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Clinical profile of Behcet's Disease patients from Saudi Arabia: A Single Tertiary Centre, Retrospective Study

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Abstract **Background**: Behçet's disease (BD) is a multisystem vasculitis with heterogeneous phenotypes and notable geographic variability. Prior single-centre reports from Saudi Arabia are limited by small samples and inconsistent diagnostic capture. **Methods**: We conducted a retrospective cohort study (2015-2020) at a tertiary centre in central Saudi Arabia. Eligibility followed International Study Group (ISG) and International Criteria for Behçet's Disease (ICBD) definitions. To ensure diagnostic consistency, the full chart cohort (N=59) is summarized for transparency where variable-level denominators were available. Data were abstracted via a structured instrument across socio-demographics, organ-system involvement, inflammatory markers (ESR/CRP), and therapies. Missingness was quantified a priori and handled via complete-case denominators. Proportions are reported with 95% Wilson CIs; small-cell comparisons used Fisher's exact tests aligned to prespecified contrasts (sex differences in mucocutaneous disease; ESR/CRP vs organ involvement). **Results**: The full cohort comprised 59 patients (male 72.9%): oral ulcers 72.9% (43/59; 95% CI 60.4-82.6), genital ulcers 55.9% (33/59; 43.3-67.8), ocular involvement 44.1% (26/59; 32.2-56.7) with anterior uveitis 28.8% (17/59; 18.8-41.4) and posterior uveitis 11.9% (7/59; 5.9-22.5), vascular involvement 13.6% (8/59; 7.0-24.5), arthritis 23.7% (14/59; 14.7-36.0). ESR and CRP were elevated in 18.6% (11/59; 10.7-30.4) and 22.0% (13/59; 13.4-34.1), respectively. Corticosteroids were prescribed in 72.9% (43/59; 60.4-82.6), colchicine 61.0% (36/59; 48.5-72.2), azathioprine 47.5% (28/59; 35.3-60.0). Sex-stratified exact tests showed no significant difference for oral/genital ulcers; a female excess in cutaneous lesions lost robustness under small-sample-valid re-analysis and was treated as exploratory. Missing disease-duration data were substantial (35.6%). Findings were interpreted primarily within the oral-ulcer-confirmed analytic framework and secondarily against the full cohort for context. **Conclusions**: In central Saudi Arabia, BD presentations were dominated by mucocutaneous and ocular disease with comparatively modest vascular involvement. Inflammatory markers lacked stable associations with organ-system involvement. Given the modest sample, incomplete documentation for some fields, and small-cell structure, results are hypothesis-generating. This criteria-clean profile offers groundwork for a prospective, multi-centre registry with standardized phenotyping and time-locked biomarkers.

Key Words Behcet Disease, Clinical Manifestations, Vasculitis, Arthritis, Recurrent Oral Ulcer, Saudi Arabia

INTRODUCTION

Recurrent aphthous ulcerations in the mouth and genitalia, arthritis, skin symptoms, and occasionally involvement of the eyes, blood vessels, nervous system, and gastrointestinal (GI) tract are all symptoms of Behcet's disease (BD), a chronic, multi-systemic immunological disorder of unknown aetiology [1]. In 1937, Hulusi Behcet, a Turkish dermatologist, made the first diagnosis [2]. A diagnosis of BD may be determined by assessing the symptoms of the clinical presentation, even if there is no particular symptom

or test that can be utilised to make this determination [2]. The "time and space" aspect of BD lesions and the diversity of symptoms make it one of the most difficult rheumatic illnesses to diagnose [2]. In North America (0.12-0.33 cases per 100,000 population), Australia, Africa, and Northern Europe (0.64 cases per 100,000 population), BD is uncommon [3].

From Mediterranean countries, especially Turkey (370 cases per 100,000), to Middle Eastern and East Asian countries, it is disproportionately common along the historic Silk Road [3]. Turkey has the greatest prevalence ratio of BD, which is uncommon in the West (0.64/100,000 in the UK and 0.12-0.33 in the US). The regional distribution of the human leukocyte antigen (HLA) B51 corresponds to the prevalence of BD [4]. Males are estimated to have a 1.5 to 5 times higher diagnosis rate for BD than females, and male patients often have more severe symptoms. According to many studies conducted in the West, women are more likely to have milder symptoms. The reasons governing its clinical presentation are yet unknown [4].

BD often manifests between the ages of 20 and 30. But according to a different investigation, male BD patients were nonetheless at risk of serious organ involvement even if they initially just had mucocutaneous symptoms [4]. They were also supported in this respect by investigations conducted in Italy and Turkey [4]. Research suggests that whereas vaginal ulcers and articular involvement are more common in women, ophthalmic disorders, papulopustular lesions, and deep and superficial vein thrombosis are more common in men [4]. Despite the fact that heart disease and favourable pathology were seen in the male group, erythema nodosum has been more often linked to females [4]. As a result, it suggests that sex influences prognosis, with males experiencing a more adverse disease progression than females due to a greater chance of major organ involvement [4]. Since little is known about Behcet's disease in the Arab world in general and the Kingdom of Saudi Arabia in particular, further research is necessary to elucidate the clinical profile and prevalence of this uncommon illness in our society.

The symptoms of BD may go into remission after treatment with anti-inflammatory, immunosuppressive, or biologic medicines, but relapse is common and cannot be predicted [5-7]. It has been argued that, due to the long-term risk of organ damage throughout disease episodes, the goal of treatment should be complete remission rather than merely a reduction in the intensity and frequency of disease attacks [8]. Some patients have been found to experience active disease while receiving intensive immunosuppressive therapy [5-7, 9]. Treatment outcomes and prognoses for BD vary widely depending on a number of factors [10, 11]. Assessing the predictors of therapy response can improve the quality and reduce the expense of medical treatment. The majority of research on BD outcomes and prognostic factors is either short-term or limited to individuals with a specific organ affected by the disease (e.g., the eye, blood vessels, central nervous system, or gastrointestinal tract). No long-term studies on BD's prognosis with multiple organ involvement have been found in Saudi Arabia, to the best of our knowledge. Due to the scarcity of data about Behcet's disease in Arab countries, especially in Saudi Arabia, further studies are needed to clarify more about the clinical profile and frequency of this rare disease in our population.

METHODS

A retrospective descriptive study included all Behcet's disease patients diagnosed according to the International Study Group for Behcet's Disease (ISG) or The International Criteria for Behcet's Disease (ICBD) from 2015 to 2020. Medical records of the Rheumatology unit of King Fahad Specialist Hospital, Buraydah, Saudi Arabia, were reviewed. Patients were included if they satisfied criteria such as a) being diagnosed as BD based on International Criteria for Behcet's Disease (ICBD) [12]; (b) being above the age of 14 at the time of diagnosis; (c) being diagnosed during the period of 2015-2020. The study was approved by the local research ethics committee in the general directorate of health affairs Qassim.

A template of the sheet of structured data extraction has been very carefully designed in order to get fine details of the patients with BD from the medical records. The sheet included a wide array of clinical, serological, and socio-demographic parameters in order to get complete documentation. Socio-demographic variables were included in terms of age, sex, nationality, marital status, weight, height, and body mass index (BMI), and date of first BD diagnosis. Clinical history has been systematically charted and included the presence or absence of comorbid illnesses in addition to specific disease manifestations in the form of recurrent oral ulceration, urogenital lesions, cutaneous disease, ocular disease, neurological complications, vascular lesions, pulmonary disease, arthritis, renal disease, cardiac disease, and gastrointestinal disease. As a corollary to the clinical history, diagnostic studies were also methodically recorded. These ranged from the routine lab results and specialized tests like histopathological studies of skin, gastrointestinal and renal biopsies and the pathergy test. Cardiovascular assessment was elaborated upon with the aid of echocardiograms, whereas chest radiographs and computed tomography (CT) scans of the chest and brain served to support the pulmonary and neurologic examination respectively. The ocular involvement was assessed with the aid of fundoscopy and slit-lamp examination. Through the inclusion of both the clinical and the diagnostic areas, the data questionnaire was fashioned to obtain a complete multidimensional picture of each case so that an integrated examination of disease burden and organ involvement is possible.

The collected data were subjected to statistical analysis using SPSS version 23 (SPSS, Inc., Chicago, IL). An independent biostatistician analysed the data. Categorical variables were presented as frequency and percentage. Pearson's chi-square test was used to assess any possible association between categorical variables. A p-value less than 0.05 was considered statistically significant.

RESULTS

Our analysis included 59 Behcet's disease patients. The analysis showed that 17 patients (28.8%) had the disease for 7-10 years, whereas 6 (10.2%) had it diagnosed more than 11 years ago. The majority of the patients were males (72.9%), and only one patient died due to Bechet's disease. About 19 (32.2%) were married, and 13 (22%) were single. It was found that 20 (33.9%) and 4 (6.8%) were overweight and obese. About 19 (32.2%) had comorbidities, where the most common was hypertension (16.9%) and diabetes mellitus (8.5%) (Table 1).

The reported clinical signs and symptoms of the patients are depicted in Figure 1. It was observed that 43 (72.9%) and 33 (55.9%) had an oral ulcer and genital ulcer, respectively. The other commonly seen symptoms included cutaneous lesions (16.9%), fatigue/malaise/lethargy (13.8%), and Erythema nodosum (10.2%).

Table 2 presents the clinical presentation details by system. Ocular involvement was documented in 26 patients (44.1%). Uveitis was present in 24 patients, with anterior uveitis affecting 17 patients and posterior uveitis affecting 7 patients. Vascular involvement was present in 13.6% of the patients. The most prevalent musculoskeletal manifestation was arthritis (23.7%), followed by arthralgia (16.9%). Other significant systemic involvements included gastrointestinal (15.3%), cardiac (15.3%), renal (8.5%), and pulmonary (6.8%). Elevated erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP) were noted in 18.6% and 22.0% of patients, respectively. Haematological abnormalities including anaemia, leukopenia, and leucocytosis were observed in 11.9%, 3.4%, and 3.4% of patients, respectively.

The analysis indicated that 43 patients (72.9%) were receiving steroid therapy. The most frequently prescribed steroid-sparing agent was colchicine (61%), followed by azathioprine (47.5%) and Anti-TNF (10.2%) (Table 3).

Table 4 presents the comparison of various ulcers and cutaneous lesions based on gender. Males exhibited higher frequencies of oral and genital ulcers, though these differences did not reach statistical significance ($p>0.05$). Cutaneous lesions were observed in 11 patients, with females demonstrating a significantly higher prevalence compared to males ($p=0.023$).

When comparing the prevalence of uveitis with various vascular disorders, no statistically significant relationships were identified with vascular involvement (Table 5).

Table 6 presents the comparison of systemic involvements with elevated ESR and CRP. No statistically significant associations were observed between elevated inflammatory markers and any systemic involvement or other complications.

DISCUSSION

In this hospital-based retrospective study, the clinical and demographic profile of BD patients was assessed in a referral centre in a central province of Saudi Arabia. The cohort showed a male predominance of 2.68:1 that seemed lower compared with reports inside Saudi Arabia but again showed the overall male predominance that has been a consistent feature in many of the Arab world countries [13]. When compared with regional and international data, the sex distribution revealed a similar pattern: the male-to-female ratio has been reported as 2.19 in Iran, 3.1 in Kuwait, 2.9 in Lebanon, 2.8 in Jordan, and 2.8 in India. In contrast, populations outside the Arab and Middle Eastern context showed differing ratios, such as 1.03 in Turkey, 0.98 in Japan, and 0.63 in Korea, reflecting either balanced or female-predominant distributions in certain Asian countries. These findings highlighted the influence of geographic, genetic, and possibly environmental factors on sex-specific disease prevalence.

Table 1: Demographic details of the patients

Parameters		N	%
Duration of Bechet disease	<=2 years	2	3.4
	3-6 years	13	22.0
	7-10 years	17	28.8
	>=11 years	6	10.2
	Not Available	21	35.6
Gender	Female	16	27.1
	Male	43	72.9
Death	No	58	98.3
	Yes	1	1.7
Body Mass Index	Underweight	4	6.8
	Overweight	20	33.9
	Obese	4	6.8
Co-morbidities	Diabetes Mellitus	5	8.5
	Hypertension	10	16.9
	Dyslipidemia	3	5.1
	Hypothyroidism	0	0
	Cancer	1	1.7

Table 2: Reported clinical manifestations details by system and lab tests among patients

Variable	N	%
Ocular involvement	26	44.1
Anterior Uveitis	17	28.8
Posterior Uveitis	7	11.9
Retinal vasculitis	1	1.7
Vascular involvement	8	13.6
Arterial thrombosis	1	1.7
Venous thrombosis	7	11.6
Musculoskeletal	24	40.6
Arthritis	14	23.7
Arthralgia	10	16.9
Neurological involvement	9	15.3
Pulmonary involvement	4	6.8
Gastrointestinal involvement	9	15.3
Renal involvement	5	8.5
Cardiac involvement	9	15.3
Leukopenia	2	3.4
Leukocytosis	2	3.4
Anemia	7	11.9
Raised ESR	11	18.6
Raised CRP	13	22.0

Table 3: Use of Immune suppressive drugs by the patients

Variable	N	%
Steroid	43	72.9
Cyclosporine	3	5.1
Mycophenolate mofetil	2	3.4
Azathioprine	28	47.5
Methotrexate	2	3.4
Colchicine	36	61
Anti-TNF	6	10.2
Vitamin D	23	39.0

Our results demonstrated that mucocutaneous involvement, particularly oral and genital ulcers, constituted the most common clinical manifestation of BD, aligning with findings from previous studies [14,20]. The prevalence of oral aphthous ulcers among BD patients has been reported as 100% in Turkey, Tunisia, the United Kingdom, and Morocco, while slightly lower rates of 97%, 99%, and 98% have been documented in Iran, China, and Japan, respectively [1,5].

Table 4: Comparison of ulcers and other cutaneous lesions based on gender of the patients

Parameter		Gender		Total	P value
		Female	Male		
Oral ulcer	No	4 (25.0%)	12 (75.0%)	16 (100.0%)	0.823
	Yes	12 (27.9%)	31 (72.1%)	43 (100.0%)	
Genital ulcer	No	8 (30.8%)	18 (69.2%)	26 (100.0%)	0.576
	Yes	8 (24.2%)	25 (75.8%)	33 (100.0%)	
Cutaneous	No	10 (20.8%)	38 (79.2%)	48 (100.0%)	0.023
	Yes	6 (54.5%)	5 (45.5%)	11 (100.0%)	

Table 5: Comparison of blood disorders with Uveitis

Parameter		Uveitis		Total	P value
		No	Yes		
Vascular involvement	No	35 (68.6%)	16 (31.4%)	51 (100.0%	0.716
	Yes	6 (75.0%)	2 (25.0%)	8 (100.0%)	
Arterial thrombosis	No	40 (69.0%)	18 (31.0%)	58 (100.0%)	0.504
	Yes	1 (100.0%	0 (0.0%)	1 (100.0%)	
Deep vein thrombosis	No	38 (67.9%)	18 (32.1%)	56 (100.0%)	0.239
	Yes	3 (100.0%)	0 (0.0%)	3 (100.0%)	

Table 6: Relationship of systemic involvements with elevated ESR and CRP

Parameter		Raised ESR		p value	Raised CRP		p value
		No	Yes		No	Yes	
Vascular involvement	No	42	9	0.620	41	10	0.256
		82.4%	17.6%		80.4%	19.6%	
	Yes	6	2		5	3	
		75.0%	25.0%		62.5%	37.5%	
Neurological involvement	No	40	10	0.528	40	10	0.374
		80.0%	20.0%		80.0%	20.0%	
	Yes	8	1		6	3	
		88.9%	11.1%		66.7%	33.3%	
Cardiac involvement	No	42	8	0.219	41	9	0.078
		84.0%	16.0%		82.0%	18.0%	
	Yes	6	3		5	4	
		66.7%	33.3%		55.6%	44.4%	
Arthritis	No	36	9	0.632	37	8	0.157
		80.0%	20.0%		82.2%	17.8%	
	Yes	12	2		9	5	
		85.7%	14.3%		64.3%	35.7%	

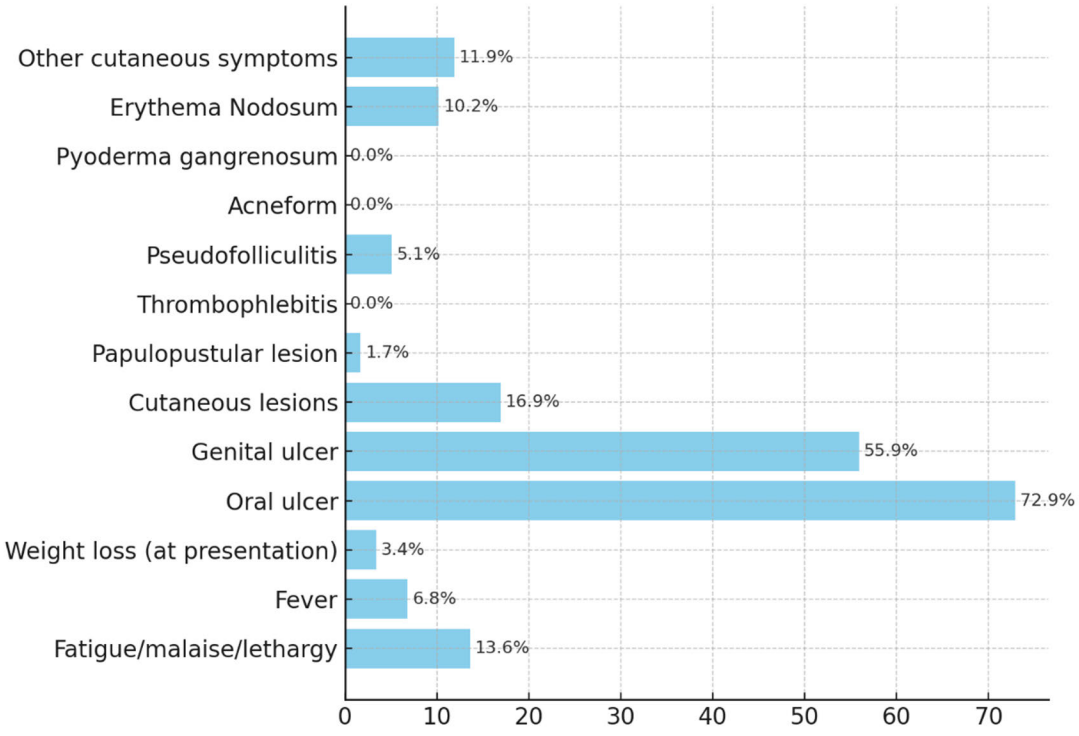

Figure 1: Clinical signs and symptoms

Among cutaneous lesions in our cohort, erythema nodosum and pseudofolliculitis were observed in only 10.2% and 5.1% of patients, respectively. This contrasts with higher prevalence rates reported in Hong Kong (74%) and Korea (84.3%) [16]. Our study found the lowest prevalence of erythema nodosum among comparable studies, with rates similar only to those reported in Egypt. This suggests that variations in disease presentation may be attributable to genetic and environmental factors specific to the study population [16].

Using a diagnostic-consistency approach (primary emphasis on oral-ulcer-confirmed cases) and small-sample-appropriate statistics, we observed a phenotype in central Saudi Arabia dominated by mucocutaneous and ocular disease, with modest vascular involvement and intermediate musculoskeletal burden. Inflammatory markers (ESR/CRP) were elevated in a minority and did not show robust associations with specific organ systems in exact tests. Therapeutic patterns, corticosteroids, colchicine, and azathioprine, aligned with organ-threat stratification in routine practice.

A major improvement over legacy summaries is cohort validity; we replaced small-sample χ^2 with Fisher's exact tests, reported 95% CIs for all key proportions, and explicitly quantified missingness. These choices guard against spurious significance from sparse tables and allow clinicians to read the magnitude and precision rather than only p-values. Where age and some duration fields were incompletely recorded, we avoided over-modelling and presented conservative narrative inferences instead of unstable multivariable outputs.

Our ocular involvement (any ocular ~44%) and uveitis breakdown sit comfortably within widely reported regional ranges, supporting external face validity of capture at our centre. Vascular findings were present but not dominant in this series; given referral patterns and documentation variability, a conservative interpretation is warranted. Musculoskeletal manifestations landed toward the lower end of regional ranges, which may reflect differences in ascertainment, referral thresholds, or disease-stage mix at presentation.

The lack of stable associations between elevated ESR/CRP and organ systems is unsurprising in a retrospective, cross-sectional abstraction where labs are not time-locked to flares. Without temporal anchoring (e.g., "lab within ±14 days of flare onset") and standardized activity indices, biomarker-phenotype links will regress toward null under small samples. This argues for a prospective registry with visit-level timestamping of clinical activity, therapy exposure, and labs.

Observed patterns, corticosteroid first-line for systemic flares, colchicine for mucocutaneous disease, azathioprine for ocular/multisystem disease, and anti-TNF reserved for refractory cases, mirror contemporary, organ-directed algorithms and suggest reasonable implementation fidelity at the treating services. The relatively low biologic exposure likely reflects both historical access patterns and cautious escalation in a centre where many cases are managed with conventional immunosuppression.

Ocular involvement represents a significant source of morbidity in BD [15]. Ocular manifestations occur in 40-70% of individuals with BD, depending on the cohort studied [16], with approximately 20% of BD patients experiencing deterioration in visual acuity or complete vision loss. Uveitis is the most frequently reported ocular condition in BD. Our findings indicated that 44.1% of patients experienced ocular abnormalities, with anterior uveitis in 28.8%, posterior uveitis in 11.9%, and retinal vasculitis in 1.7%. The incidence of ocular manifestations observed in our study falls squarely within the 30%-70% range previously reported in studies from Egypt (64.6%), Saudi Arabia (65%), and Kuwait (69%) [14,16]. The lower rates of ocular manifestations reported among BD patients in Southeast Asian countries such as China (35%) and Korea (55.9%) may be attributed to genetic or environmental factors.

Joint pain and musculoskeletal symptoms are commonly reported by individuals with BD, with knees and ankles being the most frequently affected sites and primary locations for the development of arthritis [15,16]. However, joint involvement in our cohort was less prevalent than the previously established range. Prior research has demonstrated considerable variation in joint involvement in BD, ranging from 29% to 76.8%. Arthralgia has been reported in 45.1% of patients in Lebanon and 26.3% in Egypt, while arthritis affects 30.6% of Egyptians with BD [16,20,21].

Vascular involvement was a strong predictor of death and disability in BD, and it occurred in roughly 40% of the patients [27]. Thrombotic symptoms were the most frequent kind, with venous disease being more common in comparison to arterial lesions [16]. DVT of the lower extremities was the most common one, though venous thrombosis also led to central vessels such as the inferior and the superior vena cava, the pulmonary artery, and in rare occasions, in cardiac chambers. Pulmonary embolism and Budd-Chiari syndrome resulted in roughly 17% of deaths from BD [25], and it underscores the clinical severity of the vascular disease.

In the current study, DVT presented in three patients, whereas arterial thrombosis, cerebral venous thrombosis, and femoral pseudoaneurysm presented in one patient each, in keeping with a relatively low percentage of vascular disease compared with regional reports. Vascular involvement has been described in the past in 40% of Saudi Arabian, 36.7% of Lebanese, and 34% of Kuwaiti patients with BD [1-5], indicating increased prevalence in Middle Eastern populations. Longitudinal data from a Turkish study showed that 35.4% of BD patients with vascular complications had recurrent thrombotic events upon follow-up [25], underscoring the relapsing and chronic nature of the phenotype. In contradistinction, Asian reports showed low prevalence of the disease with vascular BD representing only 5.4% of the cases from Singapore, 11% from Hong Kong, and a meagre 1.8% from Korea [15]. These results underlined the contributions of regional factors pertaining to geography and genetics and environment and proposed that regional variation in clinical

awareness and in the patterns of diagnostic testing might account for some of the observed variability.

The therapeutic goals for BD include reducing inflammation and associated symptoms, halting disease progression, preventing further damage to affected organs, and enhancing patients' quality of life [22]. Treatment approaches and prognosis are determined by the current disease severity and the organs involved [18,19]. Unfortunately, there is a paucity of high-quality therapeutic follow-up studies, resulting in treatment decisions being primarily based on case series, case reports, and limited randomized clinical trials [26].

Patients with severe organ involvement may be treated with systemic corticosteroids and various immunosuppressive medications [17,22], including azathioprine, colchicine, cyclophosphamide, thalidomide, dapsone, and methotrexate. For patients with extremely severe symptoms who have not responded to conventional treatments, anti-TNF monoclonal antibody therapy (infliximab) should be considered [23]. Corticosteroids are typically the first-line treatment for acute episodes of BD, such as gastrointestinal bleeding, systemic symptoms, musculoskeletal manifestations, vascular involvement, nervous system lesions, and respiratory and visual complications [23]. Prednisolone has demonstrated short-term efficacy, with a recommended initial dose of 0.5-1 mg/kg, followed by a gradual reduction of 5 mg once weekly over subsequent months to achieve the desired effect [24]. Indeed, prednisolone was the most widely utilized medication in our study, administered to 72.9% of patients with positive outcomes.

Based on the results of previous clinical trials [20], colchicine (1 mg/day) is considered the first-line treatment for mucocutaneous symptoms. In our study, colchicine effectively alleviated oral and genital ulcers and erythema nodosum in 61% of participants. Treatment options for ocular manifestations include cytotoxic medications such as azathioprine, methotrexate, and cyclophosphamide, with azathioprine demonstrating superior efficacy in reducing uveitis and preserving visual acuity [26]. Additionally, when used either as monotherapy or in combination with other agents, azathioprine has shown effectiveness in managing mucocutaneous lesions, arthritis, and neurological manifestations of BD. Patients treated with azathioprine made up around 47.5%, whereas patients treated with methotrexate made up about 3.4%. Anti-TNF medication was only used on a small subset of patients (10.2%) who had not improved with more conventional treatments. At the clinical level, our findings support vigilance for ocular disease and early organ-threat risk stratification in central Saudi Arabia. At the systems level, the obvious leverage is a prospective, multi-centre registry with: (i) ICBD-anchored enrolment; (ii) time-locked labs and activity indices; (iii) standardized ocular/vascular imaging protocols; and (iv) pre-specified, adequately powered multivariable analysis plans (including penalized logistic models for sparse outcomes). Such an infrastructure would convert these exploratory signals into reliable estimates capable of guiding practice and policy.

This investigation possesses notable strengths, including a substantial sample size when compared to prior studies conducted within Saudi Arabia. Furthermore, it offers a comprehensive account of clinical observations and therapeutic protocols. Nevertheless, several potential limitations are associated with the current research. Firstly, the generalizability of the findings may be restricted to ethnically and economically homogeneous populations, given that the study participants exhibited limited diversity. Secondly, this research might not accurately represent the characteristics of mild disease presentations, as such cases are typically not referred to specialized tertiary care centres. Thirdly, due to its retrospective design, there is an inherent possibility of variability in the medical record information, potentially leading to an incomplete capture of certain clinical features.

CONCLUSIONS

This study offers a summary of the clinical manifestations observed in patients with Behçet's Disease (BD) at a tertiary care hospital situated in central Saudi Arabia. The predominant clinical features identified in BD patients from Al-Qassim were mucocutaneous and ocular symptoms, with uveitis diagnosed in 44% of the cohort. In contrast, joint and vascular involvements were less frequently observed. The patterns of clinical presentation encountered were overall consistent with other regional studies and reflected a degree of similarity in the phenotypic expression of BD in similar populations. In terms of management, therapy utilized principally oral systemic corticosteroids to control acute inflammatory flares, colchicine for articular and mucocutaneous disease, and cytotoxic immunosuppressives for more severe disease of systemic or organ-threatening type. Such therapeutic approach conformed to the existing standard of therapy aimed at suppression of the immune-mediated inflammation, reduction of recurrence rates, and prevention of late complications. Additionally, deeper study of the determinants of the disease etiology at the level of the genetics, immunological level, and environment would result in a more adequate disease etiology and the creation of more precise and individually directed management strategies in the future.

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