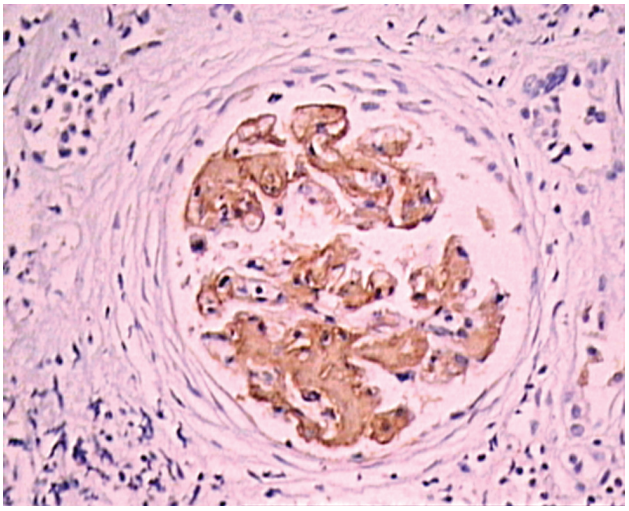

Figure 1. The glomerulus demonstrating cytoplasmic reactivity for amyloid A (Diaminobenzidine, x400).

Intestinal involvement constitutes the major gastrointestinal localization of BD. Colonic or ileo-colonic lesions may present in the form of acute complications (perforation, massive hemorrhage) or by prolonged diarrhea (4).

Genetic and environmental factors play a role in the pathogenesis of amyloidosis, such as MEFV mutations and serum amyloid A(SAA) protein gene polymorphism. M694V, M694I, V726A, M680I, and E148Q are the most frequent MEFV mutations (5).

Eprodisate, a specific drug for secondary amyloidosis, has been developed and evaluated, though it has not yet been approved by the Food and Drug Administration (FDA) (6).

In patients with BD and prolonged diarrhea, systemic amyloidosis should be kept in mind, although it rarely occurs. Coexistence of a genetic mutation such as in the MEFV gene may predispose patients to develop amyloidosis. More studies are needed to clarify the role of MEFV mutations in BD-related amyloidosis.

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Cancer of the transverse colon revealed by a gastrocolic fistula

Gastro-kolik fistül ile prezente olan transvers kolon kanseri

To the Editor,

Gastrocolic fistula (GCF) secondary to colon carcinoma is a rare entity. Establishing the diagnosis of GCF is difficult because it has nonspecific symptoms on admission. We report a case of GCF due to adenocarcinoma of the transverse colon who had only a one-month history of nausea, vomiting and weight loss.

A 50-year-old man admitted to our hospital complaining of nausea, vomiting and weight loss. Labo-

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Figure 1. A fecal flow seen by upper endoscopic examination.

Figure 2. The colon segments were opacified immediately after passage of the barium enema into the gastric lumen.

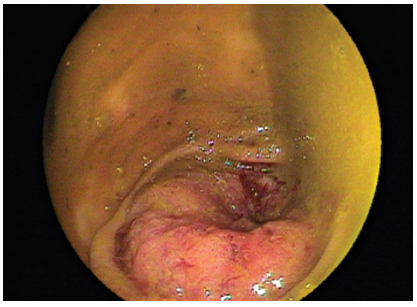

Figure 3. The central hole of the mass lesion seen by colonoscopic examination.

ratory examination revealed anemia due to the iron deficiency and high sedimentation rate. Upper endoscopic examination showed a fecal flow through the gastric folds (Figure 1). Multiple blind biopsies were taken from the mucosa. Barium studies revealed an obvious GCF between the greater curvature of the stomach and the proximal transverse colon (Figure 2). The colonoscopy demonstrated a large mass with a central hole surrounded by hyperemic, fragile mucosa, which protruded into the lumen of the transverse colon. The endoscope could be passed in to the gastric lumen through this central hole of the mass lesion during the colonoscopic examination, which supported the large fistulous opening to the gastric corpus from the transverse colon and which was previously identified by barium studies (Figure 3). The histological examinations revealed a foveolar hyperplasia and gram (–) bacteria colonization in the biopsies of the gastric mucosa, and a well-differentiated adenocarcinoma of the transverse colon. Moreover, the abdominal computed tomography determined multiple metastatic lesions in the liver, and a mass lesion infiltrating both the gastric and colonic wall. The patient declined any treatment modalities.

Although the most common cause of GCF in the past had been benign gastric ulcerations, malignant lesions have replaced them in recent years (gastric adenocarcinoma, gastric lymphoma, carcinoid tumors of the colon, and rarely, metastatic tumors and infiltrating tumors of the pancreas, duodenum and biliary tract (1). However, the GCF is an uncommon presentation of adenocarcinoma of the transverse colon (2). A variety of other causes of GCF have been reported: syphilis, tuberculosis (3), abdominal trauma, inflammatory bowel disease (4), cytomegalovirus, gastric infection in acquired immunodeficiency syndrome (AIDS) patients and gastrojejunostomy (5), and taking corticosteroids or nonsteroidal anti-inflammatory drugs.

Barium enema is the most accurate examination for establishing the diagnosis of GCF (1), with a sensitivity of 90% and specificity of 30%. Esophagogastroduodenoscopy and colonoscopy are also helpful, not just for the diagnosis but also to rule out any malignant disease.

The treatment of GCF is based on the underlying disease, but mostly consists of nutritional support with parenteral or enteral hyper-alimentation, and resective surgery, if possible (1-5).

Gastrocolic fistula (GCF) is an uncommon presentation of adenocarcinoma of the transverse colon. Persistent vomiting may suggest a probable GCF despite the nonspecific clinical findings.

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