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Inflammatory Bowel Disease; Common Dermatoses

Series Editor: Richard J. Simons, MD, FACP

Professor of Medicine

Assistant Dean for Medical Education

Director, Internal Medicine Residency Training Program

Department of Medicine

Pennsylvania State University College of Medicine

Hershey, PA

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Contributing Author: David S. Mize, MD, MS

Chief Resident and Clinical Instructor

Department of Medicine

Milton S. Hershey Medical Center

Pennsylvania State University College of Medicine

Hershey, PA

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Contributing Author: David R. Adams, MD

Chief Resident

Division of Dermatology

Pennsylvania State University College of Medicine

Hershey, PA

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Chapter 1—Inflammatory Bowel Disease: Case Studies

Series Editor:
Richard J. Simons, MD, FACP

Contributing Author:
David S. Mize, MD, MS

I. INTRODUCTION

Inflammatory bowel disease (IBD), sometimes called idiopathic IBD because of its unknown etiology, comprises 2 similar yet distinct diseases: Crohn's disease and ulcerative colitis (UC). UC is characterized by inflammation of the colonic mucosa only. This inflammation always involves the rectum and proceeds proximally in a continuous fashion to involve variable lengths of colon. UC does not involve other parts of the gastrointestinal (GI) tract besides the colon, except for occasional involvement of the terminal ileum known as *backwash ileitis*. In contrast, Crohn's disease manifests as inflammation throughout the entire thickness of the bowel wall, and many complications of the disorder develop from this transmural involvement. Crohn's disease may involve any part of the GI tract, from mouth to anus, but spares the rectum in most cases. One can sometimes find normal bowel, referred to as *skip lesions*, in between areas of diseased bowel.

In some patients, IBD can run an indolent course; others, however, may have substantial morbidity, with sequelae including chronic abdominal pain, bowel obstruction, multiple abdominal surgeries, liver disease, and colorectal cancer. Often, the primary care physician must make a diagnosis of IBD and, with the gastroenterologist, plays an important role in managing patients with chronic IBD symptoms. This article will review the presentation, course, treatment, and complications of IBD. Five case patients are presented to highlight features of the management of IBD.

II. CASE PATIENT I

PRESENTATION

Patient 1 is a 21-year-old female college student who presents to her primary care physician because of

bloody diarrhea, which began a few weeks ago. Since symptom onset, her bowel movements have become more frequent and increasingly loose, such that she now has 3 to 5 bowel movements each day. During the past week, she has noted small amounts of blood and mucus in her stool. She has been having tenesmus and crampy, left lower quadrant abdominal pain that is relieved with bowel movements. Also, she has painful, red bumps on her shins as well as pain in her ankles and knees. She denies nausea, vomiting, and weight loss. Her medical and surgical histories are both unremarkable. Currently, she is not taking any medication. Recently, she returned from summer break, which she spent volunteering at a clinic in southern Mexico and traveling throughout Central America.

On physical examination, patient 1's pulse and blood pressure are normal and do not change with postural positioning. Her abdominal examination shows tenderness in the left lower quadrant, without guarding or rebound. Perianal skin is reddened but otherwise unremarkable. Rectal examination reveals a scant amount of brown stool mixed with blood and mucus. Several red, tender nodules are noted on the anterior surface of her shins bilaterally. Examination of her joints is unremarkable.

CUTANEOUS MANIFESTATIONS OF INFLAMMATORY BOWEL DISEASE

- **What is the most likely diagnosis for patient 1's skin lesions?**
 - Erythema nodosum
 - Erythema migrans
 - Erythema multiforme
 - Erythema infectiosum
 - Erythema marginatum

Discussion

The correct answer is A. The description of the rash suggests erythema nodosum (**Figure 1**). **Erythema nodosum (EN) is the most common dermatologic**