A 73-year-old woman was admitted to our hospital because of diarrhea and in-veterate oral ulcers. Upon admission, her body temperature was 38.2°C. The abdominal examination revealed mild tenderness without guarding. Initial blood tests revealed a white blood cell count of 10,500/μL, hemoglobin level of 7.8 g/dL, C-reactive protein level of 21.7 mg/dL, and positivity for HLA-B52. The day after admission, massive bloody stools appeared. Colonoscopy of the descending colon revealed punched-out ulcers scattered throughout the rectum up to the descending colon (Fig. 1a). While genital ulcers appeared after admission, skin lesions and eye inflammation were not detected. The patient was consequently diagnosed as having intestinal Behçet’s disease. She was treated with mesalazine (3 g/day) but her condition worsened gradually, and therefore intravenous prednisolone pulse therapy (1000 mg/day) was performed. However, bloody stools continued to appear. Second-look colonoscopy detected deep longitudinal ulcers in the transverse colon that exposed the muscular layer (Fig. 1b). The patient was treated with infliximab (5 mg/kg) but complained 3 days later of severe abdominal pain and showed guarding in the left lower abdominal area. Computed tomography revealed a dilated transverse colon, similar to that seen in ulcerative colitis complicated with a toxic megacolon. Perforation of the sigmoid colon with free air (arrow).

In Behçet’s disease, while involvement of the gastrointestinal tract is relatively uncommon [1], the rate of perforation is relatively high [2, 3]. However, complication of Behçet’s disease with a toxic megacolon is extremely rare [4, 5]. Nevertheless, our case indicates that we should pay attention to patients with extensive deep ulcers. While toxic megacolon occurs in ulcerative colitis, it is not a complication peculiar to ulcerative colitis as it can occur in any case of an ulcerative lesion with inflammation that penetrates the entire colonic wall, such as can occur in intestinal Behçet’s disease.
Y. Umehara, M. Kudo, M. Kawasaki
Division of Gastroenterology and Hepatology, Department of Internal Medicine, Kinki University School of Medicine, Osaka-Sayama, Japan

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Corresponding author
M. Kudo, MD, PhD
Division of Gastroenterology and Hepatology
Department of Internal Medicine
Kinki University School of Medicine
377-2 Ohno-Higashi
Osaka-Sayama 589-8511
Japan
Fax: +81-723-672880
m-kudo@med.kindai.ac.jp