SESSION 5
ELDERLY AND IBD

INTERACTIVE CASE PRESENTATION

Henry is a 72-year-old retired geologist with a history of left-sided colitis for 8 years. He was initially treated with a tapering course of corticosteroids and maintained on 5-ASA 4.8 g daily. Past medical history is remarkable for a myocardial infarction 3 years ago, requiring 2 stents. Echo last year shows an ejection fraction of 45%. Four months ago, after receiving antibiotics for a dental infection, he developed *C. difficile*, successfully treated with vancomycin. However, since then he has been flaring (6 BM/day, 50% with blood). He is afraid to go golfing due to a fear of accidents. He is compliant with 5-ASA. He is treated with budesonide-MMX with limited benefit. Colonoscopy shows Mayo 1-2 left-sided colitis.

Decision Node 1

- What do you recommend next?

a. Prednisone taper
b. Prednisone taper with immunomodulator
c. Anti-TNF therapy
d. Vedolizumab
e. Anti-IL12/23
f. JAK inhibitor
g. Ozanimod

You recommend vedolizumab, and Henry agrees. He receives 3 induction doses followed by 300 mg every 8 weeks. Six months later, he is doing well, with 1–2 formed stools daily without blood or urgency. His fecal calprotectin (FCP) is 52. Oral 5-ASA is discontinued. He subsequently complains of inflammatory-type joint pain with morning stiffness. You try adding methotrexate, but this causes nausea and so is discontinued. Flex sigmoidoscopy shows no active colitis, only chronic changes.

Decision Node 2

- What would you do now?

a. Refer to rheumatology
b. Switch to anti-TNF
c. Switch to a JAK inhibitor
d. Switch to anti-IL12/23

You refer to rheumatology and decide to add sulfasalazine while you wait. He does not tolerate the sulfasalazine and so it is discontinued.

He sees the rheumatologist 3 months later, at which point he is clinically well from the perspective of his ulcerative colitis. The

rheumatologist agrees that this is likely IBD-related arthropathy and recommends that you switch to either an anti-TNF or JAK inhibitor.

Decision Node 3

- What would you consider prescribing next?

  a. Adalimumab
  b. Infliximab
  c. Tofacitinib
  d. Upadacitinib
  e. a or b
  f. c or d
  g. All of the above are equal options

You assess Henry in clinic and discuss treatment options. He is interested in the oral medication that the rheumatologist mentioned as he thinks this would fit best with his lifestyle. You provide him information about upadacitinib and arrange for the recombinant zoster vaccine prior to starting. He calls your office the following week as he read that that there is a black box warning for JAK inhibitors for individuals >50 years of age with cardiac risk factors. He reminds you that he had a heart attack several years ago.

Decision Node 4

- What do you tell him?

  a. You offer him anti-TNF therapy
  b. You offer him an anti-IL12/23 therapy
  c. You explain benefit and risk and still suggest a JAK inhibitor
  d. You tell him he needs to choose between having the arthritis or risk for cardiac disease

He decides on anti-TNF therapy.

Decision Node 5

- At this point you would:

  a. Still recommend recombinant zoster vaccine
  b. Reconsider anti-TNF because there is potential adverse cardiac response in patients with heart failure
  c. Recommend pneumococcal polysaccharide vaccine
  d. Stop the vedolizumab after first infliximab infusion
  e. Overlap the infliximab with vedolizumab at least through the induction of infliximab
  f. a, c and d
  g. a, c, and e