



An unusual case of Ulcerative Colitis with Behçet's disease

To the Editor,

Despite the similarities between the clinical features of inflammatory bowel disease (IBD) and Behçet's Syndrome (BS), their coexistence is uncommon (1). Here, we report a patient diagnosed with BS during clinical follow-up for ulcerative colitis (UC). Informed consent was obtained from the patient.

A 32-year-old man was admitted to the gastroenterology outpatient clinic with abdominal pain, bloody stools 6 to 7 times per day, and arthralgia and swelling of his right knee. He had a history of UC for three years and was treated with 5-ASA. The patient was hospitalized with the diagnosis of UC reactivation. During his physical examination, his temperature was 37.4°C, and he had a mucosal ulcer on his lower lip, two genital ulcers, an *erythema nodosum*-like lesion on his right lower extremity and arthritis of his right knee (Figure 1). A complete blood count showed mild leukocytosis (12700/mm³). Blood chemistry data were within the normal ranges. An elevation in C-reactive protein (15.9 mg/dL) was observed. No infectious pathogens were discovered in the stool sample. Colonoscopy revealed a diffusely fragile and hyperemic mucosa, with ulcerations throughout the entire colon and small pseudopolyps consistent with UC (Figure 2). Biopsies were taken to exclude Cytomegalovirus and *E. histolytica* infections and to confirm of the diagnosis of UC. Histopathological findings showed inflammatory cell infiltration of the lamina propria, crypt destruction and goblet cell depletion. Neither granulomas nor lesions consistent with vasculitis or infectious pathogens were noted in the histopathologic specimens. Treatment was commenced with mesalazine (3 gr/day), methylprednisolone (40 mg/day) and azathioprine (2 mg/kg/day). Although we suspected that the extraintestinal symptoms were associated with UC, der-

matology and rheumatology consults were requested for the oral and genital ulcers. Crystal arthropathies and septic arthritis were excluded by arthrocentesis. Sacroiliitis was demonstrated by pelvic x-ray analysis. The pathergy test was positive, and the ophthalmological examination revealed no evidence of uveitis. The patient was diagnosed with Behçet's Syndrome (BS) according to the International Study Group for Behçet's disease (ISG) criteria, and treatment was commenced with colchicine and triamcinolone (2). On the third day of treatment, the diarrhea abated, and the abdominal pain and symptoms of arthritis and *erythema nodosum* significantly improved.

We diagnosed the patient with coexisting ulcerative colitis and Behçet's disease rather than with intestinal Behçet's disease. The improvements of colonic inflammation and systemic findings were considered to be in response to steroid therapy.



Figure 1. a-d. Genital ulcer (a), oral ulcer (b), erythema nodosum (c), pathergy positiveness (d).

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Received: 16.4.2013

Accepted: 26.7.2013

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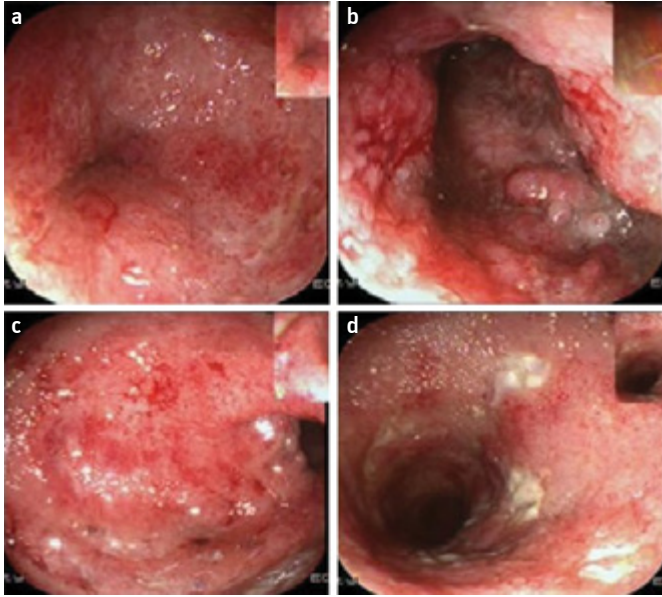


Figure 2. a-d. Colonoscopic appearance.

We planned to taper the steroid dose and continue treatment with mesalazine, azathioprine and colchicine. Then, we discharged the patient.

Inflammatory bowel disease and BS share common clinical features such as arthritis, *erythema nodosum*, and uveitis (3,4). Additionally, the differentiation of intestinal involvement between BS and Crohn's disease might be difficult (5). It is important to determine whether the patient has BS with IBD-like lesions, IBD with BS-like extraintestinal complications or both BS and IBD (6). Unless we diagnose and properly treat such patients, vascular aneurysms of BS can be life threatening, and panuveitis associated with BS can result in vision loss. Because the management and treatment of BS and IBD are markedly different (7), we suggest that during the initial presentation of a patient with suspected IBD, a diagnosis of BS also be considered and ruled out, using the ISD criteria as a guideline, especially if extraintestinal findings such as genital ulcers or a positive pathergy test are present.

Ethics Committee Approval: N/A.

Informed Consent: Written informed consent was obtained from patient who participated in this case.

Peer-review: Externally peer-reviewed.

Author contributions: Concept - C.Ç.; Design - C.Ç.; Supervision - B.Ü.; Data Collection&/or Processing - Z.Z.G., F.A.; Analysis&/or Interpretation - E.A., E.S.Y.; Literature Search - Z.Z.G.; Writing - C.Ç.; Critical Reviews - S.A.

Conflict of Interest: No conflict of interest was declared by the authors.

Financial Disclosure: The authors declared that this study has received no financial support.

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