Behçet's disease is a chronic multisystemic disease with unknown etiology affecting various parts of the body (9). Viral etiology for Behçet's disease has long been suspected. However, no evidence to indicate the involvement of a virus as an etiological agent in Behçet'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).

MATERIAL AND METHODS

In this report, a patient with Behçet's disease with acute abdominal manifestations is presented. The patient had a 4-year Behçet's disease history with his 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 vomitus. On phibicay 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 UI, ALT: 196 UI,
Alchalen Phosphatase: 68 UI, 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 cavography was unsuccessful because of technical problems. For both diagnostic and therapeutic purposes, 2000 ml transuda with density 1015 was evacuated from abdominal cavity by a peritoneal lavage procedure. The patient was treated conservatively with spiranolacton, frusemld, cholicchine, 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 tract 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 neurobehçet, enterobehçet, angiobehçet, etc. When gastrointestinal system is involved by the disease, frequently acute abdominal manifestations occurs. The contions of peritoneal serosites and small bowel perforation are the major reasons of abdominal symptoms in enterobehçet 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 superior 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 the therapy in Behçet's disease.

This patient with abdominal syndrome's manifestations has been presented, because, acute exacerbation of angiobehçet 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 occurring collateral veins on abdominal wall (see picture 4).

REFERENCES