



An Overlooked Cause in The Differential Diagnosis of Fever of Unknown Origin: Inflammatory Bowel Disease

Nedeni Bilinmeyen Ateş Ayırıcı Tanısında Göz Ardı Edilebilen Bir Neden:
Enflamatuvar Bağırsak Hastalıkları

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Dear Editor,

The study by Demir and colleagues entitled “Fever of Unknown Origin in Children: A Single Center Experience in Southern Türkiye” is noteworthy in that it shows that infections still play a common role in the etiology of fever of unknown origin (FUO) (1). However, despite systemic findings related to the gastrointestinal system, we believe that inflammatory bowel diseases (IBD) were not adequately evaluated in the diagnostic process in the mentioned series.

In the study, colonoscopy was performed in only five patients, and four of them were diagnosed with non-infectious inflammatory disease. Nevertheless, numerous symptoms suggestive of IBD were observed in the study group: Abdominal pain and tenderness were noted in 32 of 65 patients; additionally, significant decreases in hemoglobin levels and marked elevations in acute phase reactants such as erythrocyte sedimentation rate, ferritin, and fibrinogen were commonly detected. Despite these clinical and laboratory results, endoscopic evaluation was performed in only a limited number of patients, suggesting that the number of patients who could have been diagnosed with IBD would have been higher

if a more comprehensive endoscopic examination had been performed.

When considering IBDs in the differential diagnosis of FUO, important clues such as growth and development retardation and weight loss should be considered. However, such anthropometric assessments were not included in the study, which may lead to potential delays in the clinical evaluation and diagnosis process (1).

IBD, especially Crohn’s disease, may present in children not only with classic gastrointestinal symptoms but also with systemic and non-specific findings such as fever, weight loss, growth retardation, and anemia. Such cases may be included among patients diagnosed with FUO, and diagnosis may be delayed unless classic symptoms are observed (2,3).

In the literature, persistent fever is reported as the first symptom of Crohn’s disease, accompanied by laboratory parameters (elevated C-reactive protein, ferritin, thrombocytosis, microcytic anemia) that provide diagnostic clues (4). In addition, extraintestinal findings such as oral aphthae, skin lesions, and joint pain may complicate the diagnostic process

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(5). Therefore, in children presenting with FUO and no obvious focus of infection, IBD should be considered early, and endoscopic evaluation should be performed without delay in the presence of complaints such as systemic inflammation, abdominal pain, and growth retardation.

Best regards

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