SHORT REPORT
Superior Mesenteric Artery Aneurysm in Behçet Syndrome a Case Report

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Behçet’s disease is a multisystem disorder characterized by recurrent orogenital ulcerations and uveitis. Vascular involvement can include both arteries and veins, with a preponderance of venous lesions. Aneurysm of superior mesenteric artery due to Behçet’s disease has been rarely reported. We report an unusual case of superior mesenteric artery aneurysm due to Behçet disease. Aneurysm resection and reimplantation of superior mesenteric artery was performed.

Keywords: Behçet disease; Aneurysm; Superior mesenteric artery.

Introduction

Aneurysms of superior mesenteric artery (SMA) remain rare but are being more frequently encountered with the increasing use of cross sectional diagnostic imaging. They are the third most common visceral artery aneurysm. The common aetiology is atherosclerotic. Very few cases of SMA aneurysms in Behçet were reported in the literature, they appear to have a higher risk of rupture than other SMA aneurysms. The authors report a patient with Behçet disease (BD) who developed superior mesenteric artery aneurysm which was managed surgically.

Case Report

We report a case of 44 year old Moroccan man who was known to have Behçet’s disease. The diagnosis was made 6 years ago on recurrent oral aphtha, genital ulceration and recurrent superficial thrombophlebitis (he was treated by corticosteroid and colchicine). He was admitted in our unit with abdominal pain. For one month, he had observed increasing abdominal pain. On admission to the hospital, he had no fever, agitated with paroxysmal abdominal pain. His abdomen was soft on examination. Peripheral pulse was normal, his blood pressure was 150 mmHg/85 mmHg, the heart rate was 85. He had a raised C - reactive protein of 40 mg/l (normal inferior to 6 mg/l); the other routinely performed blood tests were normal. An abdominal ultrasound revealed a mass behind the pancreas with a vascular appearance. Computed tomography (Figs. 1 and 2) had showed a 2.4 cm aneurysm at the origin of the superior mesenteric artery (SMA). There were no signs of bowel ischemia. The patient was immediately taken to the operating room for surgery to avoid a rupture. A midline laparotomy was performed. The aorta was controlled proximal to the celiac trunk, then the posterior area of the pancreas was dissected, we found the aneurysm at the origin of the SMA. The aorta was cross clamped proximal to the coeliac trunk and distally in the infrarenal aorta then the aneurysm was incised. The orifice of SMA was closed and the SMA was directly anastomosed to the infrarenal aorta (Fig. 3). The cross clamping time was 22 min. Histological examination of the aneurysm wall showed slight fibrous thickening of both media and intima and a moderate infiltration of monocytes and plasmocytes in intima and adventicia. The postoperative phase was uncomplicated and the patient was discharged on the third day in good condition. Corticoids and immuno-suppressors were
prescribed. The patient was in good health at six months follow up.

Discussion

Aneurysms of SMA are rare and their frequency varies between 3.5 to 8.5%\(^1,2\) of all visceral artery aneurysms. Infectious diseases were the common aetiology. Recently many authors reported that atherosclerosis and fibro-dysplasia are the principal aetiology.\(^3\) Arterial involvement in Behcet disease is rare and is extremely rare as a cause of aneurysm of SMA. Four cases of SMA due Behcet disease are reported\(^4-7\) in the literature. The surgical management is recommended because the aneurysm can cause potentially fatal complications like rupture or thrombosis which can lead to bowel infarction. Chubachi\(^6\) has reported one case of entero-mesenteric infarction after an aneurismal occlusion of SMA aneurysm in a patient with Behcet disease (BD). When rupture occurs, intervention is warranted. Some authors recommend ligation of the aneurysm with the assessment of bowel viability, revascularisation is indicated only if bowel ischemia is present in patients undergoing operation for rupture or if preoperative evaluation suggested mesenteric ischemia.\(^3\) We have urgently performed surgery to avoid this complication. The surgical treatment of aneurysm in BD is a challenge for vascular surgeon because of the technical difficulties, the high rate of false aneurysm and graft thrombosis.\(^8\) Some authors recommended to make anastomosis at the normal arterial segments or to prefer extra-anatomic bypass in order to avoid anastomotic complications. In our case, we did not use a graft and the SMA was reimplanted in the infrarenal aorta which was macroscopically normal. Recently, many authors reported the usefulness of the endovascular management of arterial aneurysm in BD.\(^9-11\) Transcatheter embolisation of SMA aneurysm is a reasonable approach particularly in the hemodynamically stable patient with anatomically conductive lesions such as small neck, which are distal to the origin of the SMA. The use of stents-graft was also reported but never in the superior mesenteric artery location. Bautista-Hernandez\(^12\) treated successfully an aneurysm of celiac trunk in BD with stent-graft.
with good control 6 months later. Medical treatment is very important, corticosteroids and immunosuppressors are usually used, and they can decrease the rate of false aneurysms and thrombosis.

**Conclusion**

A successfully treated superior mesenteric artery aneurysm in a patient with Behcet disease is reported. Early surgical outcome in this patient was satisfactory. However, careful follow up of patients with Behcet syndrome will be necessary.

**References**


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