist with all of the details of eye examination report. The presence of scleritis alone is not enough for evaluation of the patient regarding BD, but all types of uveitis and/or retinal vasculitis need to be evaluated for BD if no other diagnosis can better explain them.

In the case of erythema nodosum without any other items the patient has to be evaluated, managed and followed by Rheumatologist with or without the cooperation of an infectious disease specialist. When each one of other above items could be appeared along with erythema nodosum the Rheumatologist has enough reason to approach to the patient for BD.

The Rheumatologist after a complete history and physical examination has to write a problem list regarding the patient including all above items, vascular lesions, cardiac, articular, neurological and gastrointestinal features and so on.

The problem list has to be completed by doing a Pathergy test and checking HLA-B51 by Rheumatologist. Finally if no other diagnosis can better explain the presence of above items and in the presence of at least 4 points out of 13 by application of “2015 Persian Gulf Criteria” [3] the diagnosis of Behcet's Disease can be established much earlier than every other classification criteria of BD including ISG, ICBBD and ICBBD revised.

References:

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2. Davatchi F. Diagnosis/Classification Criteria for Behcet's Disease. *Patholog Res Int*. 2012; 2012:607921.
3. Salehi-Abari I. 2015 Persian Gulf Criteria for Early Diagnosis of Behcet's Disease. *Open Science Journal of Clinical Medicine*. 2015; 3(5):188-190.