MEETING OF THE MINDS

FAIRMONT ROYAL YORK, TORONTO

FRIDAY, November 4, 2022

MENTORING in IBD XXIII

THE MASTER CLASS

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Thrombosis and IBD

Interactive Case Presentation with
Audience Response System (ARS)

#IBDMinds2022

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Initial Presentation

- Jolie—46-year-old female who presents to your emergency room with:
  - Abdominal cramping
  - Worsening bloody diarrhea (10 BMs/day)
  - Left leg pain

Initial Presentation

- Jolie just returned from a 6-week vacation in Indonesia during which she had progressive increase in symptoms
- History of ulcerative colitis
- Had packed her oral 5-ASA therapy in checked luggage, which was subsequently lost
- Only had one-week supply in hand luggage
- She denies sick contacts

Initial Presentation

- Jolie is on the combined oral contraceptive pill
- Family history of colorectal cancer affecting:
  - Her father (who does not have IBD), and
  - Her mother who is undergoing treatment for breast cancer

Initial Presentation

- On examination:
  - Afebrile
  - BP: 104/56 mmHg
  - HR: 102 bpm
  - RR: 16 breaths/min
  - Oxygen saturation 84% on room air
  - Abdomen is tender to palpation, left calf is swollen

Initial Presentation

- Investigations in ER show:
  - WBC: 10.4 x10^9/L
  - Hemoglobin: 109 g/L
  - MCV: 82.2 fL
  - Platelets: 468 x 10^9/L
  - CRP: 18.2 mg/L
  - Creatinine: 104 µmol/L (baseline 70)
  - Stools: negative for *C. difficile* toxin
  - Abdominal X-ray: Diffuse colonic wall thickening, no free air or significant dilation
  - D-dimer positive
- ER doctor consults the GI service

ARS Decision Node 1

- Which investigation would you like to arrange first?
  a. Flexible sigmoidoscopy to assess disease activity
  b. Colonoscopy to assess disease activity and exclude colon cancer
  c. CTPE
  d. CT chest/abdomen/pelvis to exclude malignancy
  e. PET scan to exclude malignancy

Case Evolution

- CTPE confirms a large saddle embolus
- She is too unstable for you to perform a flexible sigmoidoscopy given her high oxygen requirements

ARS Decision Node 2

- How do you want to treat the patient's pulmonary embolus?
  a. Supportive care only; no anticoagulation as she is bleeding per rectum; provide oxygen and respiratory support as needed
  b. Start unfractionated heparin
  c. Start low molecular weight heparin
  d. Start a direct oral anticoagulant
  e. Start thrombolytic therapy
  f. Arrange insertion of an IVC filter

Case Evolution

- You liaise with internal medicine who decide to start low molecular weight heparin
- Jolie's rectal bleeding worsens
- A day later, Hb is 89 g/L and not entirely explained by volume resuscitation

Case Evolution

- Fortunately, her oxygen requirements stabilize enough for you to perform a flexible sigmoidoscopy
- This reveals Mayo 2-3 colitis to beyond the extent of the examination (proximal extent is the descending colon)

ARS Decision Node 3

- What do you do next?
  a. Stop the heparin until the rectal bleeding stops
  b. Switch to unfractionated heparin
  c. Start methylprednisolone
  d. Start infliximab 5 mg/kg IV

Case Evolution

- You prescribe methylprednisolone and arrange a biologic work up
- Jolie's respiratory status stabilizes
- Quantiferon returns negative
- After 72 hours on methylprednisolone, you start infliximab 5 mg/kg

Case Evolution

- Internal medicine completes prothrombotic laboratory work up and CT chest/abdomen/pelvis given patient's family history of malignancy
  - Recommends an outpatient mammogram
- You plan outpatient colonoscopy to determine her response to infliximab

ARS Decision Node 4

- How long do you continue anticoagulation for?
  a. 3 months, as this was a provoked VTE
  b. 6 months, not too long, not too short
  c. 1 year, as the patient had a sizeable and hemodynamically significant PE
  d. Indefinitely, as she has a family history of malignancy, and the IBD is a chronic condition
  e. Call hematology, as you are now completely confused

Case Evolution

- Jolie has excellent response to infliximab with:
  - Two to three non-bloody BMs per day
  - No abdominal pain
  - CRP level of 5 mg/L

Case Evolution

- Discharged from hospital on day 9, as she is no longer oxygen dependent
- You complete colonoscopy at 3 months
- She has achieved mucosal healing

Case Evolution

- Jolie tells you that the hematologist had previously switched her anticoagulation from infusion to oral therapy
- She wants you as her gastroenterologist to switch her from intravenous infliximab to oral small molecule therapy, specifically JAK inhibitor tofacitinib

ARS Decision Node 5

- Would you put this patient on JAK inhibitor therapy?
  a. Yes, if she maintains life-long anticoagulation
  b. Yes, as she no longer has active UC and therefore is not pro-thrombotic
  c. No, as you do not want to rock the boat
  d. Tell her to ask the hematologist to manage both the anticoagulation and IBD therapy