**BACKGROUND**

Leukocytoclastic vasculitis (LCV) is an immune complex syndrome involving small vessels characterized by neutrophilic invasion, endothelial damage and fibrinoid necrosis. The most common etiologies include infections, drugs, connective tissue diseases, and malignancy. Lesion classically appearing as palpable purpura but also may appear as necrotic ulcers. Rarely, cutaneous LCV results from inflammatory bowel disease (IBD), and the pathogenesis is unclear. It has been postulated that the disrupted mucosal barrier in the inflamed gut may lead to the formation of immune complexes by the exposure of fecal antigens to intestinal immune cells. These immune complexes may then precipitate within the wall of the small vessels leading to cutaneous lesions.

**AIM**

- Illustrate an unusual case of a patient with LCV in the setting of IBD.
- Present the current literature regarding the association between these two conditions.

**CASE PRESENTATION**

HPI: 28 year old man with no significant past medical history who presented initially to an outside hospital after 1 month of intermittent rectal bleeding, diffuse abdominal pain, and weight loss. One week prior to admission, he reported increased bloody diarrhea up to 16 bowel movements per day. Simultaneously, he noted a non-pruritic, maculopapular rash on the medial aspect of his right lower extremity that began at the ankle and subsequently migrated into the groin. In addition, he developed oligoarticular arthralgias in the upper and lower extremities, splinter hemorrhages under the fingernails and severe pain in his toes with associated bluish-purple discoloration.

PMHx: Seasonal allergies, no hx tobacco use

Medications: Loratadine

Physical Exam:

- Abdomen nontender, nondistended. normactive bowel sounds. No hepatosplenomegaly.
- Extremities: Dusky purplish discoloration of the lower extremity digits

Significant Labs/Studies:

- WBC 32, Hgb 8.5, Hct 25.1, PLT 286
- Na 129, K 4.2, Cl 101, CO2 19, BUN 7, Cr 1.1
- Albumin 1.0, LFTs WNL, CRP 214
- P-ANCA 1:80, C3 low, C4, cryoglobulins, RF,ANA, C-ANCA, Hepatitis B and C serologies were normal.
- CT A/P: Pancititis with mild ascites and nonspecific mesenteric adenopathy

**REVIEW OF LITERATURE ON LCV AND IBD**

LCV is an uncommon extraintestinal manifestation of IBD. Approximately, fourteen previous cases of LCV in association with Crohn’s disease and Ulcerative colitis have been described. In the majority of cases, LCV either preceded diagnosis of IBD or occurred synchronously with intestinal symptoms. Two cases did report onset of LCV years after diagnosis. Generally, the treatment can be directed at the underlying etiology. Case reports involving IBD and LCV have described a clinical response to pulse dose steroids, mesalamine, and biologic therapies. One case required total colectomy for refractory ulcerative colitis. Our case report is the first describe the use of combination of biologic and immunomodulator therapy in the setting of IBD and small vessel vasculitis. The increasing literature supports that cutaneous lesions of unknown cause, may warrant further investigation of the gastrointestinal tract for IBD. In addition, given the fulminant presentation our case with associated hypercoagulability implies LCV may portend a more severe clinical course of IBD that may be refractory to first line therapies. Further studies are needed to confirm these observations.

**REFERENCES**