TO THE EDITOR

Oral mucosa has several functional similarities with small intestinal epithelium, including immunological functions. Oral features of Crohn’s disease include ulcerations, lip fissuring, cobblestone plaques, recurrent buccal space abscesses and mucosal tags. Recurrent aphthous ulcerations and Crohn’s disease share features such as familial tendency, psychological factors and response to corticosteroids and immunosuppressive drugs; both are considered to be of autoimmune nature. Differential diagnosis of oral ulcers in Crohn’s disease must be done mainly from Adamantiadis-Behcet disease and herpetic stomatitis and can sometimes be extremely difficult.

A 21 year-old student presented at the Emergency Department of our hospital complaining of unbearable perianal pain during the previous 3-days. Physical examination showed an erythematous and perianal area extremely sensitive to touch. Digital examination was so painful that the patient could hardly stand it. However, no signs of hemorrhoid thrombosis or any kind of fissure were evident. Discussing past medical history including sexual medical history, the patient mentioned that 4 years earlier he had been diagnosed at another hospital with “atypical” Adamantiadis-Behcet disease and herpetic stomatitis and can sometimes be extremely difficult.

In the patient presented here, oral ulcer biopsies were not suggestive of Crohn’s disease. However, granulomas in biopsy specimens should not always be considered as
the hallmark of Crohn’s disease according to our own experience from bowel biopsy studies. This presumably may also happen to biopsies from extraintestinal tissues with high suspicion of the so-called “metastatic” Crohn’s disease to sites other than the bowel. When the gastrointestinal tract is involved in a patient with Adamantidiadis-Bechet’s, the differential diagnosis from Crohn’s disease is only of aetologic importance, as the pharmacologic treatment used is similar. Oral Cronh’s disease can be misdiagnosed as Adamantidiadis-Bechet disease for many years, until correct diagnosis is made. Oral ulcers, along with other extraintestinal manifestations, especially these of skin, may be active despite remission of bowel symptoms and often require additional local therapy.

Thus, in any patient with recurrent atypical oral ulcerations or recurrent oral cavity aphthae of unknown aetiology, the possibility of Crohn’s disease should never be ignored or even underestimated, especially in younger patients. Furthermore, in any such case of atypical Adamantidiadis-Bechet disease, the gastrointestinal tract must always be carefully investigated in order to exclude other diseases, including Adamantidiadis-Bechet disease, with gastrointestinal involvement, or even quiescent Cronh’s disease.

REFERENCES