a diagnostic challenge for providers. We present a case of MCD in a woman with previously undiagnosed Crohn’s disease at initial presentation.

CASE DESCRIPTION/METHODS: A 68-year-old woman presented to the Emergency Room with an acute onset of left-sided abdominal pain. She also noted a 6-month history of watery diarrhea with up to 8 bowel movements daily, describing them as bloody with a jelly consistency. On examination a painful acute onset of left-sided abdominal pain. Ulceration visualized at the right inguinal area.

DISCUSSION: MCD is a rare dermatologic manifestation characterized by its non-caseating granulomatous histopathology in non-contiguous areas from the gastrointestinal tract. Typically the GI disease precedes the skin disease for at least six months, however the skin manifestation can be the first sign of Crohn’s disease. The diagnosis should be suspected when “knife-like” ulcerations are seen on physical exam in a patient with known or suspected Crohn’s disease. Exclusion of other granulomatous diseases that could mimic MCD is required to confirm the diagnosis. Early recognition of this disease may ultimately spare unnecessary tests or treatments.

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A Case of IgA Vasculitis in Crohn’s Disease and Recurrent Clostridioides difficile Infection
Elda Voth, MD, Emily Olsen, MD, Laura E. Reifels, MD, FACG. Mayo Clinic, Rochester, MN.

INTRODUCTION: IgA vasculitis (IgAV) is an immune-mediated systemic vasculitis characterized by palpable purpura, arthralgias, abdominal pain, and renal disease. Approximately 60% of cases occur in children; however, adults are at increased risk for more severe disease. The pathogenesis of IgAV is associated with inflammatory, infectious, autoimune, and medication triggers, including tumor necrosis factor (TNF) alpha inhibitors. We describe a case of a man with Crohn’s disease (CD) who developed IgAV in the setting of a perirectal abscess, recurrent Clostridioides difficile infection (CDI), and anti-TNF therapy.

CASE DESCRIPTION/METHODS: A 20-year-old man with ibdondic, Crohn’s disease and perianal involvement, inflammatory arthritis, and recurrent CDI presented to an outside ED with increased abdominal pain and rash on the extremities, trunk, and soft palate. Medications included etanercept, vedolizumab, and prednisolone. In the ED, the patient was hypotensive and tachycardic. CT abdomen/pelvis noted multifocal active inflammatory disease and a 3.2 cm abscess in the left ilioischial fossa. He was initiated on broad spectrum antibiotics for septic shock and underwent emergent perirectal drain placement; post-operatively, his shock resolved. He was transferred to our institution for further management. Upon arrival, the patient was hemodynamically stable and remained on broad spectrum antibiotics and high dose prednisone. Review of systems was notable for worsening abdominal pain and hematuria. Biopsy of the rash demonstrated IgA vasculitis. C. difficile toxin PCR was positive. Repeat urinalysis demonstrated nephrotic range proteinuria and hematuria, consistent with IgA nephropathy. ACE-inhibitor therapy was initiated, and skin lesions gradually improved with topical tacrolimus.

DISCUSSION: We report a case of a patient with ileoconic and perianal Crohn’s disease on TNF-alpha inhibitor therapy who developed IgA vasculitis in the setting of septic shock secondary to perirectal abscess and recurrent CDI. This case highlights anti-TNF therapy, infection and inflammatory bowel diseases as potential causes of systemic vasculitis. A high clinical suspicion is needed in order to obtain an early histopathologic diagnosis for IgAV and prompt evaluation of other organ system involvement.

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Antibiotic Dependent Pouchitis Successfully Managed With Vedolizumab in a Patient With a Prior History of Renal Malignancy
Kanthi Farrakhah, MD1, Sean Fine, MD, MS2. 1Rhode Island Hospital, Providence, RI; 2Brown Medicine, Riverside, RI.

INTRODUCTION: Pouchitis is a known complication of ileal pouch-anal anastomosis (IPAA). The mechanism is unknown but is felt to be due to altered bacterial flora and then a dysregulated immune response in the pouch. Although one of the mainstays of treatment is antibiotics, long-term use for patients with chronic pouchitis (CP) may not be addressing the underlying mechanism while also subjecting the patient to the risk of prolonged antibiotics. New limited data supports the use of biologics in the management of CP. We report a case of a man with a history of chronic antibiotic dependent pouchitis (CADP) and prior malignancy who was successfully managed with vedolizumab.