09/11/25 Morning Report with @CPSolvers

"One life, so many dreams" ***Case Presenter****: Ravi Singh (@rav7ks)* ***Case Discussants****: Rabih Geha (@rabihmgeha) and Jeffrey Shen (@)*

https://clinicalproblemsolving.com/present-a-case/

Scribing (Sarah B, Lera, and Seeme)

CC:19 year-old-woman with **recurrent oral ulcers** for 5+ years

HPI: Short ulcer-free intervals (few months at most).

- 7 years prior, had idiopathic urticaria challenging to manage. Despite dietary elimination and antihistamines of multiple allergies, she continued to experience periodic urticaria.
- At 14 had a two week tongue ulcer and lip ulcer. A possible metal allergy to braces was considered, and her braces were removed in 2020, but symptoms did not improve.
- In 2021, she developed two large non healing tongue ulcers with neuropathic pain with associated neck spasms.

Steroids and colchicine were ineffective.

Presumptive Tx of HSV did not resolve ulcers.

ROS: IBS-like symptoms, arthralgias (knees/wrists), alopecia, ear pain, headaches, lymphadenopathy, SOB, digital cyanosis, fatigue.

PMH:
Oral ulcers/pain

Meds:
Colchicine, steroids, clonazepam, fluoxetine, lidocaine, vitamins, pregabalin, cetirizine

Fam Hx: None

Health-Related Behaviors:

Allergies:
Egg Whites
Tree Nuts,
Seasonal Allergies
No Known Medication Allergies

Vitals: T: 36.6 **HR: BP: RR: Sat: BMI:** 21

Exam: General/Communication: The patient is well developed with normal communication ability and normal voice for age.

Oral/Oropharynx: Oral cavity shows moist mucous membranes. Normal dentition for age. Dorsal tongue fissure present with clean edges. It is more shallow and shorter than on prior exams.

No other exam abnormalities identified.

Notable Labs & Imaging:

Hematology: WBC: 11 (Neutrophils 9.6, nl 5.8) Hgb: 12.3 Plt: 245

MCV: 83

Chemistry: Na: nl K: nl Cl: nl HCO3: nl Cr: BUN: nl Glucose: Ca: Mg: AST: nl ALT: nl Alk-P: nl Bili:nl Albumin: 4.5 Total Protein: 7.4, Globulin: 2.9

ESR: 36 CRP: <1 LDH:

Autoimmune labs: ANA Indirect IF Assay Negative, anti-DNA -, anti-RNP -, anti-Smith -, anti-Scl-70 -, SSA/SSB -, anti-Jo-1 -, anti-Centromere -, ANCA -, RF -, thyroid panel normal, fecal calprotectin nl, tissue transglutaminase IgA nl

Other Advanced Labs/Testing:

Biopsy Results: ulcerative granuloma with stromal eosinophilia (TUGSE), CD163+, CD-31, EBER ISH neg, hyperkeratosis

Upper and Lower Endoscopy: Only identified gastritis (H. pylori negative). Colonoscopy, and capsule endoscopy, without significant findings.

NGS: HLA B51 (+)

Dx: ? Behcet's disease (unconfirmed diagnosis)

Problem Representation: This is a 19 year-old-woman with past medical history of recurrent oral ulcers which occur with systemic symptoms of arthralgias and lymphadenopathy, found to have CD163+/31+ cells and TUGSE on ulcer biopsy and NGS showing HLA B51+ consistent with a diagnosis of Behcet's disease (unconfirmed).

Teaching Points (Anmolpreet):

I] Oral ulcers: *important to look out for→ appearance, depth, heals or persists, areas of necrosis seen, systemic features.* ***Common oral ulcers***: aphthous ulcers (can recur); **Recurrence**:- imp to look for recurrent exposure (infections/toxins) leading to the presentation. Some conditions can come in waves just like Pel Ebstein fever in Hodgkin's lymphoma. When it is recurring, important to note if pt has cumulative consequences of that recurring episodes or simply inconsequential episodic disease.

Lymphadenopathy and non-healing ulcers: red flags!

II] ***Differential diagnosis:*** **1. Aphthous ulcer major:** severe form of recurrent aphthous ulcer; larger, deeper, more painful, last longer, scarring; 2. **Behcet's ds** : genital examination would help, look for ulcers; 3. **SLE** and Rowell Syndrome; 4. **Gastrointestinal:** IBD (UC/CD), GI histoplasmosis, sarcoidosis, celiac ds; **5. Primary dermatologic:** pemphigus vulgaris, epidermolysis bullosa

Surface involvement seen, internal organs - a mystery till now!

III] Predominant apparent mucosal involvement: Behcet's disease, a form of vasculitis; question lingers if it is a disease localised to mucosa or a systemic disease with prominent mucosal fingerprint.

Next steps: histological exam of lesion and radiographic exam of the body.

IV] Ulcerative granulomatous disease in mouth: Crohn's disease (fecal calprotectin), granulomatous vasculitis, sarcoidosis (non caseating)

Look for reticuloendothelial involvement; focus on vasculitis!

V] TUGSE: traumatic ulcerative granuloma with stromal eosinophilia

EGPA (history of allergy/asthma present)- 50% cases can be ANCA negative

Sarcoidosis (Melkersson Rosenthal syndrome)/ Langerhans cell histiocytosis / Drug induced reaction or a potential source of chronic trauma

VI] HLA B51: strongly associated with an increased risk of developing Behcet's disease

It can't fully explain the presentation, but response to treatment would help!!

Look for immunodeficiencies! Rx options: Dapsone, DMARD; ++ IBD-associated