SESSION 3
POUCHITIS

INTERACTIVE CASE PRESENTATION

Mira is a 26-year-old non-smoking female who was diagnosed with ulcerative colitis at age 9. She was initially treated with corticosteroids and 5-ASA. Due to fulminant colitis not responsive to intravenous corticosteroids and infliximab, she underwent a restorative proctocolectomy with subsequent ileoanal pouch anastomosis surgery at age 15. You first meet her at the pediatric to adult transition/young adult IBD clinic at age 18, where she recounts that she usually has 7 semi-formed bowel movements a day, no nocturnal wakening, but occasionally has quite marked urgency and tenesmus in the absence of blood. She admits she has been quite anxious about starting university and wonders if this may be contributing. Stool cultures are negative for enteric pathogens and C. difficile. Mira asks if you can just prescribe 'something' as she can't afford to take time off school to do a radiologic or endoscopic evaluation.

Decision Node 1

- What do you recommend next?
  - **a.** Probiotics
  - **a.** Empiric antibiotics
  - **a.** Rectal 5-ASA therapy
  - **a.** Tricyclic antidepressant (low dose)
  - **a.** An immunomodulator

Given her predominant symptoms are urgency and tenesmus, you prescribe 5-ASA suppositories for presumptive cuffitis. She happily reports that symptoms have returned to baseline after 4 weeks of daily suppositories and you recommend she uses these on an as needed basis.

At annual follow up, she reports that over the last 2 months, stool frequency has increased to 10 BM/day, and she has 1 nocturnal BM. Restarting rectal 5-ASA has not made a difference. Repeat stool cultures are negative. Pouchoscopy is arranged and confirms acute pouchitis. You prescribe 2 weeks of amoxiclav. She does well for 6 months, but symptoms recur, and her family physician prescribes another two courses of amoxiclav with only minor improvement in symptomatology. Meanwhile, she is reminded not to use NSAIDs for sports-related injuries. She requests a follow up appointment for recurrent abdominal pain associated with nausea and vomiting, urgency, tenesmus, and frequent bowel movements.

Decision Node 2

- What would you do now?

  a. Trial a different antibiotic
  b. Start an immunomodulator
  c. Start a biologic
  d. FMT
  e. Recommend radiologic evaluation of the pouch
  f. Recommend pouchoscopy

Repeat pouchoscopy demonstrates erythema of the pouch, scattered ulcerations and some narrowing at and just above the pouch inlet, so you are only able to visualize the distal 3 cm of the pre pouch ileum. You are worried about her nausea and vomiting and arrange an MRE. MRE confirms the distal inflammation but also shows a 10 cm segment of inflammation in the distal pre pouch ileum.

Decision Node 3

- What would you consider prescribing next??

  a. Continuous antibiotics
  b. Adalimumab (avoiding infliximab due to previous exposure)
  c. Vedolizumab
  d. Ustekinumab
  e. Risankizumab
  f. JAK inhibitor
  g. Ozanimod

Mira does well on induction and maintenance vedolizumab therapy. Congratulations, you had great foresight and should have co-authored the EARNEST trial (please see Professor Travis after the session)! She did require one dilatation of the pouch inlet a year after starting vedolizumab but subsequent, clinical, biochemical, radiologic, and endoscopic examinations confirm disease remission. You see her in consultation a few years later in the IBD preconception clinic. She continues to do well and is keen to start a family.

Decision Node 4

- What do you advise for mode of delivery?

  a. Vaginal delivery
  b. Cesarean section