A 34-year-old previously healthy man presents to clinic with a two months history of recurrent fevers, right lower quadrant pain and weight loss. He also reports a history of intermittent, no bloody diarrhea, for the past 6 months. He has no history of travel out of the United States. He is not taking any medications. He has no family history of colorectal cancer or inflammatory bowel disease. His physical exam is remarkable for tachycardia, cachectic-appearing young man, and scaphoid abdomen with tenderness in the right lower quadrant, no guarding or rebound tenderness. Labs significant for leukocytosis (19 x10^9/L), Hgb: 8.6 g/dL, MCV: 73 fl; and CRP: 95 mg/L. A CT enterography with IV contrast showed severe inflammation in the terminal ileum connecting to a 3 cm right iliopsoas abscess. No other areas of inflammation in the small bowel. What is the best next step in the management of this patient?

A. Check IBD serologies
B. Start broad spectrum antibiotics covering enteric pathogens
C. Initiate infliximab with prednisone
D. Ileocolonoscopy with biopsies
E. Referral to colorectal surgery

Answer: B

He likely has severe fistulizing Crohn’s Ileitis. Since he is presenting with sepsis related to an intraabdominal abscess, the best next step would be to start him on broad spectrum antibiotics while you plan for source control of the abscess. An ileocolonoscopy with ileal and colonic biopsies is absolutely necessary to confirm the diagnosis of Crohn’s disease and determine the histologic severity and extent of disease. Referral to surgery and plans for immediate drainage of the abscess by interventional radiology or surgery are also appropriate after stabilizing the patient. While starting immunosuppressive therapy is contraindicated prior to source control/abscess drainage, planning to start biologic therapy would be appropriate if the diagnosis of Crohn’s disease is confirmed. IBD serologies are not recommended because they have low sensitivity, making their use in diagnosis less helpful.