MEETING OF THE MINDS

RITZ-CARLTON HOTEL, TORONTO

2000 – MENTORING IN IBD – 2019
20 YEARS
ANNIVERSARY

FRIDAY, November 15, 2019

MENTORING in IBD XX
THE MASTER CLASS

#IBDMinds2019

Co-Chairs: **Alain Bitton**, MD FRCPC and **John K. Marshall**, MD MSc FRCPC AGAF

Crohn's and Colitis Canada
Crohn et Colite Canada

UNIVERSITY OF ALBERTA

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Extraintestinal Manifestations in IBD: Rheumatological

Case-based Workshop

Breakout Session

Initial Presentation

- 33-year-old female with an 8-year history of Crohn's disease (CD)
- She has two young children (toddler and baby)
- She has noticed increasing morning back pain, causing poor quality of life and a mild increase in gastrointestinal (GI) symptoms which she only admits to on extended questioning.

Initial Presentation

- GI symptoms include three semi-formed bowel movements (BMs)/day with no bleeding or abdominal pain
- She has been on azathioprine 100 mg/day for the last five years, and has had previous exposure to 5-ASA
- She has had one prior course of oral corticosteroids prior to azathioprine maintenance therapy, no hospitalizations, no perianal disease, and no skin or eye manifestations.

Decision Node 1

- What do you do next?
  a. Take a more detailed history?
  b. Physical examination?
  c. Laboratory tests?
  d. Colonoscopy?

Case Evolution

- On examination, her vital signs are stable, abdominal examination is unremarkable, and you wonder whether she is exhibiting back stiffness (but as a gastroenterologist, you are not quite sure how to examine a back)
- No perianal disease
- Other joints don't demonstrate obvious 'swelling', and there are no rashes
- You forget to examine her eyes.

Case Evolution

- Colonoscopy is performed
- This demonstrates:
  - Some patchy erythema in the descending colon, ascending colon and cecum, with small erosions particularly on the right side
  - Aphthae in the terminal ileum for at least 10 cm without any evidence of stenosis.

Case Evolution

- Laboratory tests:
  - Hb: 108 g/L
  - MCV: 81 fL
  - CRP: 2.0 mg/L
  - Fecal calprotectin: 98 mcg/g
  - Stool cultures: Negative for *C. difficile* toxin, C&S, O&P.

Case Evolution

- Patient not concerned regarding her GI symptoms, but wants you or another doctor to fix her back pain, as she is having trouble picking up and carrying the kids.

Decision Node 2

- What do you do next?
  a. Call for help (you have a rheumatology friend)
  b. X-ray of the lumbosacral spine
  c. MRI of the sacroiliac joints
  d. Autoimmune testing (but which anti-xxx do you write on the laboratory requisition form?)
  e. HLA-B27

Case Evolution

- You are increasingly concerned regarding her CD (you are a gastroenterologist after all)!
- You had already arranged her pre-biologic work up when she first attended for consultation three years ago, and she is up to date with her vaccinations
- You wish to talk to her about the choice of biologics while the above 'joint' work-up is pending.

Decision Node 3

- What do you do next?
  a. Stop the azathioprine as you think it is contributing to the joint pain and switch to methotrexate
  b. Add sulfasalazine
  c. Add celecoxib
  d. Start a biologic
  e. Start a biologic in combination with an immunosuppressant

Case Evolution

- You decide to start a biologic
- Much is discussed regarding the choice of a biologic
- On further questioning, your patient states her mum has multiple sclerosis and her dad is being treated for lymphoma
- Further, she would prefer a treatment that is provided by subcutaneous injection rather than infusion.

Decision Node 4

- What do you do next?
  a. Infliximab
  b. Adalimumab
  c. Vedolizumab
  d. Ustekinumab
  e. Clinical trial

Case Evolution

- Patient finally agrees on and chooses adalimumab but after much resistance
- She chose to stop the azathioprine on her own accord (without your knowledge), as she felt it was worsening her back pain
- On adalimumab monotherapy, her gastrointestinal symptoms much improved and by week 16, her fecal calprotectin has dropped to 243
- Her back pain is still present, but improved; however, she now has a ‘rash’ on her face and arms, says her hands are ‘swollen’ and is insisting on stopping all therapy, including the adalimumab.

Decision Node 5

- What are you going to do now?
  a. Stop adalimumab at her request
  b. Tell her to stop complaining and insist on continuing adalimumab and add methotrexate
  c. Investigate her rash and arrange lab tests (which ones?)
  d. Call your rheumatology colleague and make friends with dermatology too
  e. Start all over, and discuss options of sulfasalazine or methotrexate monotherapy.

Case Evolution

- You remember to review the MRI of the spine, and it does show evidence of sacroiliitis
- Her ANA is positive but dsDNA and anti-histone antibodies are negative.
- Dermatologist and rheumatologist are not convinced that the nature of her rash or joint symptoms are consistent with drug induced lupus, but the patient is insistent on stopping all therapy and seeing a new gastroenterologist, rheumatologist and dermatologist
- She is not interested in biologics, let alone, combination biologic therapy!!!

Let’s move on to the plenary session with rheumatology and gastroenterology to learn more…

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