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OPHTHALMOLOGICAL MANIFESTATIONS OF BEHÇET'S DISEASE IN ADOLESCENCE (CLINICAL CASE)

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Abstract:

This paper presents a rare clinical case of ophthalmic manifestations of Behçet's disease in adolescence. The patient was diagnosed with recurrent anterior uveitis based on a comprehensive multidisciplinary evaluation. Treatment included pulse therapy with glucocorticoids, immunosuppressive and supportive therapy, leading to clinical improvement. This case highlights the importance of early diagnosis and multidisciplinary approach in the management of uveitis associated with Behçet's

Keywords:

Behçet's disease, uveitis, adolescents, clinical case, ophthalmic manifestations.

Introduction

Behçet's disease is a systemic autoimmune disorder of unknown etiology, characterized by involvement of the skin and mucous membranes, eyes, joints, gastrointestinal and urogenital tracts, and the central nervous system [1–3,7,9]. One of the most severe ophthalmological manifestations of the disease is uveitis, which carries a significant risk of vision loss [4–6,8]. Uveitis develops in 50–70% of patients and is considered the leading cause of disability due to marked reduction or complete loss of vision [6,8]. The disease is typically characterized by recurrent bilateral uveitis, often of granulomatous nature, which may be accompanied by iridocyclitis, retinitis, and retinal vasculitis [5,8]. In adolescence, Behçet's disease often follows a more aggressive inflammatory course, with a high risk of complications such as cataract, secondary glaucoma, and irreversible changes of the retina and optic nerve, thereby necessitating early comprehensive therapy [3,8,9]. Early diagnosis and a multidisciplinary approach to management are crucial for preserving visual function and improving quality of life [2,5,9].

Objective of the Study. This report presents a clinical case of a rare course of Behçet's disease with ophthalmological manifestations in adolescence.

Materials and methods. Patient H., a 19-year-old male, presented to the Ophthalmology Department of the Gulistan Medical Cluster with complaints of pain, redness, and decreased vision in both eyes. Clinical, laboratory, and ophthalmological examinations were performed.

The patient was also evaluated by related specialists — a rheumatologist, otolaryngologist, dermatologist, urologist, dentist, and immunologist.

Results and discussion. According to the history, at the age of 13–14 years the patient developed prolonged pain and decreased vision in the right eye. Anterior uveitis was diagnosed locally, and symptomatic treatment was prescribed, which led to partial relief of symptoms. Currently, over the past three days, he developed complaints in both eyes, including photophobia, tearing, decreased vision, and ocular pain. The patient also reported frequent relapses of aphthous stomatitis, skin rashes, and arthralgia. On examination, the general condition was relatively satisfactory; however, nodular erythema of the skin and tenderness in the knee joints were noted.

Ophthalmological findings. Right eye (OD): Visual acuity 0.02 uncorrected. Conjunctiva and sclera: mixed injection with predominance of ciliary vessels. Cornea: moderately edematous with endothelial precipitates (mainly inferior). Anterior chamber: moderate depth, opalescent fluid with suspended cells and floating exudate. Pupil: irregular due to posterior synechiae, weak photoreaction. Iris: sectoral depigmentation. Lens: partially opaque in the optical zone. Vitreous body (by ultrasound): increased echogenicity, attached retina. Fundus not visualized due to corneal edema and lens opacity. Left eye (OS): Visual acuity 0.08 uncorrected. Conjunctiva and sclera: mixed injection with predominance of ciliary vessels. Cornea: mildly edematous with small precipitates. Anterior chamber: moderate depth, opalescent fluid. Pupil: deformed (posterior synechiae), sluggish light reaction. Lens: partially opaque in the optical zone. Vitreous body (by ultrasound): increased echogenicity, moderate degeneration, attached retina. Fundus not visualized due to corneal edema and lens opacity. OU: Intraocular pressure within normal limits.

Laboratory findings. Normocytic anemia (Hb 115 g/L), leukocytosis (WBC 14 × 10^9/L), elevated ESR (35 mm/h); CRP elevated (21 mg/L); HLA-B51 positive; ANA and RF negative. Skin pathergy test positive. Based on the clinical picture, specialist consultations, and differential diagnosis with other syndromic uveitis, the final diagnosis was: Behçet's disease, moderate activity. OU — recurrent anterior uveitis complicated by incomplete cataract.

Treatment (according to clinical protocol) - **Local (OU):** instillations of 0.1% dexamethasone eye drops according to regimen, mydriatics.

Systemic: Methylprednisolone 500 mg IV drip for 3 days (pulse therapy), followed by oral prednisolone 0.5 mg/kg/day; Azathioprine 50 mg twice daily; Colchicine 1 mg/day; Omeprazole once daily. Dynamics: On days 3–4 — decreased photophobia, tearing, and pain; improved anterior chamber transparency. On days 7–10 — reduced inflammatory activity, improved pupillary light reaction, partial resolution of synechiae. By day 14 — stable positive dynamics, no new inflammatory signs. Visual acuity: OD 0.03 uncorrected; OS 0.3 uncorrected. The patient was discharged for maintenance outpatient therapy.

Conclusion

Against the background of complex therapy, a positive clinical response was achieved. This case highlights the importance of early multidisciplinary diagnosis and targeted treatment of uveitis in Behçet's disease, especially in young patients [2,5,9], which significantly increases the likelihood of preserving vision and preventing disability.

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