CASE DESCRIPTION/METHODS: A 25-year-old woman was diagnosed with Crohn’s disease in 2011. After initial treatment failure with mesalamine, she was on Infliximab (INF) and later decided to discontinue with complete resolution of CP and normal troponin. The patient was discharged on colonic release budesonide and two weeks later reported no CP. Labs at that time revealed a negative troponin, low CRP 34, and a BNP of 36.7.

DISCUSSION: Mesalamine is an effective treatment in UC. Rare AE include blood dyscrasias, purpura, myelosuppression, and pancreatitis. Some of these, MIM can be fatal and a high degree of clinical suspicion is required for early diagnosis and management. The pathophysiology of mesalazine-induced inflammatory bowel disease points to a wider spectrum of the disease than previously acknowledged. MIM usually occurs within 2-4 weeks of starting therapy and early diagnosis tends to result in near complete resolution of symptoms after discontinuation of the medication2,5. This highlights the importance of prompt diagnosis and management of MIM.

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2084

An Atypical Case of Oral Crohn’s Disease
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INTRODUCTION: Oral manifestations of Crohn’s disease are wide ranging from fissuring and linear ulcerations to cobblestone plaques, mucosal tags, and buccal edema. The comminuity between them is the presence of subepithelial non-casting granulomas on biopsy not explained by another etiology. There is general agreement that oral manifestations are underdiagnosed and that there may be a wider spectrum of disease than previously realized. We present a case of oral Crohn’s that differs in presentation from others previously described in the literature.

CASE DESCRIPTION/METHODS: 25-year-old woman who was diagnosed with Crohn’s disease on colonoscopy in 2011. After initial treatment failure with mesalamine, she was on Infliximab for 3-4 years but stopped as she preferred to avoid infusions. She started Humira in January 2016 after a Crohn’s flare but did not improve despite the addition of 6-MP. She stopped both Adalimumab and 6-MP in September 2017 after developing facial and lip swelling concerning for an allergic reaction. Complement and C1 esterase inhibitor levels were within normal limits, ruling out hereditary angioedema. The abdominal symptoms worsened off treatment, colonoscopy revealed moderately active left-sided colitis. While her facial swelling improved, her lip swelling did not. On exam she initially had cobblestoning, a tongue fissure, and swelling of the lower lip. She was evaluated by oral and maxillofacial surgery (OMFS) in May 2018 and at that time had a firm, mobile 1.5 × 1 cm exophytic lesion with surface ulcerations of the right buccal mucosa and right lower lip swelling. The buccal lesion was thought to be either a traumatic fibroma or oral Crohn’s disease. It was excised after a month later and pathology revealed granulomatous inflammation with no organisms on gram stain or AFB stain, consistent with oral Crohn’s disease. She subsequently started Ustekinumab and achieved clinical and endoscopic remission. An oral prednisone taper for her lip swelling had no effect. She then had 2 tramcinolone injections by OMFS with improvement in the lip appearance.

DISCUSSION: In this case a woman with intestinal Crohn’s disease developed an exophytic lesion of the buccal mucosa diagnosed as oral Crohn’s disease on biopsy. This atypical presentation of an underdiagnosed aspect of Crohn’s disease points to a wider spectrum of the disease than previously acknowledged. It also highlights the importance of an interdisciplinary approach with dentistry to better recognize and treat oral symptoms.

2085

Suspected Crohn’s in Acute Salmonella Enterocolitis: A Journey of Differentiating Two Common Terminal Ileitis Etiologies
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INTRODUCTION: Terminal ileitis signifies a generalized inflammatory process in the most distal portion of the small bowel, with an expansive range of underlying etiologies including Crohn’s disease and salmonella. Although stool cultures may reveal a salmonella infection, the diagnosis becomes more difficult if stool cultures are positive but patients do not respond to antibiotics. Treating such pathology with two potential underlying etiologies may lead to further complications, specifically, when administering corticosteroids and immunotherapy for an autoimmune disorder may conflict with active treatment against an acute infection. Our case presents a patient who had known salmonella positive stool cultures but inconsistent colonoscopy and pathology results. He ultimately improved with steroids and anti-TNF therapy.

CASE DESCRIPTION/METHODS: A 29-year-old male with history of small bowel obstruction of unknown etiology. Patient presented with acute on chronic diarrhea and abdominal pain. He denied any recent sick contacts, ingestion of raw or undercooked food, or personal or family history of inflammatory bowel disease (IBD). CT scan identified terminal ileitis. Stool cultures returned positive for salmonella. Despite treatment with ciprofloxacin, patient’s symptoms persisted. Colonoscopy revealed diffuse inflammation and ulceration of the terminal ileum without stricture, with extension into the ascending and transverse colon. Preliminary biopsy revealed reduction in goblet cells. The patient was treated with sulfasalazine and subsequent infliximab due to the high suspicion of underlying IBD pathology after receiving a course of antibiotics. Though his hospital course was complicated by partial small bowel obstruction, his symptoms ultimately resolved.

DISCUSSION: Terminal ileitis secondary to Crohn’s disease and salmonella may overlap in presentation which can complicate therapy. In this case, it is probable that there was a component of IBD superimposed with a bacterial infection, given the acute on chronic nature of his symptoms. In the case of superimposed infection, antibiotics should be initiated prior to prescribing immunosuppressive therapy that could allow further erosion. However, waiting to initiate immunosuppressants must be balanced with a patient’s worsening clinical picture and complications such as small bowel obstruction.

2086

The Importance of Careful Appendiceal Inspection During Surveillance Colonoscopy in IBD Patients: A Case of Appendiceal Mucocele in an Ulcerative Colitis Patient
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INTRODUCTION: Appendiceal mucocele (AM) is a rare condition in which the appendix dilates and fills with mucus. These lesions can be benign or malignant and are classified into mucinous adenomas, low-grade appendiceal mucinous neoplasm (LAMN) and mucinous adenocarcinoma.
Patients with inflammatory bowel disease (IBD) are at increased risk of colorectal neoplasia, but it is unknown whether IBD is associated with AM.

CASE DESCRIPTION/METHODS: The patient is a 42-year-old female with a 24 year history of ulcerative colitis (UC) who presented with acute bloody diarrhea. She was diagnosed with UC at age 18, requiring treatment with cyclosporine and prednisone. She maintained steroid-free remission on treatment. She was clinically asymptomatic for 4 years until 2013, requiring treatment with cyclosporine and prednisone. She maintained steroid-free remission on therapy; studies show the rate of seropositivity in IBD patients is the same as the general population (70%). Due to this there is a concern for reactivation when long term immunosuppressive therapy is initiated. Here we present the case of a patient who presented with CMV colitis prior to initiation of any therapy or diagnosis of IBD; CMV colitis in immunocompetent patients remains fairly rare.

CASE DESCRIPTION/METHODS: A 30-year-old male with a history of EoE and PUD presented with seven days of painful hematochezia and constipation; he denied any fevers, however did have chills and cold sweats. He had no history of IVDA, intranasal drug use, anal sex, or risky sexual behaviors. His temperature was 103.2 F, he was tachycardic and tachypneic on presentation. CT revealed fecalization of the small bowel, significant stool burden, and rectal stool. He was started on intravenous antibiotics and nasogastric suction. He did not meet criteria for IVH in patients with UC on therapy has been associated with increased response to steroids and other immunosuppressive therapies. Prognosis is poor unless the infection is promptly identified and anti-viral therapy is started. It still remains a rare entity in immunocompetent patients.

DISCUSSION: CMV colitis is seen in patients with IBD on long term immunosuppressive therapy; studies show the rate of seropositivity in IBD patients is the same as the general population (~70%). Due to this there is a concern for reactivation when long term immunosuppressive therapy is initiated. Here we present the case of a patient who presented with CMV colitis prior to initiation of any therapy or diagnosis of IBD; CMV colitis in immunocompetent patients remains fairly rare.

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