LETTER TO THE EDITOR

Fatal Colonic Perforation in a Pregnant with Behçet's Disease

Dear Sir,

A 45-year-old woman was admitted to our emergency service with nausea and severe abdominal pain which started five days ago. She had 6 weeks of pregnancy and four years ago was diagnosed with Behçet's disease (BD) with oral, ocular and genital involvement. She had been taking colchicine 3 mg/day since from the diagnosis.

At physical examination oral aphthous ulcerations, extensive abdominal tenderness and rebound at the right lower quadrant were detected. Laboratory findings showed as follows: white blood cell count: 15,700/mm³, hemoglobin: 9.9 g/dl, and normal blood urea nitrogen, creatinine, glucose and liver function tests. Abdominal ultrasound showed fluid at the Douglas cavity and among the whole intestinal loops. Entire colon was thickened and the thickness of the wall was measured as 6.8 mm in diameter. There was an embryo and gestational sac in the intrauterine cavity consistent with 6 weeks of pregnancy. After abortus decision, an abdominal X-ray was taken showing abdominal air–fluid levels.

The patient was consulted immediately with gastrointestinal surgeons and gynecology specialists and it was decided to end pregnancy urgently. At laparotomic exploration, there was extensive pyogenic suppuration in the whole abdominal cavity. Perforations and ulcers extending to serosa in the entire colon were observed (Fig. 1A). Histological examination was supporting BD involvement of entire colon (Fig. 1B). Subtotal colectomy and end ileostomy were performed and ileum was opened to the abdominal wall. Following abdominal irrigation and cleaning, drainage tubes were placed to subhepatic, splenic and Douglas cavity. At the post operative period in spite of extensive management with antibiotic therapy, the health situation deteriorated and she died on the 16th day after the operation.

Intestinal BD is characterized by deep ulcers, most commonly located in the terminal ileum or ileocecal region which led to perforate or penetrate the intestinal wall. However, these ulcerative changes in the intestine are found in less than 1% of all patients with BD. In our patient, there were multiple perforations of the colon and in spite of urgent surgical treatment, it was mortal.

Most gastroenterologists accept BD as a separate entity that sometimes falls within the spectrum of inflammatory bowel disease. Some reports stress the similarity of colitis in
BD and ulcerative colitis. The intestinal ulcer formation in BD, which is suggestive of ulcerative colitis is the most common finding in a proctoscopic examination. These ulcers are characterized by nonspecific inflammation and edematous swelling with craters around the ulcer margin and they penetrate the serosa or fascia. However, the distribution pattern including frequent right colonic predominance, discontinuous involvement and occasional rectal sparing, is clearly different from that of ulcerative colitis. Colitis in BD also differs from Crohn’s colitis both clinically and histopathologically. Transmural inflammation in Crohn’s disease involves lymphocytes, plasma cells and eosinophils, submucosal fibrosis and granuloma formation.

Literature about BD and pregnancy is quite few. The intervention between pregnancy and BD is obscure. Although BD tends toward remission during pregnancy, the influence of pregnancy on its clinical course is quite variable among patients and even during different pregnancies in the same patient. The case we report here is a unique example to those describing aggravation and even mortal course of BD during pregnancy.

References


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