Case report - Discussion:
Remaining well a month later. Immediate resolution of her fevers, myalgia, and inflammatory markers, midabdominal aorta on PET-CT. We started oral prednisolone 40mg with vasculitis involving both proximal renal arteries and a 6 cm segment of tis but non-specific retroperitoneal stranding with medium/large vessel immunofluorescence but showed microvascular thrombi in the papillary evidence of either endocarditis or aneurism formation and so it was felt the patient has LVV. Our patient had a throat swab taken acourse of Doxycycline. drug use. A COVID-19 swab on day 2 had been negative and she had rigors, nights sweats, generalised myalgia, sore throat, headache with photophobia, anosmia, dysgeusia and a widespread rash. She was a line with guidance for the management of LVV, including the introduction of methotrexate, but it will be interesting to observe her long-term outcome with this case is extremely important to highlight a possible new inflammatory when/if patients develop antibodies, means these negative tests in the tests, at what point COVID-19 PCR becomes negative in the illness and increasing numbers of COVID-19 related systemic inflammatory conditions are likely to be recognised over the coming months. We recommend that if surgical/radiological interventions are indicated, it should ideally be performed when the disease is quiescent. However, urgent
intervention is required if the aneurysm is at high risk of rupture, rapidly
enlarging or if there is organ threatening ischemia. This was the approach
used in this patient.
Potent immunosuppression with cyclophosphamide and high dose corti-
co-steroids is indicated in arterial disease of Bechet’s. The inherent risk of
infection with these agents, being used at the peak of a global pandemic
created a challenging clinical dilemma. To complicate matters further,
the patient developed fever and cough following the 1st cyclophospha-
mide/steroid treatment and tested positive for COVID-19. His condition
was relatively mild however and made a full recovery from the virus.
Behcet’s disease can be a difficult and challenging condition to diagnose.
There is often a delay in diagnosis. Our patient was previously referred to a
tertiary Bechet’s centre but felt there was insufficient clinical grounds to
make the diagnosis at that stage.
**Case report - Key learning points:** This case provides a rare example of
an immunosuppressed patient with rheumatic disease contracting
COVID-19 after extensive vascular intervention. A poor outcome may
have been expected but in contrary the patient’s disease course was
mild. This perhaps supports the theory that immunosuppression may
play a protective role during COVID-19.
The role of immunosuppression in a hyperinflammatory COVID-19 state
is an area of much research interest. Suppression of the cytokine storm
with immune therapy has been hypothesised as a potential therapy target
for some COVID-19 patients. However, this is still unproven. Corticosteroid treatment with dexamethasone has been shown to reduce
mortality in COVID-19 patients in hospital, through the Recovery Trial. In
addition, encouraging evidence continues to emerge for the role of IL1
and IL6 inhibitors in the cytokine storm.
It is rare for a patient to present with such extensive aneurysmal disease.
Vascular complications of Bechet’s although rare need to be considered.
The management for vascular manifestations of Bechet’s disease
requires co-ordination and collaborative work between
Rheumatologists, Vascular surgery, and Radiologists. Guidance from
expert centres is highly recommended. Prompt medical and surgical
intervention is needed to prevent serious limb and life-threatening com-
plications of arterial Bechet’s disease.

Our case raises the clinical conundrum of immunosuppression therapy in
serious organ threatening rheumatic disease with concomitant COVID-
19 infection. A patient-centred approach with patient involvement in clini-
cal decisions is required. Patients and clinicians alike should balance the
risks associated with organ threatening rheumatic disease and infection
risks. The current global coronavirus pandemic makes such decisions
more difficult with an additional communicable disease prevalent in the
community. With few clinically proven therapies and no vaccine available
for COVID-19, Rheumatologists will have to grapple with this dilemma for
the foreseeable future.