thria), psychological issues (depression) and issues of substance misuse (cannabis addiction).

The aetiology remains obscure, with immunological, viral, bacterial and genetic causes proposed. It seems clear that human leukocyte antigen HLA-B*5101 is implicated, with several other susceptibility loci also associated (Piga and Mathieu, 2011).

The CNS may be involved in one of two ways, either through parenchymal disease or non-parenchymal venous sinus thrombotic episodes. The latter can result in intracranial hypertension (Al-Araji and Kidd, 2009). Both forms may co-exist and either might explain the hemiparesis seen in this case. In the parenchymal component, an immune-mediated meningoencephalitis frequently attacks the brainstem and basal ganglia but may also involve the thalamus, cortex, white matter, cerebellum, spinal cord or cranial nerves. Conventional and perfusion magnetic resonance imaging is the method of choice to detect structural and hypoperfusion defects of the neurological Behçet's disease complex (Alkan et al, 2012).

Immunosuppression with high-dose steroids and azathioprine proved successful in this case and forms the basis of treatment of neurological features. Cyclophosphamide and chlorambucil are also used. Additional agents, used for selective aspects of the syndrome, include anti-tumour necrosis factor therapy (infliximab or etanercept), interferon alpha-2a, colchicine and thalidomide.

Conclusions

Headache is a recognized feature of neurological Behçet's disease but may herald further neurological deterioration. CNS involvement frequently follows a relapsing and ultimately progressive course (Siva and Saip, 2009). BJHM

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LEARNING POINTS

- Neurological Behçet's disease 'flare ups' may present as headaches.
- Headache may also be a regular feature of a stable neurological Behçet's disease syndrome.
- Neurological presentations can include devastating ischaemic or haemorrhagic stroke.
- Psychological issues can be a feature.
- The disease is more common in males.
- Prevalence is higher in regions on the historical Silk Road (Turkey having the greatest prevalence of cases) and the far east.

Subclinical vasculitis in polymyalgia rheumatica

A 61-year-old woman presented with a few weeks' history of polymyalgia rheumatica and raised inflammatory markers. She responded well to prednisolone therapy resulting in the resolution of all her symptoms and normalization of inflammatory indices. Interestingly, her inflammatory markers had started to increase toward the end of therapy, but she remained asymptomatic.

At that time, a chest X-ray revealed a 25 mm nodule in her left lung. She underwent fluorodeoxyglucose-positron emission tomography (FDG-PET) scan, which revealed a benign lung lesion. The FDG-PET scan also picked up active vasculitis involving the right and left subclavian arteries, arch of aorta, descending aorta and abdominal aorta up to bifurcation (*Figure 1*). She also started experiencing some musculoskeletal pain and stiffness during this time and was prescribed prednisolone 40 mg daily. Her symptoms settled with normalization of C-reactive protein levels and erythrocyte sedimentation rate over the next 2 months. The prednisolone dosage has gradually been tapered down since, and currently she is totally asymptomatic. BJHM

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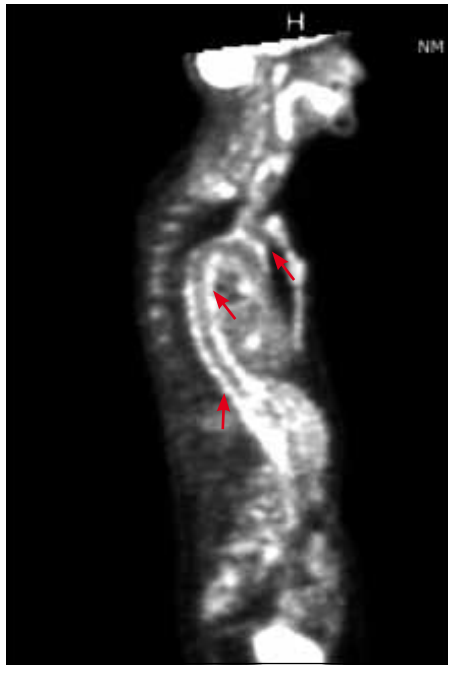

Figure 1. Whole body fluorodeoxyglucose-positron emission tomography scan with arrows showing increased radiotracer activity consistent with active vasculitis.