Case Presentations

Panelists:

Therezia Alchoufete, MS, RD, LDN
Arthur M. Barrie, MD, PhD
Patrick Buckley, MD
Jeffrey M. Dueker, MD, MPH
Whitney Gray, CRNP
Lori Plung
Marc B. Schwartz, MD
Whitney Sunseri, MD
Kelly Thomas, MD
Sean Whelan, MD

Case Presentations

Time	Patient Initials	Age	Reason for Visit
8:00	A.J.	25	Crohn's – 2nd referral, medication
9:00	B.K.	70	UC
10:00	C.L.	21	UC – transition care from children's
11:00	D.M.	88	Crohn's
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13:00	F.O.	54	UC
14:00	G.P.	60	Indeterminate Colitis
15:00	H.Q.	46	IBS vs IBD
16:00	I.R.	32	UC

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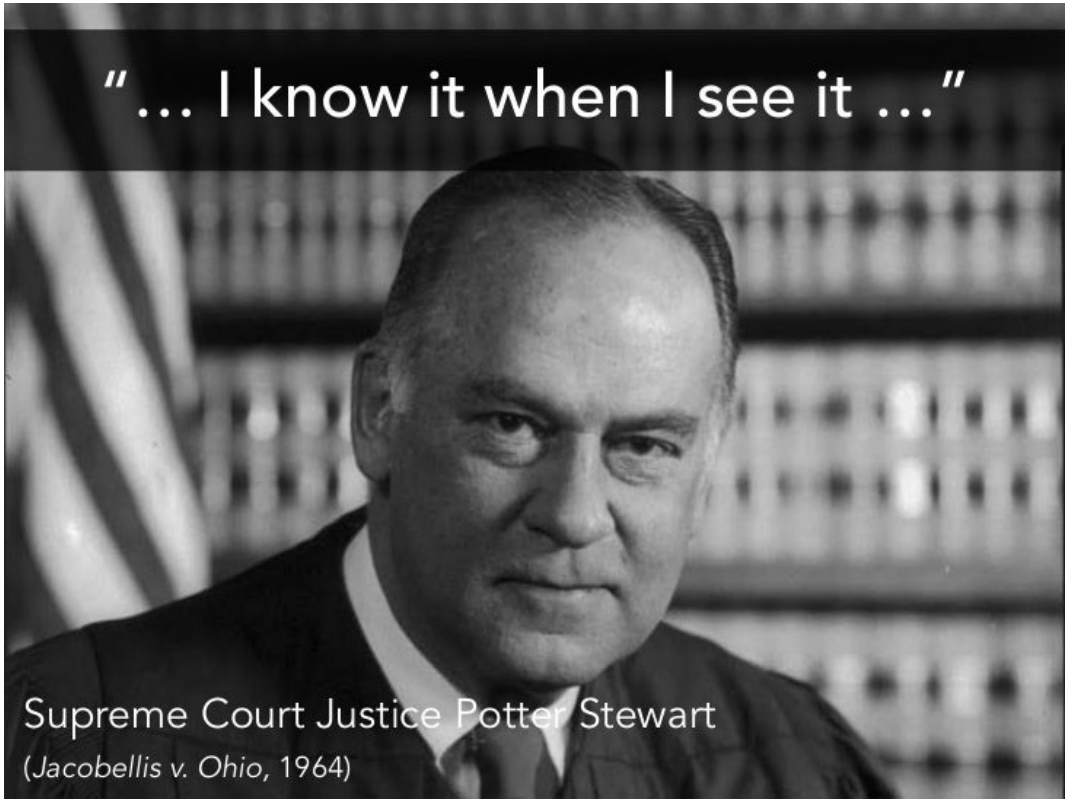
LIFE CHANGING MEDICINE

Jeff Dueker, MD, MPH

Inflammatory Bowel Disease

(IBD)



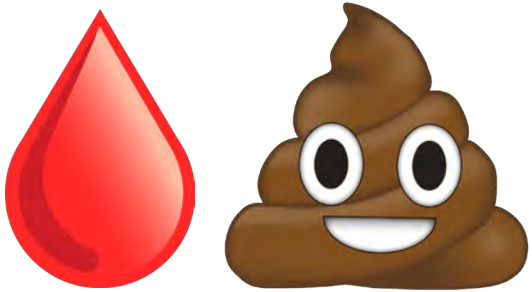
My Approach to a Visit

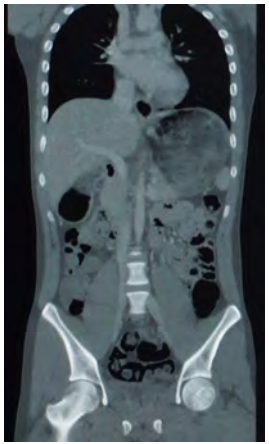
- Guiding principles

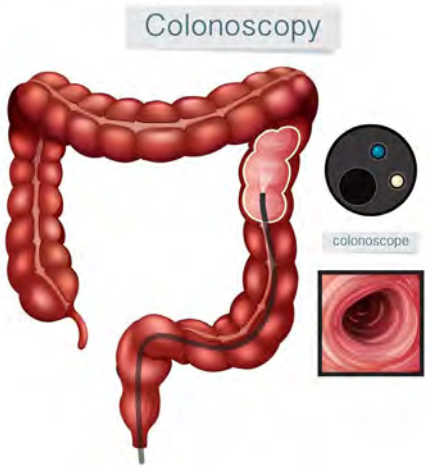
- Your symptoms are real
- I will try and figure out what is causing them

- This can be active IBD, inactive IBD with IBS, or IBS

How Do We Figure It Out

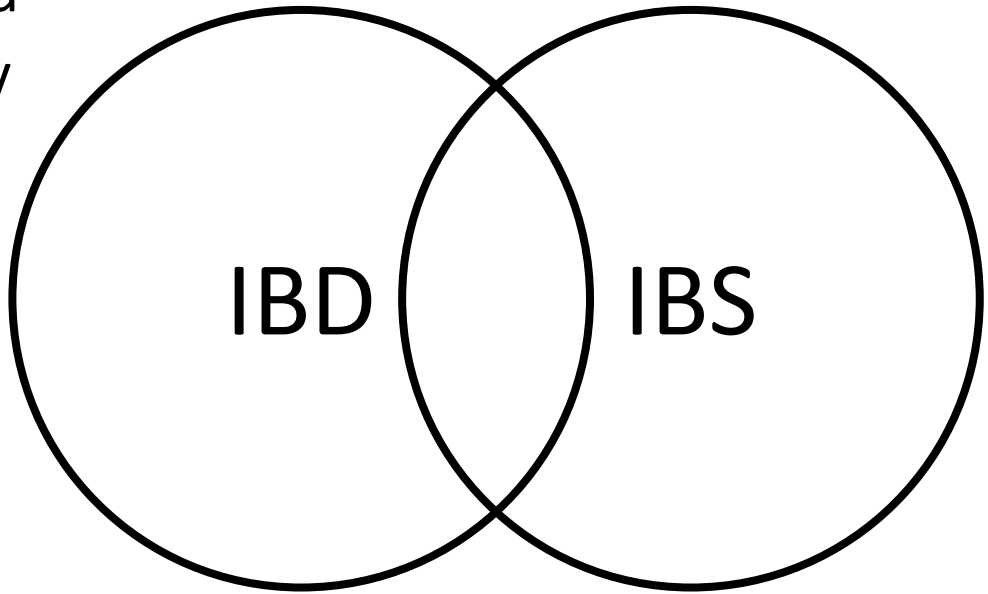






“Clinical Diagnosis”

- There is no single, definite test for IBD!
- IBD: Tissue damage
  - What needs to be treated
  - What might need surgery
- IBS: Symptoms
  - Can be debilitating!
  - Lack of tissue damage



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Case 1 Presentation - AJ

- Referral for 2nd opinion for 25 female with diagnosis of Crohn's disease
- Primary question is what IBD therapy to use?
- Let's start from the beginning

Case 1: Back in Time

- A.J. is a 16F with no significant past medical history presents to Children's PCP with abdominal pain, bloating, diarrhea, 20lb unintentional weight loss over 6 months
- Labs: Anemia (Hemoglobin 10.4, MCV 73), elevated inflammatory markers (CRP and ESR), and low Albumin (2.9)
- Stool testing is negative for infection
- Referred to Gastroenterology

Case 1: Diagnosis

- EGD: normal esophagus, scattered aphthous ulcerations in stomach, erosions/small ulcers with redness in upper small intestine
- Colonoscopy: stricture at the junction between lower small intestine and colon (ICV) but small intestine appears ulcerated and colon has patchy inflammation
- MR Enterography: inflammation in end of small intestine (>15cm) and colon
- Diagnosed with Crohn's disease

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Whitney Gray, CRNP

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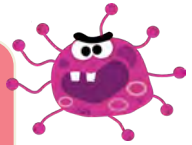
How Does Crohn's Disease Happen?

Genetic Predisposition

Environmental Trigger

Dysbiosis



Immune dysregulation

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What Are the Symptoms of Crohn's disease?

GI symptoms

- Diarrhea (sometimes with blood and mucus)
- Abdominal pain
- Decreased appetite
- Weight loss
- Perianal fistula/abscess

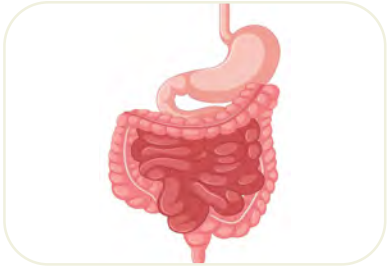
Extraintestinal symptoms

- Mouth sores
- Rashes
- Arthritis
- Eye inflammation
- Liver disease

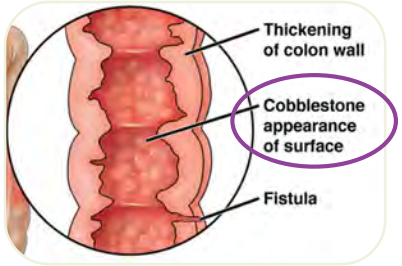
General symptoms

- Fatigue
- Fevers
- Delayed growth/puberty

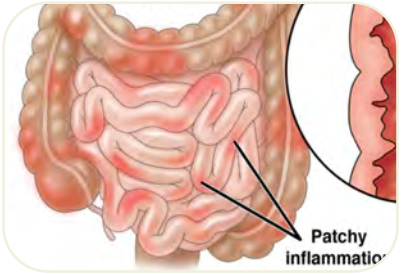
Crohn's disease



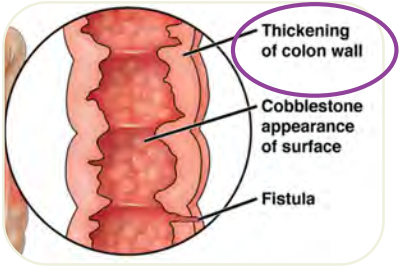
Can affect anywhere in GI tract (gum to bum)



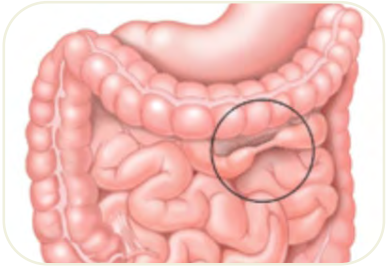
Cobblestoning, linear ulcerations, aphthous ulcerations



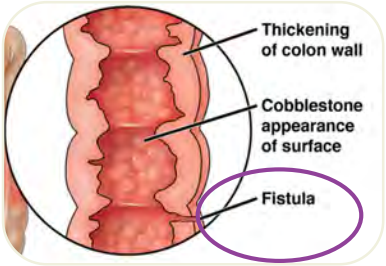
Patchy distribution (skip lesions)



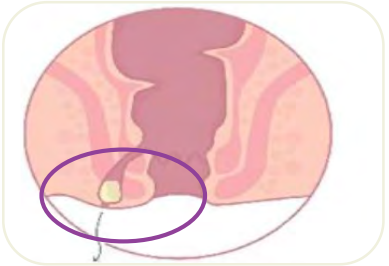
Transmural inflammation (full thickness)



Stricturing (narrowing)



Penetrating (abscess/fistula)



Perianal disease (abscess/fistula/skin tags)

Can see non-caseating granulomas on biopsies

AGA GI patient center. https://patient.gastro.org/crohns-disease/; Columbia surgery https://columbiasurgery.org/conditions-and-treatments/crohns-disease; Crohn's and Colitis Foundation https://www.crohnscolitisfoundation.org/patientsandcaregivers/what-is-crohns-disease/treatment/surgery/abscess-drainage

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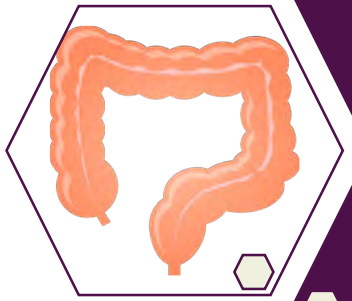
Crohn's Disease in Children

Importance of immunizations



More common to have only colonic involvement

More severe disease (potential for monogenic cause)

Impact on school/extra-curricular activities

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Whitney Sunseri, MD

Case 1: Prior Course

- A.J. is started on Infliximab and dose is increased for some continued symptoms and low drug level
- Achieves clinical and endoscopic remission and maintains remission during college and then stops Infliximab for 3 years

Case 1: Today's Visit

- Now 25 years old
- Recent ED visit for worsening right-sided lower abdominal pain, 15lb unintentional weight loss, bloating for at least 4 months
- Started on steroids and told to schedule an appointment with GI

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Arthur Barrie, MD, PhD

Case 1: Course

- Symptoms improve with steroids.
- EGD and Colonoscopy performed - EGD unremarkable. Colonoscopy with non-traversable severely ulcerated stricture at the ileocecal valve.
- CT Enterography with long segment of inflammation in the terminal/distal ileum, but no penetrating complications.
- Discussion is held about surgical vs medical therapy, including various options.

Case 1: Course continued

- Starts Infliximab, but she has a reaction with 2nd infusion and found to have antibodies.
- She continues to have symptoms, restricting her diet and is losing weight
- Unsure if she wants to try another medication or have surgery.

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Therezia Alchoufete, MS, RD, LDN

Anti-Obstruction Diet

Small, frequent meals – reduce bulk, improve digestion, manage symptoms like nausea or early satiety

Include

- Veg – peeled/cooked
- Fruit – peeled/canned/puree
- Bread – smooth, seedless
- Grains – soft, small portions
- Proteins – ground, finely chopped/shredded, shakes

Avoid

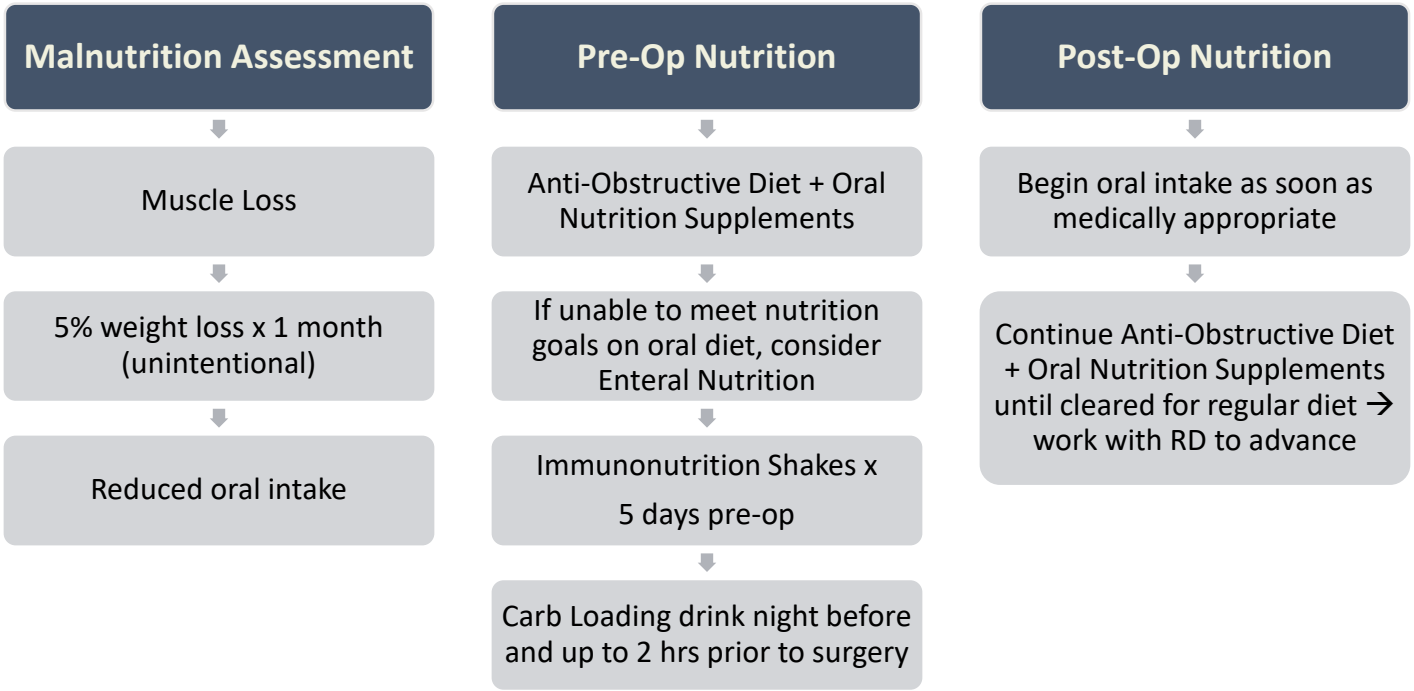
- Popcorn/Nuts/Seeds
- High-Fat Foods (fried, greasy)
- Raw, un-peeled fruits/veg
- Excessive intake of High Fiber (seedy grains/beans)

Food lists & recipes may be helpful

Frequent Monitoring – Bi-Weekly Follow Up

- Nutrition Status
- Unintentional Weight Changes
- Digestive Symptoms
- Food Fear – including post-op
- Perioperative Nutrition Management

Perioperative Nutrition Management



1. Weimann A, Braga M, Carli F, et al. ESPEN practical guideline: Clinical nutrition in surgery. *Clin Nutr*. 2021;40(7):4745-4761. doi:10.1016/j.clnu.2021.03.031

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Sean Whelan, MD

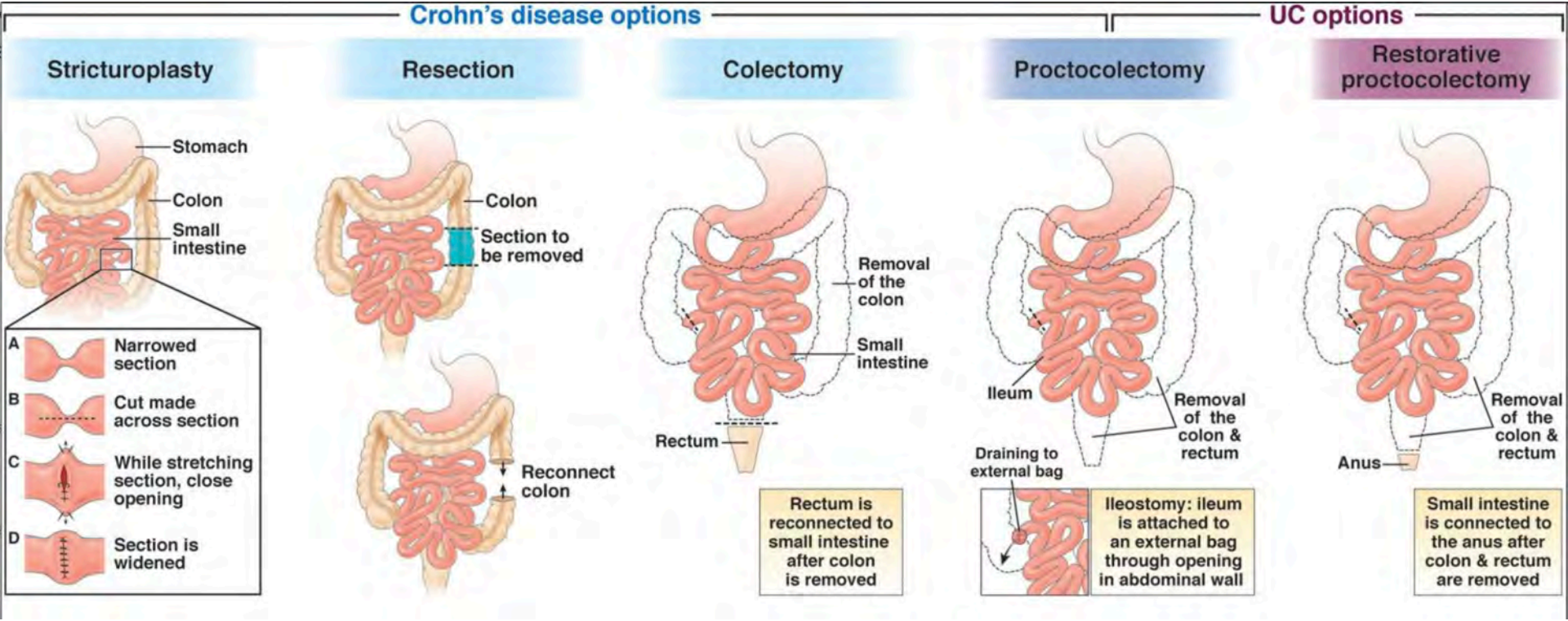

Image from aga gi patient center:
https://patient.gastro.org/inflammatory-bowel-disease-ibd/

Case 1: Course

- She decides to proceed with surgery, but due to her job elects to delay the surgery for 2 months to align with her schedule.
- In the interim, she has some worsening obstructive symptoms and is started on budesonide.
- However, in setting of upcoming surgery compounded on underlying work and family stressors, she starts to have worsening anxiety.

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Lori Plung

IBD Patient Advocate

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PEER SUPPORT

Peer support occurs when people provide knowledge, experience, emotional, social, or practical help to each other.

“Peer Support.” Wikipedia, n.d. https://en.wikipedia.org/w/index.php?title=Peer_support&oldid=1259731720.

Peer to Peer Support

- One-on-One
- Support Groups
- Online Communities
- Social Media

CONNECTING WITH AJ

- Setting up a time to meet
- Getting to know AJ and her IBD journey
- Bonding over our shared IBD experiences

YOU ARE NOT ALONE!

APPROXIMATELY

3.1 MILLION ADULTS [1]
and
100,000 YOUTH UNDER TWENTY [2]

HAVE IBD IN THE US

1. “IBD Facts and Stats.” Center for Disease Control, June 21, 2024. https://www.cdc.gov/inflammatory-bowel-disease/php/facts-stats/index.html .
2. “Landmark Study Reveals Over 100,000 American Youth Living with Inflammatory Bowel Disealandmark-study-reveals-over-100000-american-youth-living-with-inflammatory-bowel-diseasese.” Crohn’s & Colitis Foundation, November 20, 2024. https://www.crohnscolitisfoundation.org/.

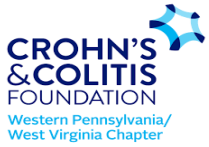
How Can I Help AJ?

Support Group

- Kind and Supportive
- Safe and Non-Judgmental
- Virtual and In person
- Variety of Support Groups
- Crohn’s & Colitis Foundation

Resources

- Crohn's & Colitis Foundation
- Girls with Guts
- IBD Specific Podcasts
- IBD UNITE
- UPMC IBD Center Website



UPMC Inflammatory Bowel Disease Center

TIPS AND TRICKS

- Advocate
- You’re part of the team
- Knowledge is power
- “I’m a phone call away”

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Patrick Buckley, MD

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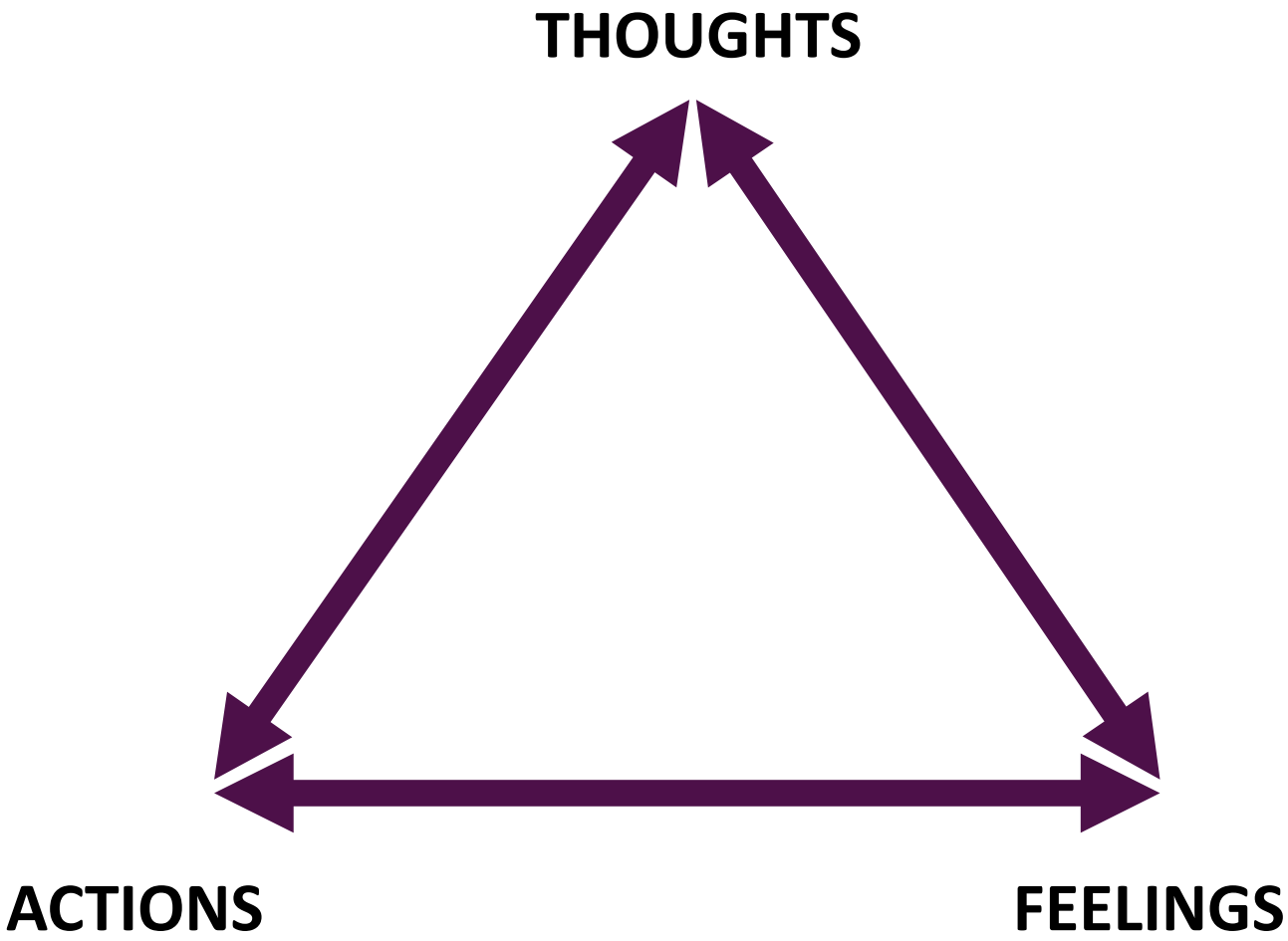

 THOUGHTS	 FEELINGS	 ACTIONS
Identify & challenge catastrophic thoughts	Normalize and validate anxiety through education & peer support	Establish a step-by-step plan for recovery, including coping with stress
Encourage balanced self-talk about possible outcomes	Practice relaxation techniques to reduce physiological arousal	Gradual exposure to surgery-related cues

What About Medication?

- Difficulty adjusting to stress of upcoming surgery? Or preexisting anxiety disorder?
- **Considerations:** Timeline, side effects, absorption
- **Many Effective Options**

Case 1: Surgery and After

- She is admitted to the hospital for planned resection and surgery goes great!
- She follows up after surgery with her surgical and medical team.

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Kelly Thomas, MD

Management of Post-Operative Crohn's

- Low Risk
  - No prophylaxis
    - Fecal Calprotectin < 50 ug/g +/- IUS at 3 months
      - Colonoscopy at 6-12 months
        - No recurrence: colonoscopy every 1-3 years
    - Fecal Calprotectin > 50 ug/g +/- IUS at 3 months
      - Colonoscopy
        - Recurrence: Increase/change Biologic/Small Molecule
- High Risk (tob use, # surgeries, penetrating/perianal dz, male, non-white)
  - Biologic Prophylaxis
  - If off prophylaxis
    - Colonoscopy at 3-6 months
      - No Recurrence: colonoscopy every 1-3 yrs
      - Recurrence: Biologic/Small Molecule

Regueiro et al. A Review on the Management of Postoperative Crohn's Disease. Practical Gastro. Feb 2024.

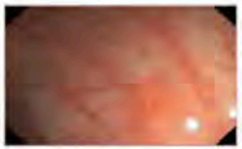
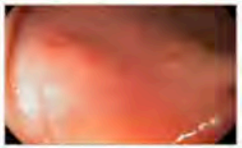
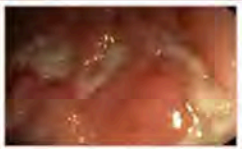
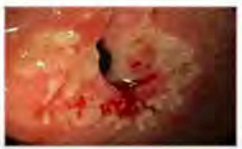
Case 1: Post-Op Course

- A.J. discusses options and decides to not start therapy
- She has a fecal calprotectin at 4 months which is 127
- She is having some abdominal bloating, cramping abdominal pain
- She has a repeat colonoscopy around 6 months that shows inflammation with multiple small ulcers at the surgical connection and into the last part of the small intestine

Post-Op Endoscopic Evaluation

- Rutgeerts score
  - Standardized endoscopic scoring system

Higher risk for clinical and/or surgical recurrence

GRADE	ENDOSCOPIC FINDING	ENDOSCOPY
i0	No lesions	
i1	<5 aphthous lesions	
i2	i2a. Lesions confined to the anastomosis i2b. 5 aphthous lesions with normal mucosa between lesions; areas scattered with larger lesions	
i3	Diffuse aphthous ileitis over inflamed mucosa	
i4	Diffuse inflammation with large ulcers, nodules and/or strictures	

Clinical Practice Update on Endoscopic Scoring in IBD. Clinical Gastro and Hepatology. Sept 2024

Case 1: Course

- She starts on Adalimumab after the colonoscopy
- She is in endoscopic remission at a surveillance colonoscopy 6 months later
- However, she continues to have ongoing abdominal cramping, bloating, and intermittent loose stool

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Marc Schwartz, MD

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16:00	I.R.	32	UC

Case 2 Presentation - BK

- 70M healthy male with history of ulcerative colitis referred for a second opinion with the primary question of “is it okay to continue his therapy”

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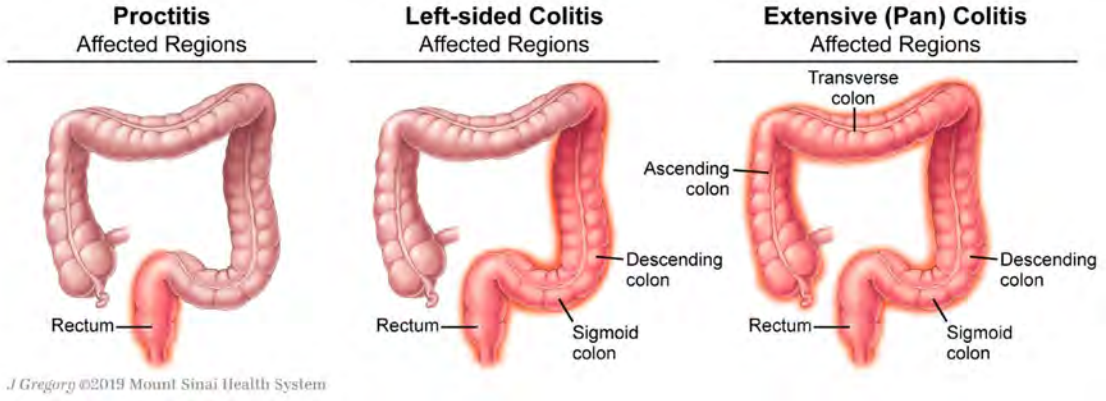
Jeff Dueker, MD, MPH

Ulcerative Colitis (UC)

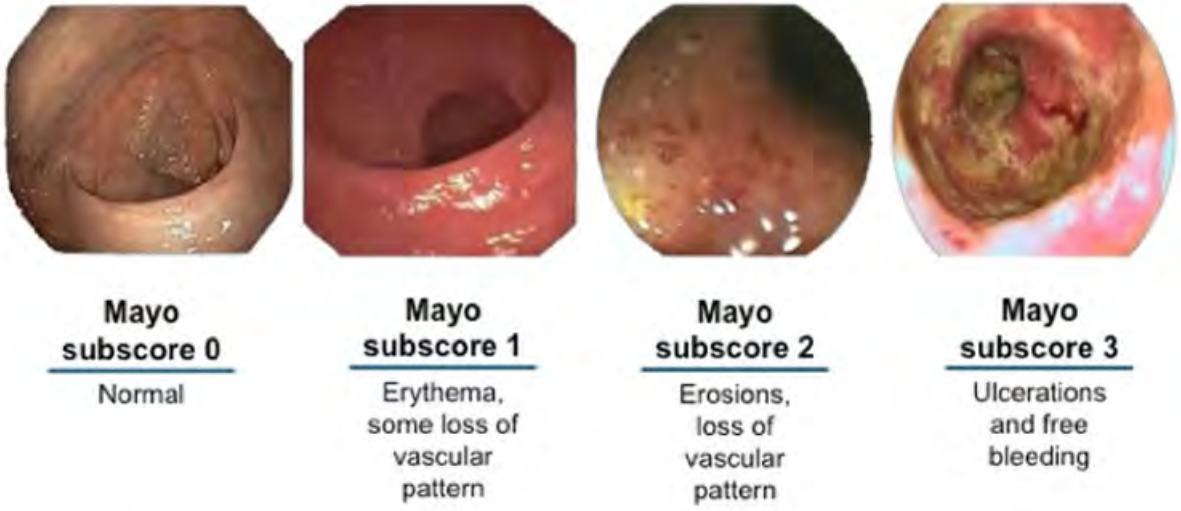
- Inflammation of the colon
- Involves the rectum – drives symptoms
- Diarrhea, with blood, urgency, stool frequency
- Severity > distribution determines risk



UC Disease Activity

- Symptoms (Mayo score)
  - Stool frequency
  - Rectal bleeding
- Fecal calprotectin
- Colonoscopy

(not always extent)



Schroeder KW, et al. *N Engl J Med.* 1987;317:1625-1629.[7]

UC Medical Treatment

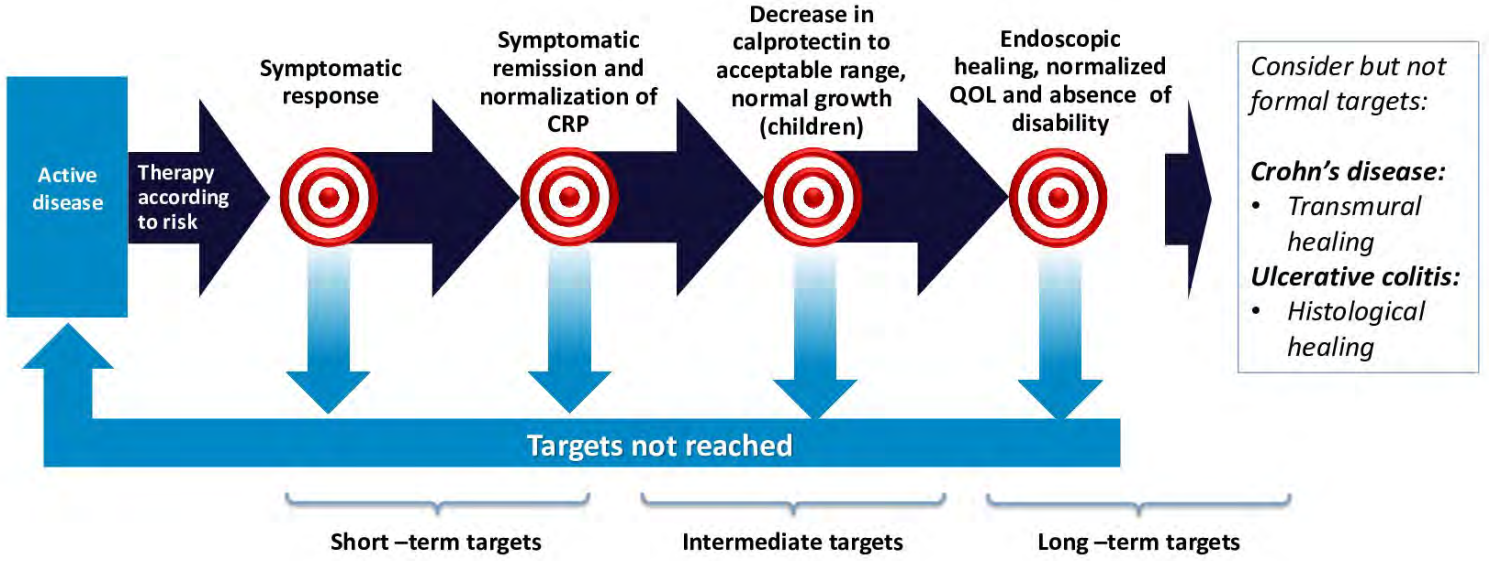
- Treatment matches severity

- Choice individualized
  - How it is given
  - Potential side effects
  - Other medical issues
  - Cost/coverage

5ASA (mesalamine)	Thiopurines
Anti-TNFs Anti-integrins Anti-IL 12/23 Anti-IL 23	JAK inhibitors S1P inhibitors

UC Treatment Targets

Figure 2: Treatment targets in both Crohn's disease and ulcerative colitis



Case 2: Chart Review

- About 2 years ago, B.K. had new onset bloody diarrhea and has a colonoscopy revealing mild-borderline moderate L-sided UC
- He was started on oral mesalamine and has some symptom improvement, but symptoms were still impacting his quality of life: increased frequency, unable to travel, rare incontinence.
- Repeat colonoscopy was performed without significant improvement
- At that time, what therapy options would you have been considering and what would be your disease assessment?

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Arthur Barrie, MD, PhD

Adult outpatients with moderate to severely active ulcerative colitis

Moderate to severely active UC defined as:

- Moderate to severe symptoms with Mayo endoscopy sub-score 2 or 3
- Mild symptoms, with high burden of inflammation or poor prognostic features
- Patients with corticosteroid-dependence, or refractory to oral corticosteroids

SUGGEST early use of advanced therapies and/or immunomodulator therapy, rather than gradual step up after failure of 5-aminosalicylates

Conditional recommendation, very low certainty of evidence)

RECOMMEND using any of the following, over no treatment:
Infliximab, Golimumab, Vedolizumab, Tofacitinib*, Upadacitinib*, Ustekinumab, Risankizumab, Guselkumab, Ozanimod, and Etrasimod

(Strong recommendation, moderate certainty of evidence)

SUGGEST using any of the following, over no treatment:
Adalimumab, Mirikizumab or Filgotinib*

(Conditional recommendation, moderate certainty of evidence)

Implementation considerations:

- Biosimilars of Infliximab, Adalimumab, and Ustekinumab can be considered equivalent to their originator drug in their efficacy
- Subcutaneous formulations of Infliximab and Vedolizumab can be considered as an alternative to the respective intravenous maintenance doses for most patients
- Extended induction or dose escalation of several advanced therapies can be considered for some patients with severe disease

ADVANCED THERAPY-NAÏVE PATIENTS (FIRST-LINE THERAPY)

SUGGEST using a HIGHER efficacy, or INTERMEDIATE efficacy medication, rather than a lower efficacy medication.

(Conditional recommendation, low certainty of evidence)

HIGHER EFFICACY MEDICATIONS: **Infliximab, Vedolizumab, Ozanimod, Etrasimod, Upadacitinib*, Risankizumab, Guselkumab**

INTERMEDIATE EFFICACY MEDICATIONS: **Golimumab, Ustekinumab, Tofacitinib*, Filgotinib*, Mirikizumab**

LOWER EFFICACY MEDICATIONS: **Adalimumab**

**The FDA label recommends the use of JAK inhibitors only in patients with prior failure or intolerance to TNF antagonists. Filgotinib is not available for use in the United States*

AGA Living Clinical Practice Guideline on Pharmacological Management of Moderate-to-Severe Ulcerative Colitis
Singh, Siddharth et al.
Gastroenterology, Volume 167, Issue 7, 1307 - 1343

Case 2: UC Course

- He elected to start vedolizumab infusions, but before he starts, he was admitted with acute severe UC and concomitant C diff colitis
- He is treated for C diff, but continued to have >10 bloody bowel movements daily with only partial response to steroids

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Marc Schwartz, MD

Case 2: UC Course

- He was started on dose escalated Infliximab, but had no response
- He was subsequently started on Upadacitinib with a great response and discharged home
- He was referred from another provider with a question of continuing vs switching to alternative therapy?

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Kelly Thomas, MD

Case 2: Conclusion

- With shared decision-making between B.K. and his provider, he decided to continue Upadacitinib

Q&A

Panelists:

Therezia Alchoufete, MS, RD, LDN
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Kelly Thomas, MD
Sean Whelan, MD

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