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Vasculitis and oral and genital ulcers: Behçet´s syndrome or HIV infection?

Sir,

Rheumatic diseases in the course of human immunodeficiency virus (HIV) infection are not common. Septic arthritis and psoriatic arthritis are the most frequent rheumatic syndromes described (1, 2). Vasculitis is being increasingly reported in the setting of HIV infection. Behçet's syndrome is a disease with protean vasculitic manifestations that has been occasionally described in association with HIV infection (3-6). We present a case of Behçet's syndrome and HIV infection.

A 40-year-old Caucasian woman was admitted to hospital with a 15-day history of swelling and pain of the right ankle, right knee and right wrist. She complained of recurrent oral and genital ulceration. Her past medical history revealed that she used to be an intravenous drug abuser (heroin). She abandonned the habit 5 years ago.

On physical examination there were erythematous papules, vesicles and ulcers (0.5 cm in diameter) on both arms and legs. Several ulcers were noted on the buccal mucosa and vagina. Arthritis was present on the right knee, ankle and wrist. The rest of the physical examination was normal.

Laboratory findings included: ESR 60 mm/hr, haemoglobin 99 g/L, and leucocyte count 7.02 x 10^9/L with a normal differential. Electrolytes, BUN, creatinine and a liver function test were within the normal range. Rheumatoid factor (nephelometry) and antinuclear antibodies (rat substrate) were negative. HLA was not determined. Pathergy was not present. A chest x-ray was normal. Knee aspiration yielded a yellow fluid with 1840/mm^3 WBC (6% polymorphonuclear, 15% lymphocytes, 79% monocytes). Crystals were not observed and a culture was negative. A skin biopsy was performed and microscopic examination showed a leukocytoclastic vasculitis. HIV serology (enzyme linked inmunosorbent assay and Western blot analysis) was positive and CD4 lymphocytes were 174 mm^3. Plasma HIV-1 RNA (Amplicor, Roche Molecular System, Inc., Madrid) was of 357.476 copies/ml. Cultures from the genital ulcers were negative. Biopsy of the oral ulcers showed an eroded epidermis and lymphocytic and monocytic inflammatory infiltrates in the dermis. There was no evidence of malignancy or infection. An ophthalmological examination was normal.

Treatment with prednisone (40 mg daily) was begun and her symptons improved quickly. Retroviral treatment with estavudine, amivudine and indinavir was added. When prednisone was tapered to 10 mg, the arthritis and oral and genital ulcers recurred.

The association of Behçet's syndrome and HIV infection is rare. We performed a literature search (Medline 1985-1997) and found 4 other cases (3-6), whose characteristics are summarized in Table I. All patients fulfilled the international criteria for Behçet's disease, except for the one reported in reference 5 (oral and genital ulcers) (7). The association of Behçet's syndrome and HIV infection is controversial. The two diseases share many clinical features, namely arthritis, oral and genital ulcers and vasculitis. Interestingly enough, in a Spanish study HIV serology (ELISA) was performed on a cohort of 23 patients with Behçet's disease and negative results were obtained in all cases (8). There are no epidemiological studies to suggest an association between the two diseases, but considering the cases reported in the literature, an association between HIV infection and Behçet's disease may exist (3-6).

Table I. Characteristics of patients with Behçet's disease and HIV infection.

	Age	Sex	Race	Transmission	Stage
Reference 4	33	male	white	heterosexual	B1
Reference 3	25	male	white	i.v. drug abuser	A2
Reference 5	69	male	white	heterosexual	A2
Reference 6	27	female	black	heterosexual	B3

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Highly positive dsDNA antibodies in minocycline-induced lupus

Sir,

We read with great interest the cases reported by Knights *et al*. dealing with the condition of minocycline-induced arthritis (1). We would like to report the first case of minocycline-induced lupus associated with high titers of dsDNA antibodies.

A 22-year-old female was admitted in August 1997 for a four-week history of jaundice and abdominal pain. Her past medical history included facial acne for which she had been taking minocycline 100 mg daily for 2 years. Two weeks before her hospitalization, she stopped minocycline on her own initiative because her acne was improving.

On admission she had no fever, arthralgia, myalgia, nor cutaneous involvement (except for a slight facial acne). Her physical examination was normal. Laboratory studies revealed acute hepatic cytolysis (ALAT 12N,