Giant Oral Ulcers of Behçet's Disease Mimicking Squamous Cell Carcinoma

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Sir,

Behçet's disease (BD) is a chronic systemic vasculitis characterized by oral and genital aphthae, arthritis, cutaneous lesions, ocular, gastrointestinal and neurological manifestations (1, 2). The diagnosis of BD is based on clinical criteria established by the International Study Group (ISG) (3). Oral ulcers are the most frequent findings and therefore are important clinical criteria for diagnosis. We report here a case of BD with chronic, large and destructive ulcers of the lower lip, clinically mimicking squamous cell carcinoma (SCC).

CASE REPORT

A 39-year-old man presented with a 3-year history of continuous, debilitating ulcers of the lower lip. The patient had been referred to another hospital in October 2001 with recurrent oral and genital aphthae and a large, non-healing ulcer on his lower lip, suggesting a SCC. A biopsy specimen taken from the labial ulcer had shown regenerative epithelial changes with epithelial hyperplasia, and a dense mixed inflammatory infiltrate. The pathergy test was negative. He had no evidence of ocular or neurological diseases. Although the histopathological features were non-specific, the ulcer was regarded as a low grade SCC clinically and the patient was referred to the plastic surgeons for total excision of the lesion. The presence of oral and genital ulcers led to a diagnosis of incomplete BD, and colchicum 1 mg/day was administered. As healing was slow, he was switched to oral prednisolone. However, the patient did not comply with the recommendations and was lost to follow-up.

In May 2003, the patient was admitted to another dermatology clinic with the same manifestations. BD was again suspected and the large labial ulcer was diagnosed as SCC on the basis of clinical findings. The second biopsy specimen from the lower lip showed a moderately dense inflammatory infiltrate and findings consistent with a chronic, non-specific ulcer. Histopathological features suggestive of malignancy were not present. The patient was placed on colchicum, but failed to use the medication regularly and did not come to control visits. Nine months later, he was seen as an inpatient at the Plastic Surgery Clinic of our hospital, where plastic reconstruction of the giant ulcers of the lower lip was planned. Examination revealed large and deep, irregular ulcers, covered by a yellow-grey membrane (Fig. 1A). The ulcers made speaking and chewing difficult. The lesions had caused considerable loss of tissue with the commisures of the lips disappearing. As the mouth could not be closed completely due to the ulcers destroying the normal contour of the lip, a constant hypersalivation was present. In addition to the described ulcers, multiple aphthae were seen on the tip of the tongue and buccal mucosa. Oral hygiene was very poor, with dental caries, dental plaques and halitosis. On genital examination, multiple superficial ulcers and scars on the scrotum and penile shaft were found. He also had papulopustular lesions and ulcers resembling aphthae, on the right supraclavicular area. The pathergy test was again negative. A biopsy specimen obtained from one of the papulopustular lesions showed a spongiotic dermatitis, acute superficial folliculitis, small vessel vasculitis and a mixed inflammatory infiltrate including lymphocytes, neutrophils and histiocytes. Ophthalmological and neurological examinations revealed normal findings. However, cranial magnetic resonance imaging revealed multiple focal, perivascular hyperintense areas in the white matter compatible with vasculitis.

Clinical and histological findings met the ISG criteria for BD. As the features of two separate biopsy specimens obtained at different times revealed non-specific findings and were not consistent with SCC, the labial ulcer was regarded as a destructive oral ulcer of BD. The patient was administered

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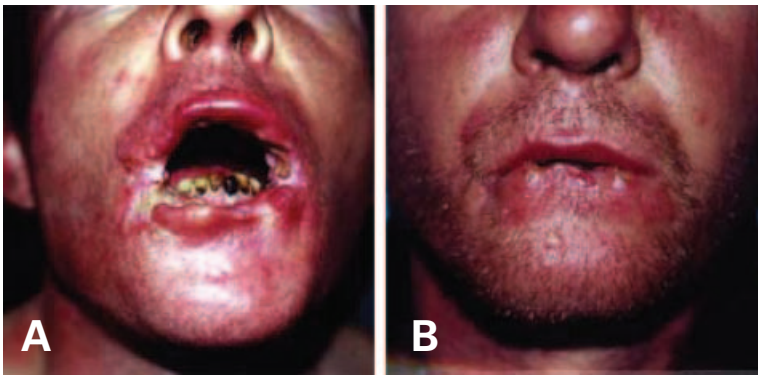

Fig. 1. (A) Large destructive ulcers on the lips before treatment. (B) After treatment with corticosteroids, the lesions healed with scarring.

methylprednisolone 48 mg/day and the ulcers healed dramatically after only 4 weeks of treatment (Fig. 1B).

DISCUSSION

As there is no specific test, clinical criteria are used for the diagnosis of BD. The ISG criteria are the currently accepted diagnostic criteria for BD, which require the presence of oral ulcers in addition to two of the criteria including recurrent genital ulceration, eye lesions and skin lesions (3). Our patient fulfilled the ISG criteria, having oral and genital aphthae and papulopustular lesions with histologically proven vasculitis.

Oral aphthae in BD are typically painful, 2–10 mm or larger, usually superficial and sharply circumscribed with a yellow fibrinoid base and a surrounding red halo. Genital ulcers usually occur on the scrotum and penis in men, and on the vulva in women. They are morphologically similar to the oral ulcers, but are usually deeper and larger with a tendency to leave scars. In women, these ulcers may lead to deep destruction of vulva, fenestration of labia minora or labial perforation (2, 4, 5). The cause of the clinical differences between oral and genital ulcers remains to be explained. However, it may be speculated that anatomic features and microbial flora of these parts contribute to the scarring tendency.

Patients with chronic and destructive oral ulceration present a challenge; the diagnosis is sometimes difficult. As our patient had non-healing, progressive and destructive oral ulcers, this led us to consider Sutton's ulcer, pyoderma gangrenosum, SCC and extraordinarily large oral ulcers of BD.

Various kinds of cutaneous lesions have been described in BD, including pyoderma gangrenosum-like lesions (2, 4). The difference between the true pyoderma gangrenosum and pyoderma gangenosum-like lesions of BD is not clear. Indeed, there are several case reports describing pyoderma gangrenosum associated with BD (6, 7). In either case, the ulcers have characteristic clinic manifestations including ragged and undermined borders, a dusky red or purple peripheral rim, a boggy base with purulent and haemorrhagic exudate, partially covered by necrotic eschar.

In our case, the exclusion of a malignant disease seems to be the most important feature of a differential diagnosis. Although the clinical appereance was highly suggestive of SCC, repeated biopsies did not yield evidence of malignancy and the lesions showed a rapid and dramatic response to steroid therapy, so we were able to eliminate SCC. It may be speculated that SCC may originate in a chronic BD ulcer similar to other chronic ulcers predisposing to develop malignancy. However, in a recent literature search, we could not find an example of this relationship.

The oral ulcers in our patient may be considered as analogous to the destructive genital ulcers of BD. Immunological disturbances and hypersensitivity to oral bacteria have been implicated in the pathogenesis of Sutton's disease as in BD (8). We think that the poor oral hygiene seen in our patient may have contributed to the development and/or persistence of lesions.

In conclusion, chronic, severe and destructive oral ulceration in BD may mimic oral SCC. These ulcers, which are analogous to vulvar destructive ulcers seen in BD, may be considered as Sutton's ulcers associated with BD.

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