and effective endoscopic alternative for closure of enteric fistulas in patients who want to avoid surgical options. However, large, prospective studies are needed to compare the long term outcomes from OTSC clip repair compared to surgical intervention for fistulae.

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Crohn's Appendicitis

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Background: Inflammatory bowel disease (IBD) represents a spectrum of disorders characterized by chronic inflammation of the gastrointestinal luminal organs. Granulomatous appendicitis, or Crohn's appendicitis, is another rare presentation of IBD and is usually found on a pathology specimen after the appendix is removed. This case report presents a patient who manifested his Crohn's colitis with acute appendicitis. The patient's diagnosis was made based on his clinical presentation without performing appendectomy.

Case: 37 yo male with h/o mild Ulcerative colitis/proctitis for one year presented with acute abdominal pain and diarrhea. Patient had a negative McBurney's sign, yet his abdomen was tender to palpation in the peri-umbilical area. WBC 12.3 THDS/CMM, Hgb 11.8 G/DL, INR 1.6. The stool negative for any infection, including clostridium difficile. CT scan of abdomen and pelvis demonstrated a thick wall dilated appendix consistent with acute appendicitis. There was also a colonic wall thickening from rectum to traverse colon, consistent with colitis. The diagnosis of appendicitis was entertained. Due to the fact that patient's clinical presentation was more consistent with exacerbation of his colitis, the decision was made not to perform appendectomy. Colonoscopy was performed and demonstrated moderate to severe pancolitis. Biopsies revealed crypt abscesses and chronic inflammation. A diagnosis of Crohn's appendicitis with colitis was made and the patient was started on high dose IV Methotrexate. Patient's clinical condition deteriorated and he was switched to IV Infliximab. Within 12 hrs of Infliximab infusion, the patient improved and was discharged from the hospital.

Discussion: Granulomatous appendicitis has been categorized as primary Crohn's disease of the appendix based on its pathologic features (1). Appendectomy is often the surgical procedure in patients with Crohn's disease. Few data exist on appendiceal Crohn's disease.

This case report demonstrates the importance of correlating clinical and radiographic findings in diagnosing Crohn's appendicitis. Medical treatment of Crohn's appendicitis without appendectomy proved to be sufficient.


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WITHDRAWN

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Crohn's Disease, Malignant Melanoma, and Churg-Strauss Syndrome: A Treatment Dilemma

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A 71-year-old man with Churg-Strauss disease on low-dose prednisone (prior azathioprine use), diabetes, atrial fibrillation, and diverticular disease presented with hematochezia, pain with defecation, & increased stool frequency. He denied abdominal pain, fever, nausea, emesis, weight loss, constipation, joint pains, skin rash or eye pain. Vital signs were normal, abdomen was soft, non-tender, non-distended, and rectal examination revealed perianal irritation and significant pain without fistulae. Laboratory studies revealed elevated CRP of 92.8 mg/L (normal 0.5), normal C. difficile, Shigella PCR and stool culture.

A CT abdomen revealed 5-10 cm concentric wall thickening in the sigmoid colon with associated peri-colonic mesenteric hyperemia. Colonoscopy revealed nodularity and irregularity in the rectum and an inflammatory stricture in the sigmoid colon with deep ulcerations, and pathology revealed active chronic colitis with ulceration. Of note, a colonoscopy 5 months prior was normal. Treatment with aminosalicylates was unsuccessful and due to unclear diagnosis and concern for malignancy, laparoscopic sigmoid resection with primary anastomosis was performed. Surgical pathology showed moderately active chronic colitis with creeping fat, stricture formation, transmural chronic inflammation, and granulomas consistent with Crohn's disease. Six months later, he developed recurrent rectal bleeding and colonoscopy revealed moderately ulcerated rectal mucosa and mild inflammation of his colonic anastomosis consistent with moderately active Crohn's disease. In the interim, he underwent excision of a mole on his back and pathology was consistent with malignant melanoma. Therefore, the decision was made to defer anti-TNF therapy and the patient was treated with vedolizumab, a gut selective anti-integrin molecule.

In addition to typical dermatologic manifestations such as pyoderma gangrenosum and erythema nodosum, patients with inflammatory bowel disease (IBD) are at increased risk for non-melanoma skin cancers and malignant melanoma. A meta-analysis revealed that IBD was associated with an increased risk of malignant melanoma, independent of treatment with biologic therapy, and is increased with anti-TNF treatment and immunomodulatory medications. In contrast, since vedolizumab selectively blocks gut leukocyte trafficking, it is likely to have lower systemic immunosuppression and lower risk for melanoma.