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LEARNING POINTS

- Charles Bonnet syndrome is a rare condition, unfamiliar to clinicians and the wrong diagnosis can lead to stress and anxiety for elderly patients.
- To diagnose Charles Bonnet syndrome clinical assessment should include a detailed history (including collateral history), neurological and ophthalmological assessment, and relevant investigations.
- Reassurance and education may provide significant relief to an elderly patient already struggling with failing vision, social isolation and other comorbidities.

IMAGES IN MEDICINE

A combination of pulmonary artery aneurysm and deep vein thrombosis

A 31-year-old Caucasian male presented with fever, chest pain and haemoptysis. He had been being investigated for recurrent deep vein thrombosis and multiple bilateral pulmonary embolisms episodes over the last year.

A computed tomographic pulmonary angiogram showed progression of his pulmonary emboli despite a therapeutic international normalized ratio. It also showed a segmental pulmonary artery aneurysm (Figures 1a and b) which led to a unifying diagnosis of atypical Behçet's disease, aka Hughes–Stovin syndrome.

Immunosuppression with prednisolone and azathioprine led to complete resolution of the pulmonary aneurysm. There

was no recurrence or extension of his deep vein thrombosis or pulmonary emboli and he remained anticoagulated.

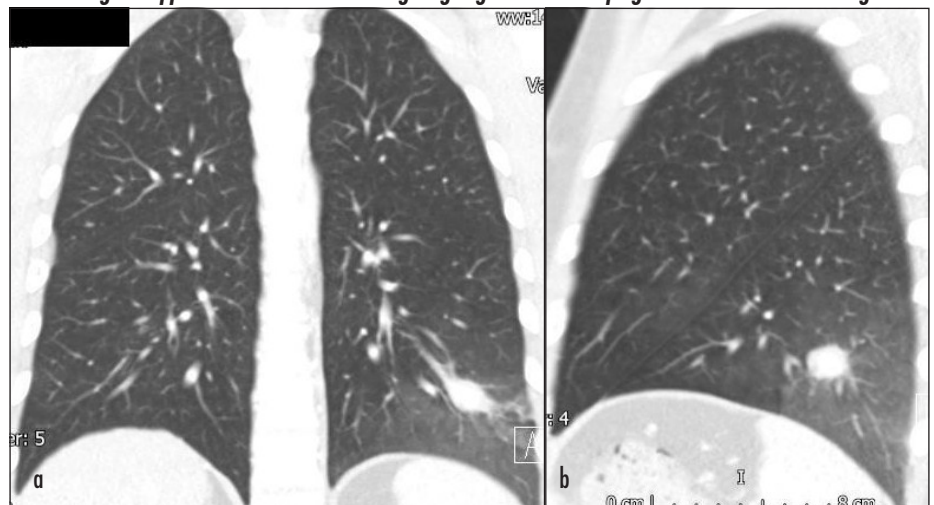
Hughes–Stovin syndrome is a *forme fruste* (incomplete form) of Behçet's syndrome characterized by recurrent thrombophlebitis, deep vein thrombosis and multiple pulmonary and/or bronchial aneurysms (Khalid and Saleem, 2011).

Unlike those with Behçet's disease, patients with Hughes–Stovin syndrome tend not to have oral or genital ulcerations, skin lesions, iritis or arthralgia (Erkan et al, 2004). **BJHM**

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Figure 1. a. Segmental pulmonary artery aneurysm in the left lower lobe of lung with overlying thrombus. b. Ground glass appearance of the surrounding lung segment is in keeping with a recent haemorrhage.



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