



SESSION 2

ADVANCED MEDICAL THERAPIES FOR IBD

CASE-BASED BREAKOUT WORKSHOP

Ryan is an otherwise healthy 42-year-old electrician who was diagnosed with ulcerative colitis (UC) 4 years ago. He had a history of rectal bleeding for 5 years initially attributed to hemorrhoids. Colonoscopy revealed inflammation to the mid sigmoid colon (Mayo 2). Fecal calprotectin was 1238 µg/g. He started oral and rectal 5-aminosalicylate (ASA) with some improvement observed in the bleeding and bowel urgency but developed chest pain a week later. Ryan went to the emergency room (ER), was assessed with an electrocardiogram (ECG), which demonstrated non-specific ST segment and T wave changes; echocardiogram showed mild hypokinesis and a thickened myocardium. The diagnosis of myopericarditis was made.

Discussion Point 1

a. What are some adverse events associated with 5-ASA use?

The oral and rectal 5-ASA is discontinued given concerns this was associated with the myopericarditis, and Ryan is provided budesonide enemas for induction of remission, which is well tolerated. Symptoms improve despite use of non-steroidal anti-inflammatory drug (NSAID) for analgesia. You are aware a maintenance strategy for his UC is required but he preferred to see if his symptoms return after he completed the 2 weeks of rectal steroids. Three months later symptoms return, infective screen is negative, and repeat fecal calprotectin is 1894 $\mu\text{g/g}$ with Mayo 2 colitis to the mid transverse colon. A 'pre-biologic' work up is completed.

Discussion Point 2

What would you prescribe next and why?

- a. Another course of steroids (rectal, colonic release, systemic)
- b. Azathioprine
- c. S1P receptor modulator
- d. JAK inhibitor
- e. anti-TNF
- f. anti-IL12/23
- g. anti-IL23 p19
- h. anti-integrin

After a discussion of effectiveness and safety of the options, Ryan chooses vedolizumab (anti-integrin) with IV induction and q2w subcutaneous injections. He responds well for 18 months but does not like the injections and states that attending infusions are too troublesome, so he wants to stop all medications. Further, he discloses that he fell at work 4 weeks ago, broke his leg and then



had a 'blood clot' for which he has started blood thinners. He attributes the fall to feeling clumsy with tingling in his hands and feet and mentions his sister has a diagnosis of multiple sclerosis. You arrange an MRI brain/spine and fortunately no demyelinating lesions are identified but early changes of sacroiliitis are noted, and bloodwork confirms he is HLA-B27 positive..

Discussion Point 3

What would you prescribe next and why?

- a. Another course of steroids (rectal, colonic release, systemic)
- b. Azathioprine
- c. S1P receptor modulator
- d. JAK inhibitor
- e. anti-TNF
- f. anti-IL12/23
- g. anti-IL23 p19

You both agree on switching to etrasimod (2mg oral daily) and this is well tolerated. His UC is under control but at the 12 month follow up, he states he has been diagnosed with diabetes, has been started on oral medications, and he has recurrent back pain. You have heard that etrasimod may predispose individuals to macular edema and you ponder what other options are available if his UC starts to flare. Unfortunately, he is back in your office 18 months later, reporting marked bowel urgency, tenesmus, and rectal bleeding. Flexible sigmoidoscopy demonstrates 5cm of Mayo 2 proctitis but mucosal healing above. He does not want to use any form of steroids as his diabetes has been harder to control and asks what other options he has as his proctitis symptoms are not compatible with working as an electrician in a crawl space.

Discussion Point 4

- a. If you were to prescribe an anti IL23 p19 inhibitor, which (mirikizumab, risankizumab, guselkumab) would you prescribe and why?
- b. There may be a new kid on the block ... what are the TL1A inhibitors? Wrap up the case and head to the plenary to learn more.

