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Spontaneous Cecum Perforation Associated with Entero-Behçet

Enterobehçete Bağlı Spontan Çekum Perforasyonu

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Dear Editor,

First identified by Hulusi Behçet in 1937 and its etiology still unknown, Behçet's disease is a chronic multi-systemic vasculitis that can affect almost every organ and system. Entero-behçet disease refers to the gastrointestinal system involvement. In a study conducted in Turkey, the gastrointestinal involvement rate of Behçet's disease in Turkey was found to be 1,4% (1). In this letter, we aim to provide a case of isolated cecal perforation connected to entero-behçet. A thirty-six-year-old female who had a known story of Behçet's disease was admitted to our emergency department with abdominal pain. The physical examination showed common defence and rebound tenderness in the abdomen. The patient's WBC values were high (15000). We have observed free fluid in the right lower quadrant abdominal and the pelvis in the pelvic ultrasound. The patient did not have a story of steroid use. We did not observe any pathologies in the gynecological examination either. We decided to apply emergency exploration. The exploration showed perforation foci in two different areas in the cecum the largest of which was 1 cm. Thus we agreed to apply ileocecal resection was performed double barrelled ileo-colostomy. The patient was discharged in good health on postoperative day 5. The postoperative pathology report was consistent with vasculitis and entero-behçet.

We closed the double barrel and colostomy by administering end to end anastomosis after 6 months. Behçet's disease may manifest itself with vasculitis related chronic abdominal pain as well as vasculitis, secondary ischemia, necrosis, and perforation that cause acute abdomen issues (2). Having considered the appendicitis induced pathologies and gynaecological pathologies on the foreground, we decided to apply an exploration by using a standard MC-Burney incision. We found two perforated areas on the back wall of the cecum prior to the operation. Then we expanded the incision towards the right and upwards. Because the inside of the abdomen was contaminated and the patient had a history of Behçet's disease, we considered the application of anastomosis unsafe. Instead we performed double barrelled ileo-colostomy followed by ileo-cecal resection. We were able to establish full exploration by extending standard MC-Burney incision laterally and upwards during the surgery. We discharged the patient without any issues on postoperative 5th day.

We closed the double barrel and colostomy by applying end to end anastomosis after 6 months. There are studies reporting intestinal involvement and perforation due to intestinal involvement in Behçet's disease. Practitioners should keep in mind the possibility of entero-behçet related intestinal ischemia and perforation in Behçet's disease patients with acute abdominal symptoms. In these patients, applying midline incision as the surgical incision method will facilitate the exploration. In such cases, surgical exploration should be made carefully.

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