## CLINICAL CASE FOR RESIDENTS (IV)

## 29-year-old man with abdominal pain, ascites, and mucocutaneous lesions

### 1. Case Presentation

A 29-year-old man presents with 10 days of progressive abdominal pain, mainly in the right upper quadrant and epigastrium. The pain is moderate, pressure-like, non-radiating, and worsens with deep palpation. He reports abdominal distension, anorexia, nausea, evening low-grade fever, and migratory arthralgias of knees and ankles without swelling.

Over the past six months, he has experienced recurrent painful oral ulcers diagnosed as recurrent aphthous stomatitis; two episodes of unilateral red eye labelled as conjunctivitis; and, in the last two weeks, tender erythematous nodules over the anterior shins.

***Past medical history:***

- No chronic diseases

- Regular alcohol intake (30–40 g/day)

- No medications

- Family history: premature cardiovascular disease

- No recent travel or exposures

***Physical examination:***

- BP 118/72 mmHg

- HR 92 bpm

- Temperature 37.6 °C

- Abdomen: moderately distended; hepatomegaly 4 cm below the right costal margin; shifting dullness compatible with ascites; no peritonism.

- Skin/mucosa: healing oral aphthae; tender erythematous nodules on shins.

- Musculoskeletal: knee/ankle tenderness without swelling.

- Remainder unremarkable.

***Laboratory tests:***

AST 88 U/L (0–40)

ALT 102 U/L (0–41)

Alkaline phosphatase 310 U/L (40–129)

GGT 420 U/L (8–61)

Total bilirubin 2.1 mg/dL (0.2–1.2)

INR 1.3 (0.8–1.2)

Albumin 3.1 g/dL (3.5–5.0)

Total protein 6.2 g/dL (6.4–8.3)

CRP 28 mg/L (<5)

ESR 48 mm/h (<20)

CBC: no leukocytosis or anemia

Viral serologies (HBV, HCV, EBV, CMV): negative

Autoimmune liver antibodies: negative

Iron studies: normal

Renal function: normal

Chest X-ray: normal.

Abdominal X-ray: non-specific bowel loop distension.

Ultrasound: ascites and suspected hepatic venous outflow abnormality (requires confirmation).

## 2. Main Clinical Problem

Subacute abdominal pain with hepatomegaly, ascites, cholestatic liver enzyme elevation, systemic inflammation, and mucocutaneous manifestations — raising suspicion for a multisystem vasculitis, especially Behçet disease with large-vessel involvement.

## 3. Differential Diagnosis

***A. Budd–Chiari syndrome secondary to Behçet disease (most likely diagnosis)***

Supporting features:

- Hepatomegaly, ascites, and subacute abdominal pain.

- Mixed/cholestatic liver enzyme elevation.

- Systemic inflammation.

- Recurrent oral aphthae.

- Episodes of unilateral red eye suggesting possible uveitis.

- Tender erythematous nodules consistent with erythema nodosum.

- Migratory arthralgias without synovitis.

- Young male patient — classical profile for vascular Behçet.

- Ultrasound suspicion of hepatic venous outflow obstruction.

Key investigations:

- Doppler ultrasound of hepatic veins.

- CT or MR venography.

- Ophthalmologic evaluation.

- Pathergy test (optional).

- Consider thrombophilia workup (secondary role in Behçet).

***B. Alcohol-related liver disease with acute decompensation***

In favor: alcohol intake, hepatomegaly, enzyme abnormalities.

Against: mucocutaneous vasculitic lesions, systemic inflammation disproportionate to expected alcoholic hepatitis, young age.

***C. Viral or autoimmune hepatitis***

In favor: hepatomegaly and elevated enzymes.

Against: negative viral and autoimmune studies; presence of typical Behçet features.

***D. Systemic vasculitis other than Behçet (e.g., ANCA-associated vasculitis, PAN)***

In favor: systemic inflammation.

Against: no mononeuritis multiplex, no renal proteinuria or casts, normal blood pressure, mucocutaneous pattern more compatible with Behçet.

Requires ANCA testing if suspicion remains.

***E. Portal or mesenteric vein thrombosis (non–Behçet-related)***

In favor: abdominal pain and ascites.

Against: no major prothrombotic risk factors; prominent Behçet stigmata.

Requires Doppler or CT angiography.

## 4. Most Likely Diagnosis

Budd–Chiari syndrome due to large-vessel venous involvement in Behçet disease.

## 5. Description of the Diagnosis

Budd–Chiari syndrome results from obstruction of hepatic venous outflow, most commonly due to thrombosis. Behçet disease may affect large veins through inflammation of venous walls, predisposing to extensive thrombosis. Clinical manifestations include abdominal pain, hepatomegaly, ascites, elevated liver enzymes, mucocutaneous lesions, ocular inflammation, and systemic inflammatory markers. Imaging (Doppler, CT/MR venography) confirms hepatic venous obstruction.

## 6. Key Elements Supporting the Diagnosis

- Recurrent aphthous ulcers
- Episodes of unilateral red eye
- Erythema nodosum–like lesions
- Migratory arthralgias
- Abdominal pain + hepatomegaly + ascites
- Cholestatic/mixed liver enzyme pattern

• Suspicion of hepatic venous obstruction

• Demographic profile typical of vascular Behçet

## 7. Activity Plan for Residents

Group work (30 min): identify the main syndrome, build the differential diagnosis, select imaging and lab tests, propose initial management.

Presentation (15 min).

Supervisor-led discussion (15 min).