(21230) - INTESTINAL VASCULITIS PRESENTING WITH PENETRATING DISEASE: A CASE REPORT

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Introduction: Gastrointestinal involvement with vasculitis is most prevalent in patients with immunoglobulin A vasculitis, antineutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis, polyarteritis nodosa (PAN), and Behçet syndrome; Gastrointestinal manifestations vary, but abdominal pain, nausea, vomiting, diarrhea, and gross or occult blood in the stool are frequent. Imunossupresion is usually the preferred therapy.

Aim: to describe a case of intestinal vasculitis presenting with penetrating disease.

Case Summary: We report the case of a 52-year-old male patient who presented to the emergency department with myalgia, arthralgia, and petechia. The symptoms began ten days before the admission, with intense, diffuse, colicky abdominal pain that progressively subsided and was replaced with small-joint peripheral arthritis, diffuse myalgia, and lower limb petechia. He denied fever, viral symptoms, and other gastroenterological symptoms, including diarrhea. He had no significant past family or medical history and denied recent travels or animal contact. Lab values were significant for C-reactive protein (CRP) of 17mg/dL and serum sodium of 124mEq/L. He had no anemia or thrombocytosis; kidney function and urine analysis were normal. Creatinkinase levels and lactate dehydrogenase were normal. Point of care ultrasound (POCUS) revealed wall thickening of the proximal third of the ascending colon and cecum (11mm), appendix (9mm), and last ileal loop (7mm). An ill-defined hypoechogenic formation, with 17x18mm, was seen between the latter- mentioned areas. We further characterized this area with an abdominopelvic computed tomography (CT), which reported a combined segment of inflamed small bowel and colon with an extension of 130cm and 17x22mm formation with complex liquid density in-between the appendix and last ileal loop, suggestive of an abdominal abscess. We

assumed the diagnosis of an intestinal vasculitis complicated with superimposed bacterial infection and started IV ciprofloxacin and metronidazole and went NPO. Stool cultures were negative. The erythrocyte sedimentation rate was 71mm/Hr, and p-ANCA titers were 1/80 (PR3 and MPO negative). The remaining immunological panel, viral, and bacterial serologies were negative. There was no evidence of multisystemic vasculitis. After five days of IV antibiotics, the patient showed significant clinical improvement, as the CRP went down to 0.98mg/dL. Ultrasonography showed homogeneous contrast enhancement of the hypoechogenic region (CEUS technique). However, it raised concerns for intestinal fistulae, confirmedon pelvic CT as a 6mm entero-enteric fistula. We discharged the patient on exclusive enteric nutrition and oral antibiotics, with tight clinical and POCUS follow-up. At the one-month appointment, all symptoms had regressed, and there was no US evidence of the phlegm, allowing the patient to resume diet and stop antibiotics. Skin biopsy revealed a leucocytoclastic vasculitis. Ileocolonoscopy performed one month after the hospital admission showed mucosal hyperemia of the ileum, ascending, and transverse colon, which on histology showed a nonspecific inflammatory pattern. Magnetic resonance enterography at 1.5 months showed enhancement without bowel wall thickening of the last ileal loop or evidence of complications. Fecal calprotectin was 8mg/kg, and considering all available evidence, Crohn's Disease was deemed a less likely diagnosis. Skin lesions reappeared two months into the follow-up, with no evidence of intestinal manifestations. We took a conservative approach after a discussion with dermatology. At six months, the patient feels well and has no signs of recurrence.

Relevance: Small vessel vasculitis affecting only the skin and gastrointestinal tract is rare, and the presence of penetratingdisease (often in the context of superimposed infection) makes it more challenging. Other plausible diagnoses were Crohn's disease with cutaneous vasculitis (excluded due to absence of chronic evolution) or yersiniosis (excluded due to negative stool tests, but we did not have serologies available). The use of immunosuppressive agents was limited due to abscess formation. In summary, this case illustrates the complexity of diagnosing and managing intestinal vasculitis with penetrating disease. General rules for managing inflammatory bowel disease and its complications can be applied.

Palavras-chave : Intestinal vasculitis, Abdominal abcess