SESSION 2
ULCERATIVE COLITIS

CASE-BASED BREAKOUT WORKSHOP

Erica is an otherwise healthy 27-year-old lawyer who has had longstanding left-sided ulcerative colitis on oral 5-ASA 4.8 g per day with her previous flare 4 years prior. You see her in your office because of a 6-week history of 5 to 6 loose stools per day, mostly bloody, and associated with abdominal cramps and a 10 lb weight loss. There is no history of antibiotic use or recent travel.

Tests done the week before by her family practitioner reveal:

- CBC-Hb 109 g/l, platelets 550, CRP 15 mg/l
- Fecal calprotectin >2100 mcg/g, stool *C. difficile* and C&S negative

You discuss therapeutic options and suggest a course of oral corticosteroids. She has taken prednisone in the past and asks if there are any other options.

Discussion Point 1

- Is there a role for biologic therapy or oral small molecules as induction agents without using corticosteroids?

After discussion, you initiate oral prednisone 40 mg /day. A colonoscopy shows Mayo 2 colitis, extending from the rectum to proximal transverse colon. Biopsies show active chronic colitis, no dysplasia.

She returns to your office 2 weeks later with concerns about sleep disturbance and minimal improvement despite oral steroid, as she now has 4 loose stools/day, mostly bloody, and some cramps. You discuss the various therapeutic options and mention the need to escalate to advanced therapies. She has seen TV commercials on various US channels about these agents and is concerned about risks of infections, cancer, and the potential impact on future pregnancy.

Discussion Point 2

- In a bio-naive UC patient, how do you select which advanced therapy to use?
- What pre-biologic screening tests do you do, and are these the same for all agents?

After discussion, you jointly decide on vedolizumab. She receives a 3-dose induction and is on a maintenance regimen every 8 weeks. Her prednisone is tapered and discontinued over a 2-month period. You see her 6 months later and after feeling much better she now has a recurrence of low-grade symptoms with abdominal cramps and 3 to 4 soft stools/day, half of which are bloody with mucus. The vedolizumab is increased to every 4 weeks, but she remains

symptomatic after 3 months and her fecal calprotectin is elevated >2100 mcg/g. She asks about other therapeutic options and shares her preference for an oral medication.

Discussion Point 3

- Is there a role for TDM in this patient who is failing vedolizumab?
- How do you select an advanced therapy in a UC patient who is bio-experienced?

After discussion, ustekinumab is initiated. Within 1 month her symptoms have resolved and she remains on maintenance therapy every 8 weeks. She subsequently undergoes a surveillance colonoscopy, which shows endoscopic remission (Mayo 0). Surveillance biopsies throughout the colon show no dysplasia but several areas of mild active chronic colitis with or without basal plasmacytosis. She sees you in follow-up and asks to stop the ustekinumab because she wishes to get pregnant.

Discussion Point 4

- What is your recommendation? Are there any guidelines or suggestions for ceasing biologic therapy in UC?
- In your practice, do you aim for histologic healing before stopping biologic therapy in UC?