Non Healing Axillary Abscess

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Presenting complaints

40 year old female, resident of delhi

- Pain and swelling in right axilla * 20 days
- Multiple ulcers in mouth * 20 days

History of Presenting Illness

She was a known case of

1. Hypothyroidism for 3 years - Thyronorm 25 mcg

2. Rheumatoid arthritis (RA factor and Anti CCP positive) on Methotrexate and HCQ for last 3 years

Vitals

PR – 100/min

BP – 120/70 mmHg in right arm in supine position

SpO2 – 97 % on room air

Temperature – 100 F in left axilla

Systematic examination

CNS – conscious, oriented in TPP, No FND

CVS – S1, S2 were present, No added sounds

Respiratory system – B/L air entry present, No added sound

Per abdomen – soft nontender, No organomegaly

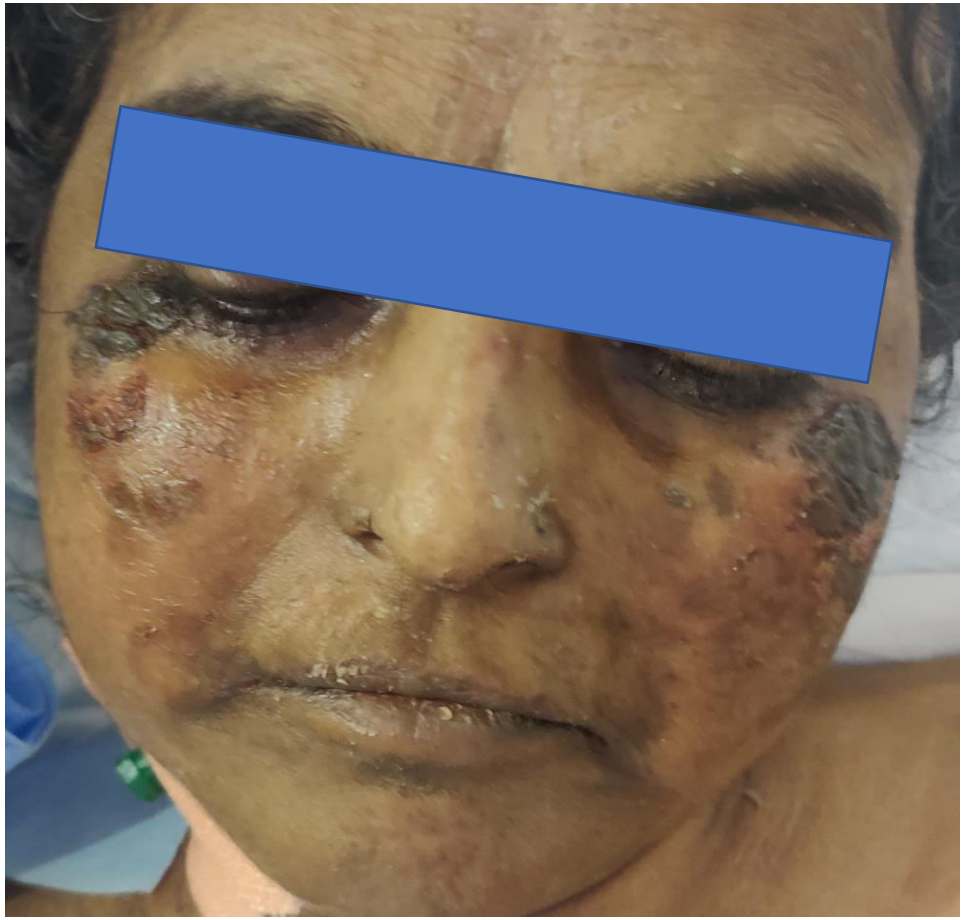
Local Examination

- A fluctuant, tender swelling with raised local temperature was present in the right axilla of size approx. 8*8 cm.
- A clinical diagnosis of Right axillary abscess was made.
- It was incised and drained and pus sent for culture and sensitivity.
- Pus C/S revealed Escherichia coli and Staphylococcus aureus.
- Antibiotics were upgraded as per sensitivity.

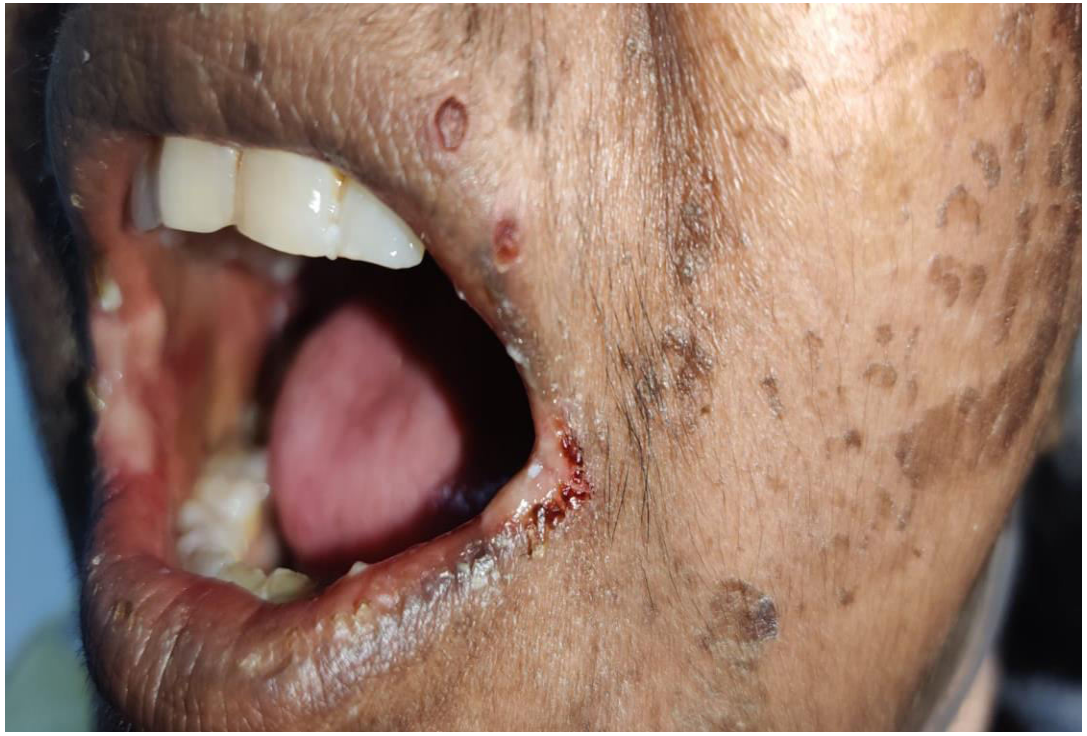
So was it just a case of

- Rheumatoid arthritis
- Hypothyroidism
- Right axillary abscess ?

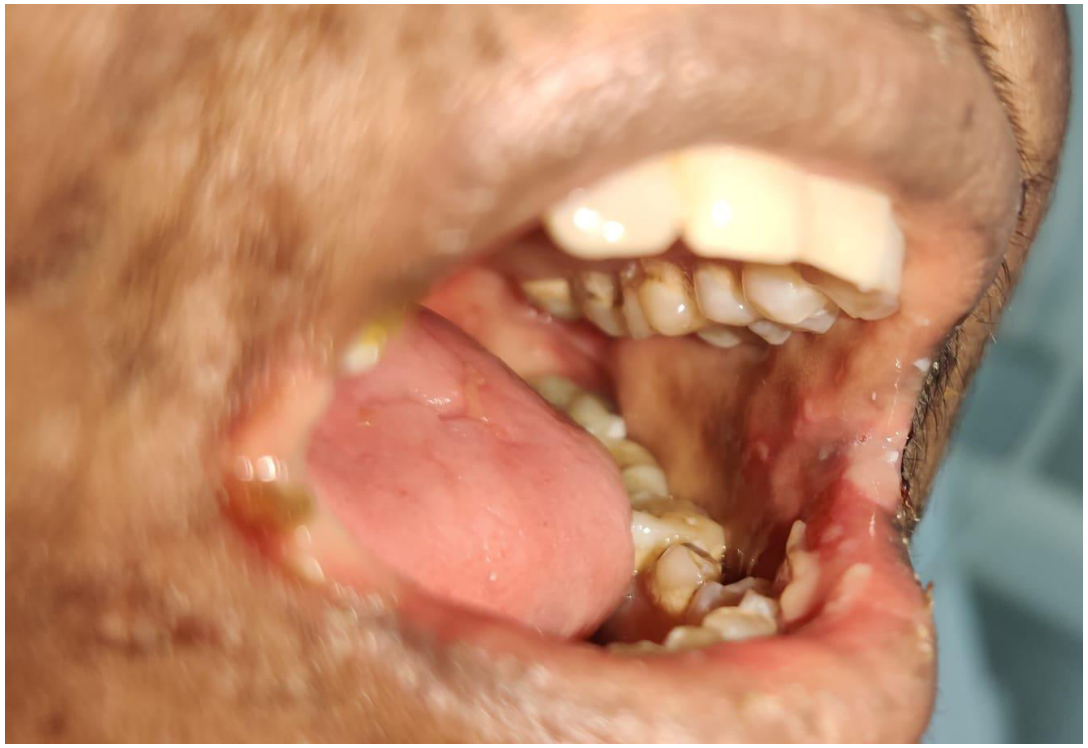
Other significant findings -



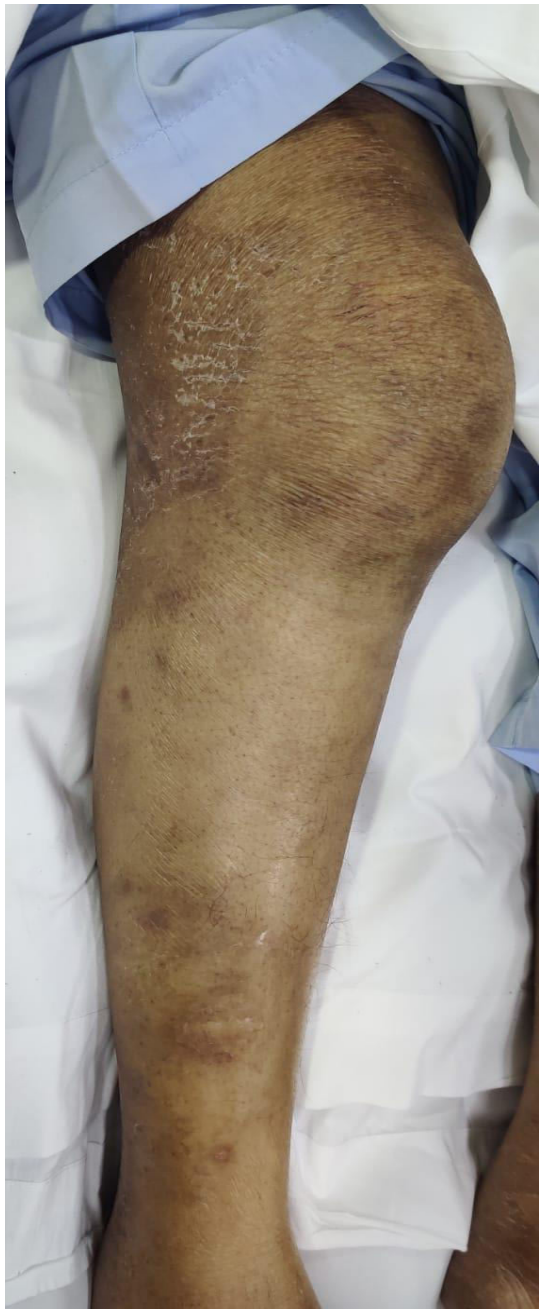
A) Ill-defined erythema with overlying hemorrhagic crusting and superficial ulceration over both cheeks



B) Multiple ulcers/excoriations involving the angles of mouth

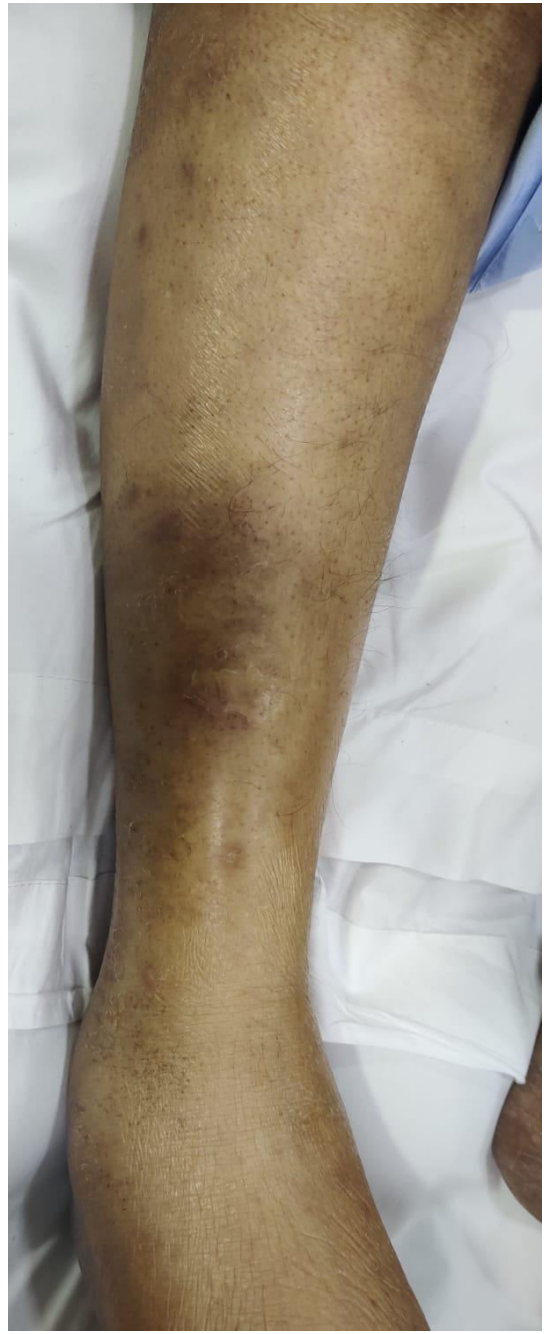


C) Multiple Ulcers in labial and buccal mucosa with white base and erythematous borders



D) & E)

Multiple healed nodules
with hyperpigmentation
over shin of tibia
non tender now
Were tender initially



Revisiting History

- She gave history of recurrent oral painful ulcers since last 10 years
- She also told about severe pain while passing urine for last 20 days
- There was similar episodes in the past but she never noticed any lesions

- On examination – Genital ulcers were present (photo not taken)

Opthalmology examination

- WNL
- No signs of Uveitis
- Normal cornea, fundus and macula.

Investigations

	Investigations	Values
CBC	Hb	8.2 gm/dl
	TLC	19.8 * 10^3/mm^3
	Platelets	230 * 10^3 thousand/mm^3
KFT	Creatinine	0.83 mg/dl
	Sodium	136 meq/l
	Potassium	4.5 meq/l
LFT	Billirubin (total/direct)	0.62/0.42 mg/dl
	SGOT/SGPT	17/14 IU/L
	ALP/GGT	82/31 IU/L
	TP/Albumin	6.06/2.1 gm/dl
ESR		119 mm/hr
CRP		246 mg/dl
Procalcitonin		5.2 ng/ml

Work up

- Viral markers were negative (HIV/HbsAg/HCV)
- RA factor – 28 IU/ml
- Anti CCP – negative
- Serum Methotrexate levels < 0.04 micromol/L

- ANA by IF was 1 : 80 positive Homogenous pattern.
- ANA profile – Scl 70 positive – very weak.
- Anti ds DNA – equivocal.
- c-ANCA and p- ANCA were negative.
- C3, C4 were normal.

Department of Pathology (Division of Histopathology - Immuno)

Name	: [redacted]	Age/Sex	: 40 Yrs/Female
Registration No.	:	Ward No.	:
Lab Request No.	:	Room No.	: 1380 /03
Episode No.	:	Location Type	: In Patient
Specimen	:	Collected On	: 25/11/2022 07:49AM
Referred By	:	Received On	: 25/11/2022 09:24AM
External Doctor	:	Reported On	: 26/11/2022 03:52PM
Location	: GENERAL & LAPAROSCOPIC SURGERY (UNIT I) - Dr. B.B Aggarwal		

Lab No: F-3983/22

Test Results for HEp2 IIFA / Anti Nuclear Antibodies by Indirect Immunofluorescence

Result: Positive
Pattern: Homogenous
Intensity: +
Titre: 1:80

Dr. Sunayana Misra
Associate Consultant Pathologist

Fluorescence Intensity: (+: Weak, ++: Moderate, +++: Strong, ++++: Very Strong Intensity pattern)

Pattern	Type of Antibody / Antigenic determinants	Disease Associations
Homogenous	DsDNA , Nucleosomes (Chromatin), Histones	SLE, Drug Induced LE, other Rheumatic diseases
Speckled	Sm, U1-RNP, SSA(Ro), SSB(La), Scl-70	SLE, Sjögren's Syndrome, Mixed Connective Tissue Disease, Evolving Rheumatic Disease, Scleroderma
SSA	SSA	Sjogren's Syndrome, SLE, Neonatal Lupus
Nucleolar	Fibrillarin, Pm-Scl, RNA Polymerase, NOR90, Th-To	Scleroderma, Scleroderma/Myositis
Centromere	CENP A, B, C	CREST form of Scleroderma
Nuclear Dots	Sp-100, MND, NSp-I	Primary Biliary Cirrhosis
PCNA	PCNA	SLE
Nuclear Membrane	Nuclear Lamins	Lupoid Hepatitis, SLE, RA
Cytoplasmic	Mitochondria, Actin, Vimentin, Golgi Appratus, Jo-1, Ribosomes	Autoimmune Hepatitis, Myositis, Primary Biliary Cirrhosis, SLE

Note: ANA is reported in low titres in a significant proportion of healthy population and results need to be correlated clinically. Autoantibodies may not always correlate with the observed pattern and confirmatory tests for positive results are recommended

Sir Ganga Ram Hospital
H-2008-0017
June 16, 2020 - June 15, 2023
Since June 16, 2008
MC - 2194

Department of Pathology (Division of Histopathology - Immuno)

Name	: [redacted]	Age/Sex	: 40 Yrs/Female
Registration No.	:	Ward No.	: ICU GW
Lab Request No.	:	Room No.	: ICUGW /05
Episode No.	:	Location Type	: In Patient
Specimen	:	Collected On	: 29/11/2022 12:38PM
Referred By	:	Received On	: 29/11/2022 02:56PM
External Doctor	:	Reported On	: 30/11/2022 03:38PM
Location	: GENERAL & LAPAROSCOPIC SURGERY (UNIT I) - Dr. B.B Aggarwal		

Lab No.: F-4036/22

Anti- ds DNA (ELISA)*

ABSORBANCE: 0.282 Abs

CONCENTRATION: 20.926 U/ml

INTERPRETATION: Suspicious

REFERENCE: Positive > 25 U/ml, Negative < 16 U/ml, Equivocal 16-24 U/ml.

Dr. Pallav Gupta
Consultant Pathology

HLA B 51

Positive

H-2008-0017
June 16, 2020 - June 15, 2023
Since June 16, 2008

Sir Ganga Ram Hospital

Histocompatibility and Immunogenetics Laboratory

Name	[redacted]	Age/Sex	: 40 Yrs/Female
Registration No.		Ward No.	: ICU GW
Lab Request No.		Room No.	: ICUGW /05
Episode No.		Location Type	: In Patient
Specimen		Collected On	: 29/11/2022 03:11AM
Referred By		Received On	: 29/11/2022 04:26PM
External Doctor	:	Reported On	: 02/12/2022 04:13PM
Location	: GENERAL & LAPAROSCOPIC SURGERY (UNIT I) - Dr. B.B Aggarwal		

DNA ANALYSIS FOR HLA-B Locus **HLA lab no.: HAM- 1799**

HLA – B*27 Allele **Absent (Negative)**

HLA – B*51 Allele **Present (Positive)**

Comment: The patient is **positive** for HLA-B*51 allele associated with Behcet's disease and **negative** for B*27 allele associated with ankylosing spondylitis & uveitis.

Dr.Monika Jain
Sr.Consultant & Incharge

Dr. Ratna D.Puri
Sr. Consultant &Director

International study group diagnostic criteria for Behcet disease

Recurrent oral aphthous ulcers (at least 3 times in one year)

Plus 2 of the following

1. Recurrent genital ulcers

2. Eye lesions (anterior or posterior uveitis or retinal vasculitis)

3. **Skin lesions (erythema nodosum, pseudofolliculitis, papulopustular lesions or acneiform nodules)**

4. Positive pathergy test

Final diagnosis

- Rheumatoid arthritis
- Hypothyroidism
- Right axillary abscess S/P Incision and drainage
- Sepsis
- Behcet disease

Why was the ulcer not Healing ?

- This was because of Pathergy phenomenon.
- Pathergy reaction is an enhanced inflammatory response observed in BD when traumatic insult or other types of inflammatory stimuli to the skin.[1]
- A more severe injury, such as a surgical procedure, can result in persistent ulceration in a patient with pathergy.[1]

Discussion

Behcet disease

- Systemic vasculitis

- First described by Turkish dermatologist – Hulusi Behcet
- Middle east , Mediterranean region
- Most prevalent in turkey (1 in 250 adults)

- 20 – 40 years of age
- M = F , More severe in males

- Crossroad of Autoinflammatory and Autoimmune disorders

System	Symptoms
1. Mucocutaneous	**Oral ulcers** – most common 1st to appear and last to go in the couse of disease Multiple, painful, well defined erythematous borders **Genital ulcers (75 %)**– most specific On scrotum/labia
2. Skin (75 %)	Acne like papulopustular lesions Nodular lesions – Erythema nodosum due to panniculitis and superficial vein thrombosis
3. Arthritis - 50 %	Mono or oligo arthritis – non erosive, non deforming
4. Eye - 70 %	Bilateral panuveitis Hypopyon in 10 % Male gender, Posterior compartment = Poor prognosis
5. Vascular – 40 %	Venous > Arterial Superficial or deep venous thrombosis, Budd Chiari syndrome, Inferior vena cava syndrome, pulmonary artery aneurysms (25 % mortality)
6. CNS – 5 %	Parenchymal(basal ganglion, brainstem and spinal cord) vs Non parenchymal(cerebral venous thrombosis)
7. GIT	Ulcers in Ileocecal region which resemble Crohns disease

Treatment

- Topical steroids
- Colchicine
- Oral glucocorticoids

- Immonusuppressants – Azathiopurine
- Apremilast
- TNF alpha inhibitor – Infliximab
- Inteferon alpha

Thank you

Keep Smiling