Behcet’s Disease Complicated with Descending Colon Perforation

Mehmet Arhan    Mehmet İbiş    Seyfettin Köklü    Yasemin Özün    Erkan Oymacı

Department of Gastroenterology, Türkiye Yüksek İhtisas Hospital, Ankara, Turkey

Dear Sir,

Gastrointestinal disease presents in 50% of Behcet’s disease patients, and typically affects the ileocecal area [1]. Mortality is low in Behcet’s disease; however, intestinal perforation is one of the common causes of death. In this case report, we present a patient who had Behcet’s disease complicated with radiologically proven descending colon perforation and who had a good response to surgical treatment.

A 37-year-old man, diagnosed with Behcet’s disease 11 years ago, was admitted to our hospital with complaints of abdominal distention, vomiting and obstipation for 7 days. Previous medical history revealed azathioprine 50 mg/day and cyclosporine 200 mg/day for a year. Physical examination revealed abdominal distension with diffuse tenderness. Bowel sounds were silent on auscultation. On digital rectal examination, the rectum was empty, with no evidence of perianal pathology.

The results of laboratory investigations were as follows: hemoglobin 8.7 g/dl, white blood cells 17,600/mm³, platelets 374,000/mm³, sedimentation rate 55 mm/h. Biochemical tests including liver and kidney function tests, and serum electrolytes were within normal limits. Abdominal X-ray showed an ileus pattern with air-fluid levels in the abdominal cavity and an ultrasonography demonstrated dilated bowel and free fluid in the left lower quadrant. Computerized tomography revealed diffuse thickening of descending colon and abdominal free air and fluid.

He was hospitalized with the diagnosis of ileus and bowel perforation. On the first day of hospitalization a laparotomy, left hemicolectomy, Hartmann procedure and end colostomy were performed. The histopathologic examination of resected colon revealed diffuse aphthous ulcers, coagulation necrosis, ischemic perforation, necrotizing lymphocytic venulitis, vascular thrombosis, and serositis.

He was discharged on the 13th day of hospitalization. The patient’s clinical course has since been stabilized, and colocolostomy was performed three months later. Control endoscopic examinations of the remaining colon were normal. He was well clinically during the 12-month follow-up period after operation while taking azathioprine and cyclosporine.

Behcet’s disease is a multisystem disease and gastrointestinal involvement is frequent. The gastrointestinal manifestations of Behcet’s disease usually appear 4.5–6 years after the onset of the oral ulcers but the interval may be as long as 30 years [2]. The intestinal lesions of Behcet’s disease are manifested as mucosal inflammation or ischemia/infarction secondary to small and large vessel involvement, respectively, and range from nonspecific colitis to diffuse ulcers. The lesions are most commonly found in the ileocecal area, and colonic involvement is less frequent. Bowel perforation is one of the serious complications and colonic involvement has been reported to occur in right colon (especially cecum) most frequently. To our knowledge, sigmoid colon perforation in intestinal Behcet’s disease has been reported once in the literature [3] and descending colon perforation has not been reported before. As a summary, colonic perforation is an unusual complication of Behcet’s disease and may occur in any part of the colon without pioneering abdominal symptoms during the course of Behcet’s disease.

References