Erythema nodosum-like lesion on heel in a patient assumed Behçet's disease

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DESCRIPTION

A 35-years-old Japanese man was evaluated for fever and right heel pain. One year prior, he had an episode of fever, stomatitis, oligoarthritis, lumbago and blurred vision. Despite the extensive investigations, he only had a diagnosis of uveitis with unknown aetiology and all the symptoms remitted without specific treatments during a month. One month prior, his fever and the symptoms recurred and right heel pain was gradually emerged. Local physicians gave him oral antibiotics and nonsteroidal anti-inflammatory drugs (NSAIDs) under the working diagnosis of heel cellulitis, but the lesion was persisted. He denied dyspnoea, cough, chest pain, abdominal pain, diarrhoea, heel injury, genital ulcers and the other skin lesions.

At the time of presentation, he was afebrile with oral diclofenac. Eyes were slightly congested. On examination of right heel, there was a 5-cm circular, poorly demarcated and erythematous lump (figure 1). MRI without contrast revealed heel panniculitis without osteomyelitis nor thrombophlebitis (figure 2). Ophthalmologist diagnosed bilateral panuveitis, and blood test showed the positivity of HLA-A*26 and B*51. His all episodes were explained by Behçet's disease (BD) depending on the panuveitis, aphthous stomatitis, arthritis and HLA typing. The heel lesion was assumed to be an atypical erythema nodosum (EN) or an EN-like lesion as a result of vasculitis, for example, phlebitis. Diclofenac was switched to colchicine. Fever and the heel pain were remitted but adalimumab was added to control panuveitis. After 2 months, he

Figure 2 T2-weighted short-tau inversion recovery image of the heel. Subcutaneous fat tissue on medial side of right heel shows high signal intensity (arrows), which is consistent with panniculitis. Surrounding fascia also shows high intensity but no signal changes in bones or vessels.

had no symptoms and the heel lesion diminished completely.

BD is a systemic inflammatory condition triggered by undetermined complex aetiology in genetically predisposed individuals.¹ The concept of disease was established in 1937 by a dermatologist, Hulusi Behçet.² In spite of the history, skin lesions of BD are often not easy to distinguish from the lesions caused by other aetiologies. This is because large variety of skin manifestations can occur in BD, including pseudofolliculitis, pyoderma gangrenosum and EN-like lesions caused by vascular involvement.³ We could not easily accept his lesion as 'single EN on heel', as it is scarcely reported in literatures.³⁻⁵ MRI sometimes help to reveal the presence of vasculitis on foot,⁶ but did not in this case. Biopsy was considered but not performed because it is invasive and we thought other clues including panuveitis are enough to classify him as BD.

There are at least 17 diagnostic/classification criteria for BD which have various diagnostic sensitivities and specificities.⁷ His presentations met some of these criteria including Japanese one, and not others including International Study Group diagnostic criteria unless we regard the heel lesion as consistent with BD.⁸ It is still important to accumulate atypical dermatological findings of BD for

Figure 1 The erythematous lesion on right heel (arrow).

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further better diagnostic procedure, even though many decades have passed since the name was established.

Patient's perspective

All doctors I met before called the heel 'cellulitis', but antibiotics were not effective. So, I was relieved to be diagnosed.

Learning points

- ▶ A patient who has an unusual painful erythematous lesion with panuveitis may be Behçet's disease (BD).
- ▶ Skin findings are keys to diagnose BD, although it is often difficult to distinguish typical ones from others caused by different aetiologies.
- ▶ For an atypical erythema nodosum-like lesion, skin biopsy is the gold standard to investigate underlying causes, but MRI may be a non-invasive alternative to add a diagnostic information.

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