

SESSION 2 CANCER AND IBD

Case-based breakout Workshop

Ann is a 63-year-old female with a long-standing history of ileocolonic and perianal Crohn's disease (CD) with a history of multiple resections. She is an on-and-off smoker and has 1–2 drinks per week. She is on infliximab 5 mg/kg every 4 weeks and methotrexate (MTX) 12.5 mg weekly and is in clinical remission. She presents with weight loss, painful swallowing and cervical lymphadenopathy. She underwent ultrasound of a necrotic lesion and biopsies show poorly differentiated carcinoma. She was referred to ENT for quadroscopy. Biopsies of tonsils revealed bilateral infiltrating, non-keratinizing, moderately differentiated squamous carcinoma. She is awaiting surgery and oncology assessment.

Her investigations revealed:

- WBC: 6.6 x 10⁹/L
- Hb: 109 g/L
- CRP: 2.4 mg/L
- Alb: 28 g/L
- Fecal calprotectin (FCP): 156 mcg/kg

Decision Node 1

- Would you perform a colonoscopy and/or MRE prior to treatment of her malignancy? Why or why not?
- What do you do with her infliximab and MTX?
- Is her tonsil cancer related to her IBD or IBD medications?

After discussion with the patient you decided to hold her MTX and infliximab while she undergoes treatment for her malignancy. She is afraid her disease will flare if she holds her CD medications for too long.

She underwent surgical resection for her malignancy. She was seen by the oncologist who recommended cisplatin chemotherapy and radiation. The patient declined chemotherapy but accepted radiotherapy.

Decision Node 2

- How long do you hold her medications?
- Does the type of oncological treatment (surgery, chemotherapy, radiotherapy) influence your decision?
- What is her risk of flaring when you hold her medications?





She undergoes six weeks of radiotherapy. She had a percutaneous endoscopic gastrotomy (PEG) tube inserted to help with nutrition as she had difficulty swallowing post-operatively. You do FCP testing every three months.

- FCP (January): 228 mcg/kg
- FCP (April): 1286 mcg/kg

Clinically she is doing okay, with two to three bowel movements daily and no significant abdominal pain. Her perianal disease is inactive. She has completed her radiotherapy. You decide to restart therapy, as the FCP is rising.

Decision Node 3

- Do you restart both infliximab and MTX?
- Would you have done anything differently if she was on chemotherapy?

She receives a standard three-dose induction regimen of infliximab adjusted to her new weight. You decide to use monotherapy and not restart the immunomodulator. Repeat FCP in four months is 56 mcg/kg. She continues to follow with oncology, ENT, and gastroenterology. She requires repeat dilations of her post-radiotherapy esophageal stricture.

Decision Node 4

- Would you have chosen a non-anti-TNF agent when the FCP increased?
- How will your knowledge of safety and efficacy of other anti-TNF agents, ustekinumab and vedolizumab, affect the choice of one drug over the others in patients with cancer?
