MEETING OF THE MINDS

FAIRMONT ROYAL YORK, TORONTO

FRIDAY, November 4, 2022

MENTORING in IBD XXIII

THE MASTER CLASS

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

UNIVERSITY OF CALGARY MEDICINE

McGill UNIVERSITY

McMaster University

UNIVERSITY OF TORONTO FACULTY OF MEDICINE

Obesity and IBD

Case-based Breakout Workshop

#IBDMinds2022

MENTORING in IBD XXIII
THE MASTER CLASS

Initial Presentation

- Maia—28-year-old female engineer
- 9-year history of ileocolonic Crohn's disease, well controlled on azathioprine
- For two months she has had:
  - Up to four to six BMs per day
  - Abdominal cramps
  - More recent decrease in appetite

Initial Presentation

- Maia not initially concerned, as she had gained 12 kg over 18 months, which she attributes to lack of exercise, and working from home with easy access to snacks during COVID pandemic
- Baseline weight 55 kg
- Current weight 67 kg—wants to get back to baseline
- Height 1.55 m
- Current BMI of 27.9 kg/m^2
- Azathioprine dose constant at 100 mg daily

Initial Presentation

- Her investigations reveal:
  - WBC: 3.2 x 10^9/L
  - Hb: 109 g/L
  - CRP: 11 mg/L
  - Alb: 38 g/L
  - Fecal calprotectin: 1342 mcg/g
  - Stool C and S negative
  - *C. difficile* negative
  - Colonoscopy reveals absence of deep ulcers, but aphthae in ileum and right colon, with surrounding erythema and edema
    - Rest of colon appears unaffected
    - SES-CD score = 7

Discussion Point 1

- Would you continue azathioprine?
  - If so, would you prescribe the same dose, or dose escalate based on symptoms or weight?
- Would you measure TPMT and/or 6-MP metabolites?
- Would you consider budesonide or prednisone?

Case Evolution

- After discussion with patient, you increase azathioprine to 150 mg and trial prednisone as she is not keen to start a biologic agent
- At 8-week review, stool frequency and consistency improved, and abdominal pain resolved
- However, she has developed lymphopenia
  - Weight increased to 72 kg
  - BMI 30.0 kg/m^2

Case Evolution

- You stop azathioprine hoping her weight will plateau now that prednisone has been tapered off
- Biologic work-up is initiated but Maia insists that she feels well and not interested in starting advanced therapy

Case Evolution

- A year passes—Maia returns for follow up
- She intentionally lost some weight
  - Now weighs 69 kg
  - BMI 28.7 kg/m^2
- Lymphopenia long resolved, but…
  - CRP 11 mg/L
  - Fecal calprotectin now 5874 mcg/g

Case Evolution

- Repeat colonoscopy reveals:
  - Deep ulcerations in ileum and right colon
  - Surrounding erythema and edema
  - Aphthae in transverse colon
  - Relative left colonic sparing
  - SES-CD score of 16
- Prior biologic work up unremarkable
- She has received appropriate vaccinations

Discussion Point 2

- Which biologic agent would you choose and what factors would guide your decision?
- Specifically, does mode of administration influence your decision, and if so, why?
- Does the availability of weight-based or fixed dosing influence your choice, and if so, why?

Case Evolution

- You decide to initiate infliximab treatment
- Given history of lymphopenia, you do not restart azathioprine
- Instead, you start 15 mg oral methotrexate weekly with 5 mg folic acid per week
- She absolutely refuses another course of prednisone

Discussion Point 3

- What dose of infliximab do you prescribe, and how do you monitor dosing?
- What additional monitoring may be relevant with methotrexate therapy?

Case Evolution

- Maia receives standard three-dose induction regimen of infliximab, with a post-induction clinical response, but…
  - Infliximab level pre-4th dose (week 14) is 2.4 mcg/mL
- You continue 5 mg/kg but optimize dosing to every 6 weeks

Case Evolution

- At six-month follow-up she expresses concern about further weight gain of 6 kg which she attributes to infliximab
  - Current weight 75 kg
  - BMI 31.2 kg/m^2)
- Despite prior dose optimization, infliximab level now undetectable with low level antibodies
- Bowel ultrasound demonstrates:
  - Ongoing activity in ileum and right colon with creeping fat
  - Moderate hepatic steatosis

Discussion Point 4

- Would you further dose optimize or stop the infliximab?
  - If so, what alternative would you favour in this situation?
- How will your knowledge of safety and efficacy of anti-TNF agents, ustekinumab, and vedolizumab affect the choice of one drug over the others?
- Will you continue methotrexate with the next biologic therapy?

Case Evolution

- After discussion, you switch to ustekinumab
- Maia is upset that you poisoned her liver with methotrexate
- She receives weight-based induction dose of ustekimumab 390 mg and subcutaneous doses 90 mg q8 weekly
- She declines ongoing methotrexate

Case Evolution

- Six months after starting therapy, Maia has a clinical response:
  - 1 formed BM/day
  - CRP 3 mg/L
  - Fecal calprotectin 537 mcg/g
- Her weight has not changed
- She wishes to start a weight loss ‘pill’ or consider surgery, as diet and exercise are not producing desired results

Discussion Point 5

- What are the options for weight loss medications?
- What are the options for weight loss surgery?
- What do you do next?

Case Evolution

- You are fortunate that you are attending Mentoring in IBD and eagerly await the expert opinions of our guest speaker and the panel discussion…