Angio-Behc,et Disease With Symptoms Of Acute Abdominal Syndrome: Vena Cava Inferior Syndrome

Prof.Dr.Alımet BİLGE, Dr.Mustafa ŞAHİN, Prof.Dr.Ümit SOYUER,
Dr.Recep HARMANDA, Dr.Burhan KERKÜKLÜ

Departments of General Surgery and Dermatology Erciyes University, KAYSERİ

SUMMARY

Behcet's disease is a chronic multisystemic disease with unknown etiology affecting various parts of the body. Symptoms are associtaed with inOolved systems. The cause of acute abdominal symptoms and ascites in a patient has been understood to be due to angiobehqet disease with inferior vena v cava occlusion. The case treated conservatively as a rare form of Behcet's disease with symptoms of acute abdomen is presented here.

KeyWords: Angio-Behcet, Inferior vena cava occlusion, Acute abdomen.

ÖZET

AKUT KARIN SEMPTOMLARI VEREN ANGİOBEHÇETHASTALIĞI: VENA CAVA İNFERİOR SENDROMU

Behçet hastalığı, kronik seyirli, birçok sistemde tutulum gösteren ve etyolojhi bilinmeyen bir hastalıktır. Genel semptomlar tutulan sistemlerle ilgilidir. Bir hastada ani asit ve akut kann semptomlarının sebebinin vena cava inferior tıkanması yapan Behçet hastalığının nadir bir formu olması ve ayırıcı tanıda akut karın ile karışması nedeniyle ilginç bularak takdim ettik

Anahtar Kelimeler: Angio-Behçet, Vena cava inferior tıkanması, Akut karın.

Behcet's disease is a chronic multisystemic disease with unknown etiology, affecting various parts of the body (9).Viral etiology for Behcet's disease has long been suspected. However, No evidence to indicate the involvement of a virus an an etiological agent in Behcet's disease has yet been obtained (1). On the other hand, in spite of the failure to prove a virus theory, the recurrent clinical pattern of the disease as well as immunopathological features including vasculitis, uveitis and inflammatory lesions of the central nervous system are still compatible with the presence of a persistent immune response to an infectious agent, possibly to virus (11). A japan research group has found out that, the causal factors of the disease are primarily environmental rather than genetic (9). Although, Familial aggregation occurs rarely, it is one of the well accepted features of Behget's disease (2). The disease is rare in general but known to be relatively common in Japan and Turkey (6,9).

Geliş Tarihi: 20.1.1990 **Kabul Tarihi: 10.2.1990**

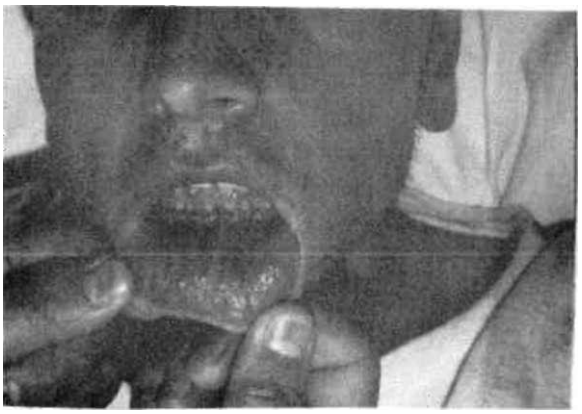
Yazışma Adresi: Dr.Mustafa ŞAHİN
Nato Cad. 63/13
KAYSERİ

MATERIAL AND METHODS

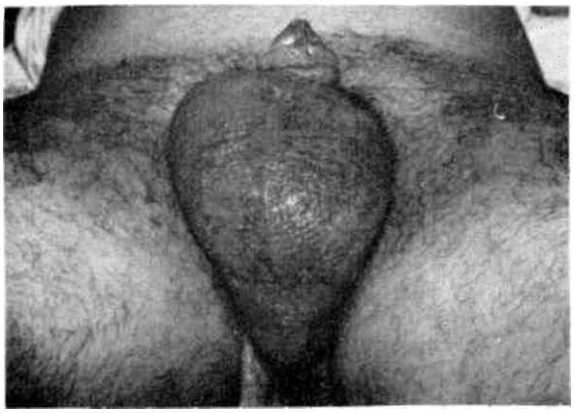
In this report, a patient with Behget's disease with acute abdominal manifestations is presented. The patient had a 4-year Behcet's disease history with is father's 20 years history.

Case report: Y.A. 20 years old, soldier. After parachute training in army service, he had abdominal pain, distention and diarrhoe. He had been treated conservatively during the first 20 days and then sent to the surgical department with acute abdominal symptoms, such as, pain, distention, diarrhoe, nausia and vomltus. On phybicay examination, oral ulcers, genital ulcers, skin lesions, rebound tenderness, free fluid in the abdominal cavity and severe edema on abdominal wall and lower extremities were found (see pictures 1-4).

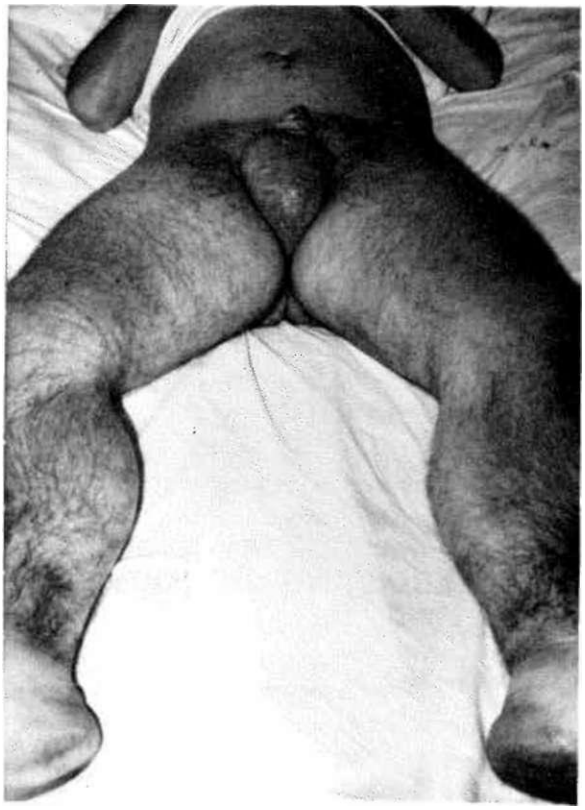
Laboratory findings were: Hb: 9.2 gr %,WCB: 13800 per cubic mm, AST: 222 Ul, ALT: 196 Ul,



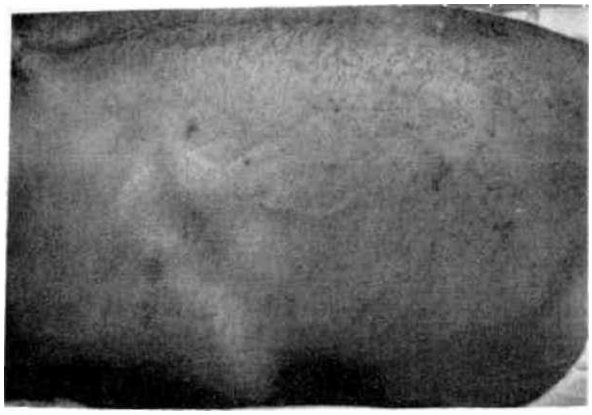
Sekili. Oralaphts.



Şekil 3. Genital ulcers.



Şekil 2. Genital ulcers.



Sekil 4. Collateral veins on abdominal wall.

Alchalen Phosphatase: 68 Ul, Total protein: 5.6 gr %, Albumine:2.6gr %, Ultrasonography revealed free fluid in abdominal cavity and a moderate hepatosplenomegaly. Vena cava inferior was also demonstrated, larger than normal, by ultrasonography. Inferior vena cavagraphy was unsuccesifull because of technical problems. For both diagnostic and therapeutic purposes, 2000 ml transuda with densty 1015 was evacuated from abdominal cavity by a peritoneal lavage procedure. The patient was treated conservatively with spiranolacton, frusemld, cholchicine, salycylazosulphadiasine and heparine. Edema and ascites were ergressid in 40 days and the patient was sent to home,

DISCUSSION

Today, it is well known that, Behcet's disease has many vascular, neurological and gastrointestinal symptoms. In addition to trlsymptombehcet, many other physical findings and laboratory tests are used in diagnosis and prognosis of the disease (5). Although the manifestations of the disease are changing according to the involved system, two types of criteria known as major and minor criteria are defined. Oral aphts, genital ulcers, skin lesions and ophtalmic lesions are called major criteria. Arthritic symptoms, gastrointestinal truct symptoms, epididymitis, vascular lesions and central nervous system pathologies are accepted as minor criteria (5-8). The disease is termed accord-

ing to the involved system as neurobehcet, enterobehcet, angiobehcet, etc. When gastrointestinal system is involved by the disease, frequently acute abdominal manifestations occurs. The conitions of peritoneal serosites and small bowel perforation are the major reasons of abdominal symptoms in enterobehcet disease (3,5).

Some patients come to physician with occlusive symptoms of superior or inferior vena cava (3). Peritoneal effusion in the case of occlusion of inferior vena cava can cause abdominal manifestations like thoracic manifestations of supreior vena cava syndrome (1). Clinical manifestations very according to the level of occlusion in inferior caval vein. Acute abdominal manifestations occur when the occur when the occlusive lesion sited above the level of abdominal organs venous return. If the occlusion occured above common hepatic vein, the manifestations of acute abdominal syndrome are obviousand the clinical condition is severe (7).

By using phylebography, the occlusion of veins and occlusion level can be demonstrated (4). On the other hand, ultrasonography is an easy and effective method to detect large venous lesions and to follow up theteharapy in Behcet's disease.

This patient with abdominal syndrome's manifestations has been presented, because, acute exacerbation of angiobehcet disease caused by blunt trauma is a rare condition (10). Because of hepatosplenomegaly, ascites, severe edema on abdominal wall and lower extremities and venous fullness on two legs, the case has been considered as vena cava inferior occlusion at the level of common hepatic vein. This clinical pathology should be terated conservatively as reported above. In this case all manifestations disappeared after occuring collateral veins on abdominal wall (see picture 4).

REFERENCES

1. **Çobanlı B: Pleural symptoms and pulmonary manifestations in Behcet's disease, Turkish Clinics M.J., V(5)5, 423-424,1985.**
2. **Düşen N, Konice M, Övül C, Aral O: A preliminary Family Study on Behcet's Disease in Turkey. Behcet's Disease Ed: GORO inaba, Edited by Japan Med. Research Foundation N: 18,103-115,1981.**
3. **Dündar SV: Vascular system in Behcet's Disease, Turkish Clinics M.J., V(5)5,435-438,1985.**
4. **Dündar SV, Yazıcı H: Superior vena cava syndrome. Mayo Clin. Proc, V(57) 785, Dec 1982.**
5. **Gürler A: Diagnostic criteries and clinical observations on Behcet's Disease, Turkish clinics M.J., V(5)5,403-309,1985.**
6. **James G, Thomson A: Recognition of the diverse cardiovascular manifestations in Behcet's disease. Am Heart J, 457-458, 1982.**
7. **little AG, Zarins CK: Abdominal aortic aneurysm and Behcet's Disease, Surgery, 9(3): 359,1982.**
8. **Shen LL, Cui GG, Liang RM: Valve prolapse in Behcet's Disease. Br.Heart J, V(54), 100-101,1985.**
9. **Shozaburo J, Kenji T, Shudo N, Shiro K, Kenji KJ, Toskiyuki Y: Epidemiologic Studies on Behcet's Disease. Behcet's Disease Ed: GORO inaba, Edited by Japan Med. Research Foundation N:18,51-56, 1981.**
10. **Urayama A, Sakuragi S, Sakai F, Tanaka Y, Koseki T: Angio-Behçet Syndrome, Behcet's Disease Ed: GORO inabe, Edited by Japan Med. Research Foundation N:18, 171-176,1981.**
11. **Yamanouchi K. Shishido A, Kabune F, Sakata II, Inaba G: Virological Approaches to Behcet's Disease in Japan. Behcet's Disease Ed: GORO inaba, Edited by Japan Med. Research Foundation N: 18,57-65,1981.**