Inflammatory Bowel Diseases

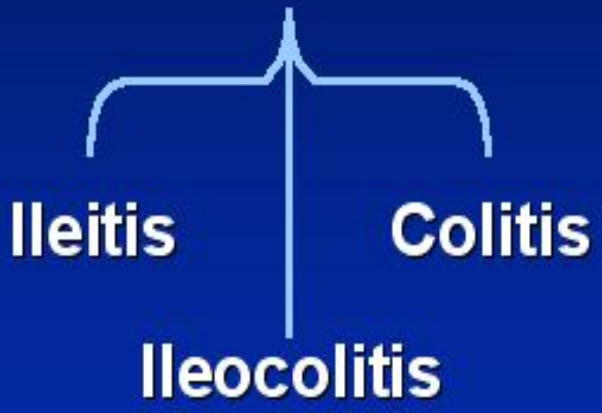
Inflammatory Bowel Diseases

Ulcerative Colitis

Mucosal ulceration in colon

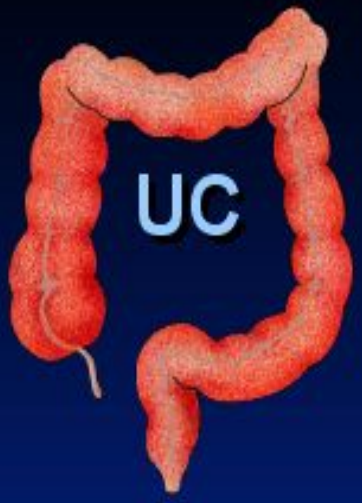
Crohn's Disease

Transmural inflammation



Other Colitides

- Microscopic colitis
- Diversion colitis
- Diverticular colitis
- Pouchitis



- Diffuse mucosal inflammation limited to colon
- Affects rectum
- May involve all or part of rest of colon

- Patchy transmural inflammation
- May affect any part of GI tract

Epidemiology of IBD

	Ulcerative Colitis	Crohn's Disease
Incidence (North America) per person-years	2.2–14.3/100,000	3.1–14.6/100,000
Age of onset	15–30 & 60–80	15–30 & 60–80
Ethnicity	Jewish > Non-Jewish Caucasian > African American > Hispanic > Asian	
Male:female ratio	1:1	1.1–1.8:1
Smoking	May prevent disease	May cause disease
Oral contraceptives	No increased risk	Odds ratio 1.4
Appendectomy	Protective	Not protective
Monozygotic twins	6% concordance	58% concordance
Dizygotic twins	0% concordance	4% concordance

Etiology and Pathogenesis

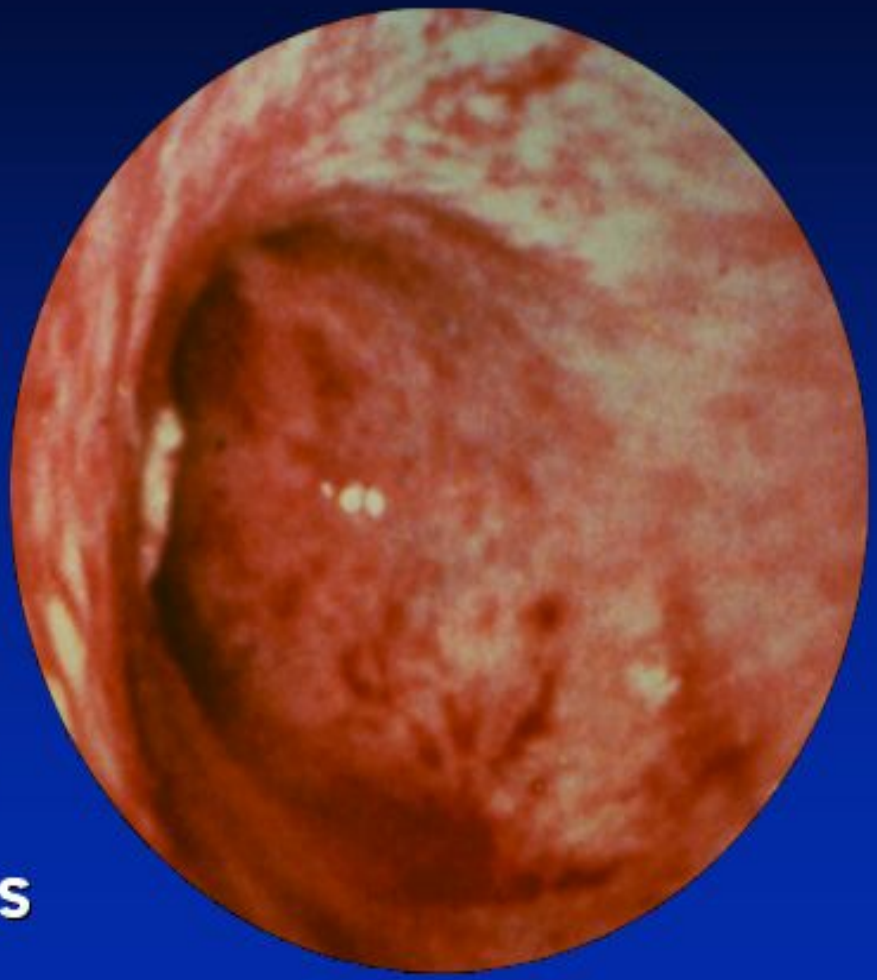
- Genetically predisposed individuals
- Chronic activation of the mucosal immune system may represent an appropriate response to an unidentified infectious agent
- Inappropriate response to the endogenous microbial flora within the intestine, with or without some component of autoimmunity

Genetic Considerations

- ***CARD15***
  - senses bacterial muramyl dipeptide and regulates intracellular signaling
  - expressed by intestinal epithelial cells, including Paneth cells, monocytes, macrophages, and dendritic cells
  - Loss-of-function mutations in CARD15 are highly associated with CD
  - decreased intestinal antimicrobial activity by diminishing defensin production by Paneth cells
  - excess NF-kB activation

Colitis

- Ulcerative colitis
- Crohn's disease
- Radiation
- Ischemia
- Infections
- Antibiotics
- NSAIDs
- Diversion colitis
- Diverticular colitis



IBD - Differential Diagnosis

	Acute Infections	IBD
Duration symptoms	<2 weeks	>4 weeks
Onset of symptoms	abrupt	insidious
Platelets	normal	>450,000
Hct	normal	low
Biopsy	neutrophils predominate	mixed infiltrate, abnormal crypt architecture, ↑ lymphoid aggregates, basal plasmacytosis

IBD - Differential Diagnosis

Clinical features	IBD	IBS
Anemia, ↑platelets, ↑sed. rate, ↓albumin	+	–
Weight loss, fever	+	–
Perianal disease	+	–
Bloody stools, tenesmus	+	–
Fecal WBC, occult blood	+	–

IBD

Ulcerative Colitis

- Colon only
- Mucosal inflammation
- Continuous distribution
- Rectal involvement

Pathology

- **Ulcerative Colitis: Macroscopic Features**
  - mucosal disease that usually involves the rectum and extends proximally to involve all or part of the colon
  - 40–50%-rectum and rectosigmoid, 30–40%- extending beyond the sigmoid, 20%- total colitis
  - Proximal spread occurs in continuity without areas of uninvolved mucosa
  - terminal ileum (1-2 cm) in 10–20% of patients- *backwash ileitis*
  - biopsies from normal-appearing mucosa are usually abnormal
  - mucosa is erythematous, hemorrhagic, edematous, and ulcerated
  - inflammatory polyps (pseudopolyps) may be present as a result of epithelial regeneration
  - mucosa may appear normal in remission
  - In prolonged disease mucosa is atrophic and featureless and the entire colon becomes narrowed and shortened

UC Physical findings

- Abdomen: tenderness and distension, but can be normal
- Extra colonic: arthritis, skin changes liver disease
- Usually normal perineum

UC Laboratory findings

- No specific findings
- ESR ↑, CRP ↑, anemia (chronic disease, Fe↓), WBC ↑
  K ↓, Albumin ↓(protein loosing)
  Disturbed LFT

UC Clinical Features

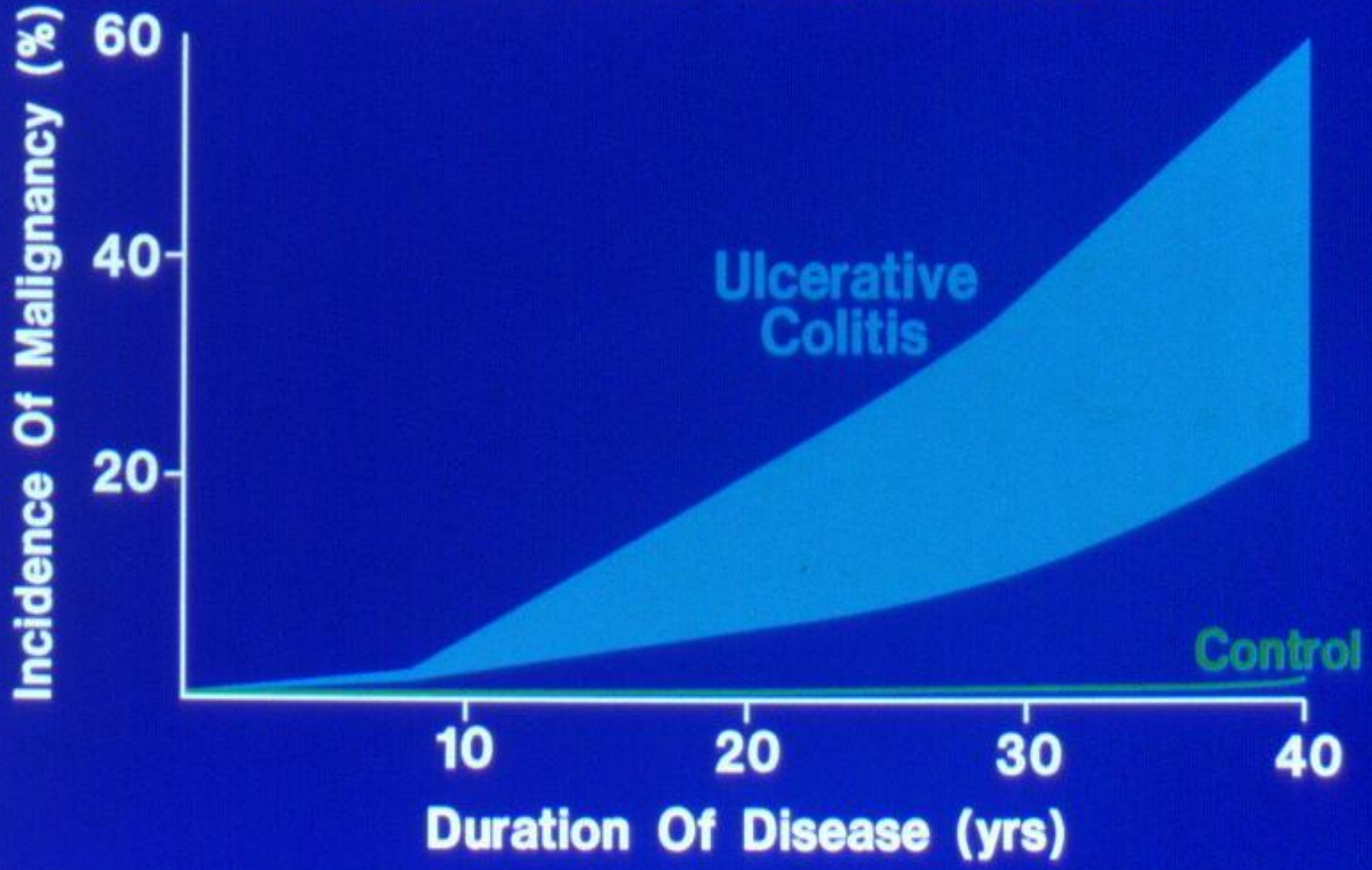
- Relapsing disease (~ 80% 1yr)
- Symptoms usually parallel disease extent (More disease→more systemic signs & need for operation)
- Proctitis may be hard to treat and cause blood loss and disturbing tenesmus
- Disease may extent more proximally with follow up (~40% in proctitis, ~ 10% in left sided)

UC- Complications

- Bleeding
- Perforation
- Toxicity
- Cancer

Colorectal Cancer In Ulcerative Colitis

CUMULATIVE INCIDENCE



Crohn's disease (CD)

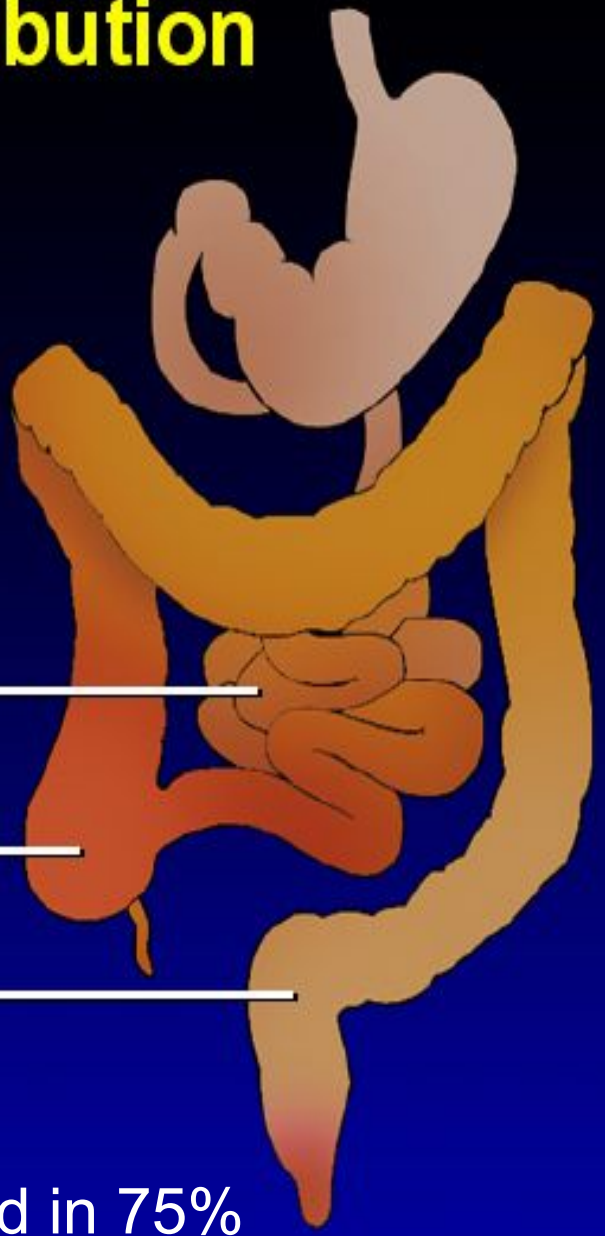
- Transmural disease, symptoms depend on site of involvement and complications
- Abdominal pain, diarrhea (usually not bloody), weight loss, fever
- Mouth to anus

CD

Anatomic Distribution

Freq. of involvement

most — least



Small bowel alone 33%

Ileocolic 45%

Colon alone 20%

Terminal ileum is involved in 75%

CD Small bowel

- Abdominal pain (mainly RLQ), may be constant and dull, may be colicky (obstruction)
- Diarrhea
- Vomiting (obstruction)
- Weight loss, fatigue, fever

- Acute presentation may resemble appendicitis

- May present as FUO or chronic subtle disease

CD Colon

- Colon: diarrhea, less rectal bleeding (less colon & rectum involved), **characteristic rectal sparing**.

- Perianal involvement: fissures, fistulas, perirectal abscess

CD Perianal Disease

- Fissures
- Fistulas
- Perirectal abscess

CD Pathology
Macroscopic Features

- terminal ileum is involved in 75%
- the rectum is often spared in CD
- CD is segmental with skip areas
- Perirectal fistulas, fissures, abscesses, and anal stenosis are present in one-third of patients with CD, particularly those with colonic involvement
- serosal and mesenteric inflammation promotes adhesions and fistula formation
- "creeping fat"

Vienna Classification of CD

Consensus of International Working Party, World Congresses of Gastroenterology 1998

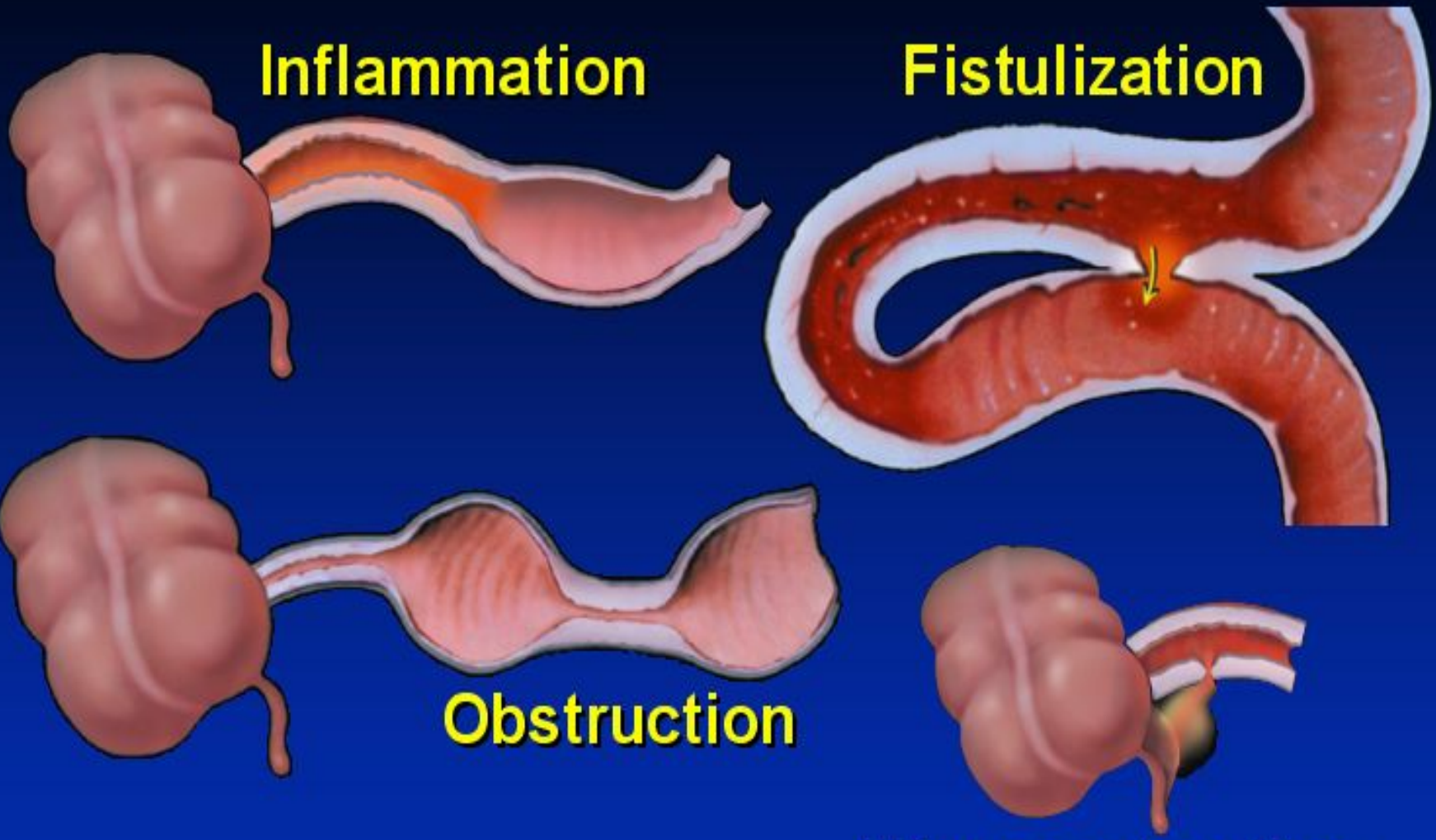
One Choice Each Category

Age at diagnosis
- 1 <40 years
- 2 ≥40 years

Location
- 1 Terminal ileum
- 2 Colon
- 3 Ileocolon
- 4 Upper GI

Behavior
- 1 Non-stricturing, non-penetrating
- 2 Stricturing
- 3 Penetrating

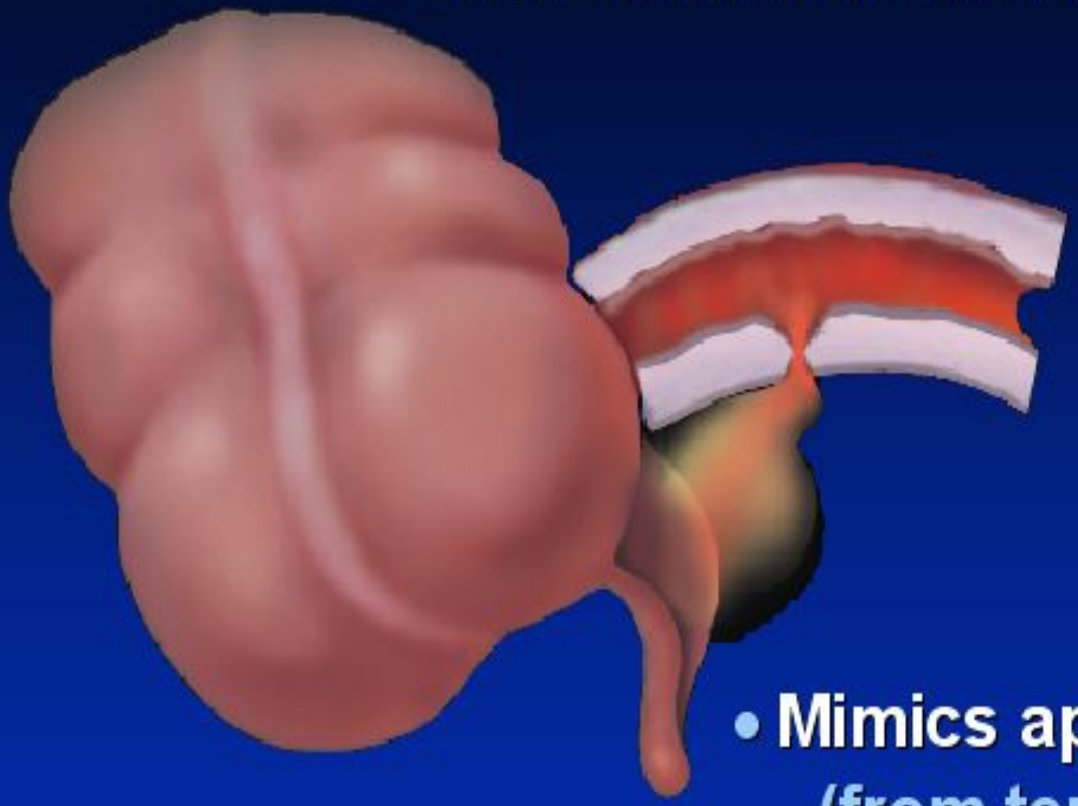
CD - Clinical Patterns



CD - Clinical Patterns

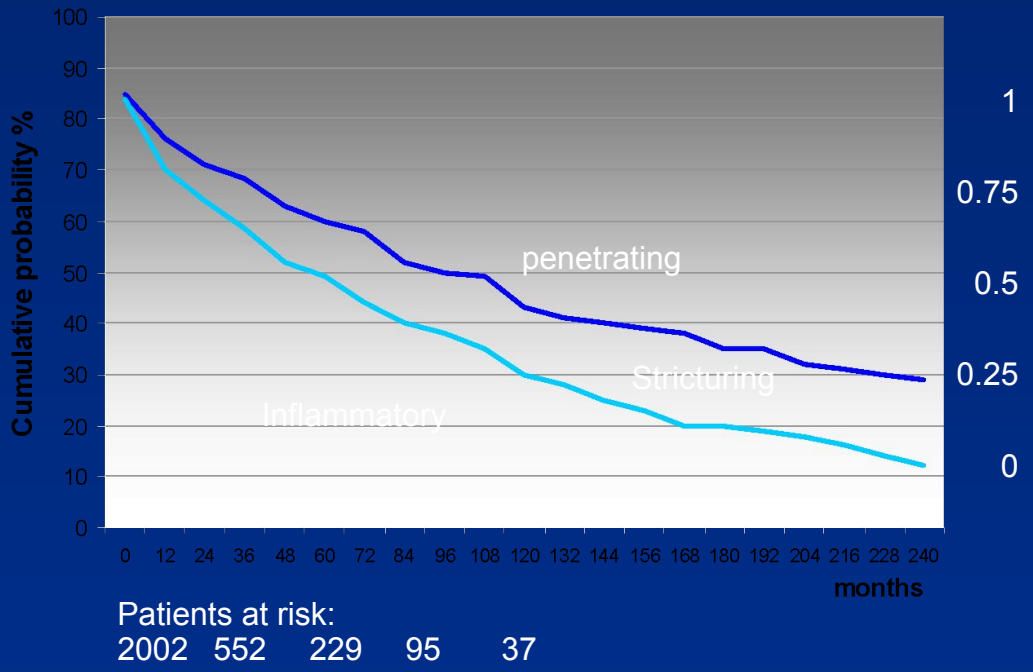
- **Enteroenteric**
  May be asymptomatic
- **Enterovesical**
  Recurrent UTIs, pneumaturia
- **Retroperitoneal**
  Psoas abscess signs: back, hip, and thigh pain; limp
- **Enterocutaneous**
  Drainage via scar
- **Perianal**
  Pain, drainage
- **Rectovaginal**
  Drainage: feces and/or air

Confined Perforation



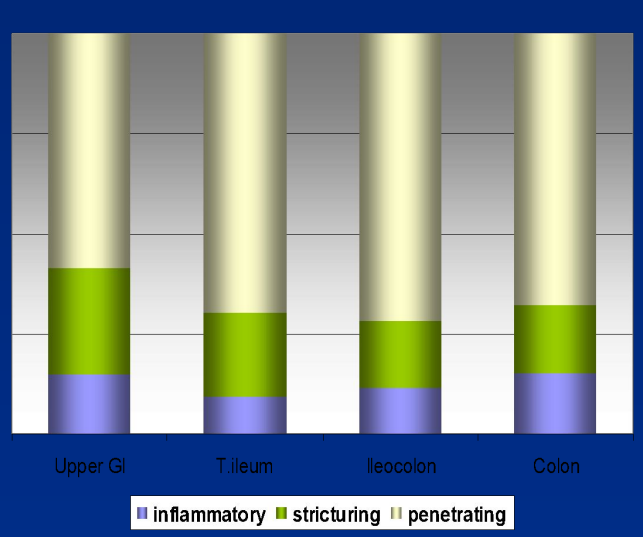
- Mimics appendicitis (from terminal ileum)
- Mimics diverticulitis (from sigmoid colon)

Natural history of CD accumulation of disease complications



Kaplan-Meier estimates of remaining free of complications in 2,002 patients with Crohn's disease since onset of the disease.

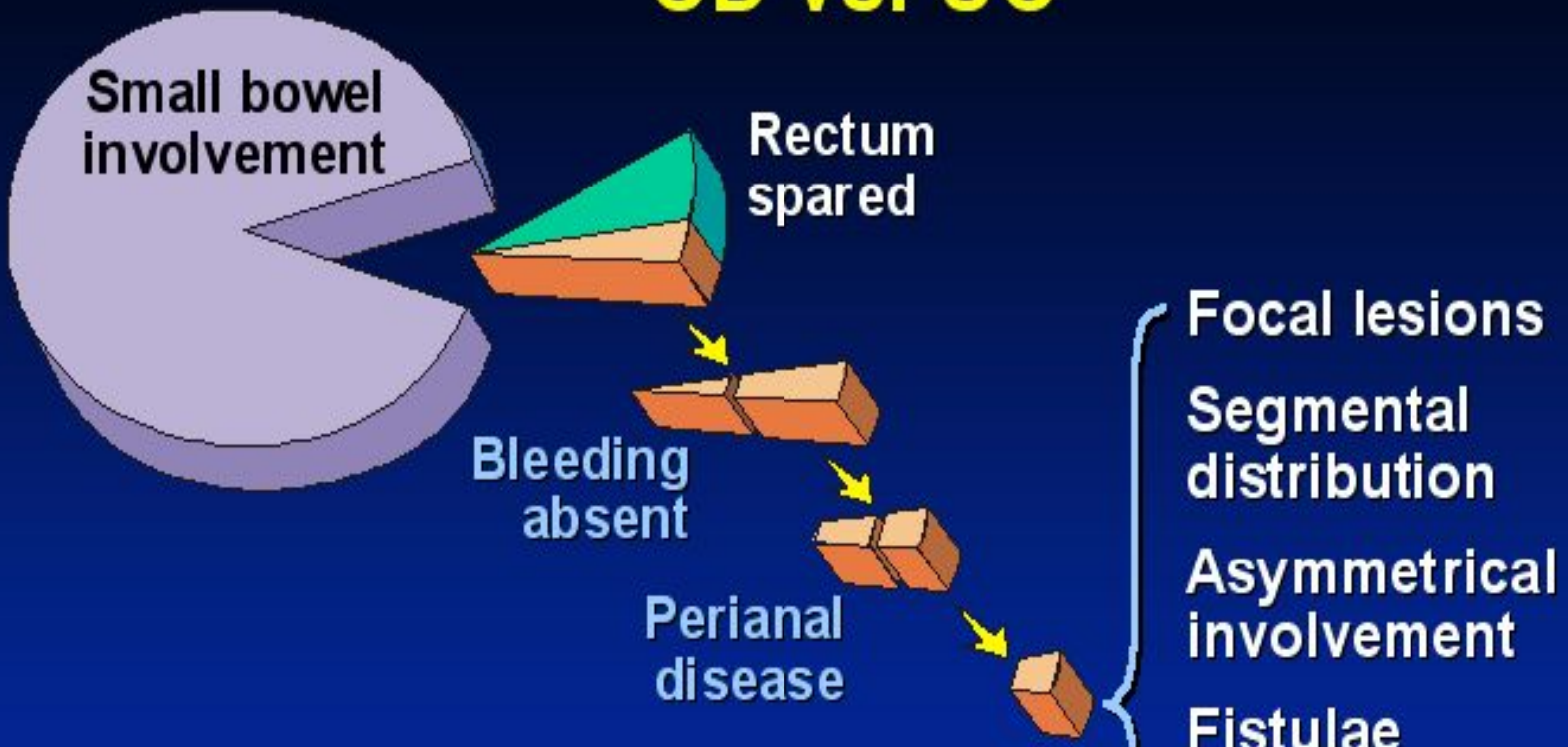
2065 pts
Follow up 1974-2000



Kaplan-Meier 20-year cumula cidence of stricturing and penetrating complication

Cosnes J. et al, Inflammatory Bowel Diseases 2002;8:244-250

CD vs. UC



- Focal lesions
- Segmental distribution
- Asymmetrical involvement
- Fistulae
- Granulomas
- Endoscopic features
- Serology

Extraintestinal Manifestations

- Arthritis
  - Peripheral -dependent on disease activity
  - Axial-independent of disease activity
- Ocular
  - episcleritis, uveitis
- Skin
  - erythema nodosum
  - pyoderma gangrenosum
- Liver
  - PSC

Extra-intestinal manifestations, co-morbidities and complications of CD

Uveitis[1]

Pyoderma gangrenosum[2,3]

Psoriasis[4]

Spondyloarthropathy[5]

Extraintestinal Manifestations Rheumatologic

Peripheral arthritis- 15–20% of IBD patients

- more common in CD
- worsens with exacerbations of bowel activity
- asymmetric, polyarticular, and migratory and most often affects large joints of the upper and lower extremities
- In severe UC, colectomy frequently cures the arthritis

Ankylosing spondylitis

- more common in CD than UC
- HLA-B27 antigen
- AS activity is not related to bowel activity

Extraintestinal Manifestations Rheumatologic

Sacroilitis

- Symmetric
- equally in UC and CD
- often asymptomatic
- does not correlate with bowel activity
- does not always progress to AS

Extraintestinal manifestations - Skin

Pyoderma gangrenosum- more in UC patients

- may occur years before the onset of bowel symptoms
- independent of the bowel disease
- respond poorly to colectomy
- very difficult to treat and often require intravenous antibiotics, intravenous glucocorticoids, dapsone, azathioprine, thalidomide, intravenous cyclosporine, or infliximab


3. 27. 2002

Extraintestinal Manifestations - Skin

- **Erythema nodosum** (15% of CD patients and 10% of UC patients)
  - correlate with bowel activity
  - concomitant active peripheral arthritis

– Perianal skin tags are found in 75–80% of patients with CD
– Aphthous stomatitis and "cobblestone" lesions of the buccal mucosa
– Metastatic CD- cutaneous granuloma formation

Erythema nodosum

Extraintestinal Manifestations

- **Ocular:**
  - The most common are conjunctivitis, anterior uveitis/iritis, and episcleritis
  - Uveitis is associated with both UC and Crohn's colitis
  - Prompt intervention, sometimes with systemic glucocorticoids, is required to prevent scarring and visual impairment
- **Hepatobiliary**
  - Fatty liver
  - Cholelithiasis is more common in CD than UC
  - PSC- 1–5% of patients with IBD have PSC, but 50–75% of patients with PSC have IBD
    - fatigue, jaundice, abdominal pain, fever, anorexia, and malaise
    - Ds: ERCP or MRCP
    - cholangiocarcinoma
    - increased risk of colon cancer
    - ursodeoxycholic acid (ursodiol)

Extraintestinal Manifestations

- **Urologic**
  - calculi, ureteral obstruction, and fistulas
  - nephrolithiasis (10–20%) occurs in patients with CD
    - hyperoxaluria
- **Metabolic Bone Disorders**
  - Low bone mass
    - risk is increased by glucocorticoids, cyclosporine, methotrexate and total parenteral nutrition (TPN)
    - Malabsorption and inflammation mediated by IL-1, IL-6, and TNF
  - Osteonecrosis
    - bone scan or MRI
    - within 6 months of starting glucocorticoids

Extraintestinal Manifestations

- **Thromboembolic Disorders**
  - increased risk of both venous and arterial thrombosis
- **Other Disorders**
  - cardiopulmonary manifestations: endocarditis, myocarditis, pleuropericarditis
  - interstitial lung disease
  - amyloidosis

Diagnosis

- History
  - How long?
  - How bad: no. of stools? Blood?

- Signs of rectal involvement (urgency, frequency incomplete evacuation)
- Pain (nature, awakes at night, location, relation to defecation)
- Additional inflammatory signs: fever, weight loss (anorexia, diarrhea, sitophobia)
- Additional signs of complications: arthritis, rashes, ulcers, perineal diseases

Diagnosis

- Laboratory tests- non specific and reflect disease severity & involvement

- Anemia- normocytic normochromic (chronic disease), Iron ↓, B12 ↓ (CD of TI, BOG), FA ↓ (malabsorption due to disease involvement)
- Electrolytes- K ↓, Ca ↓, Mg ↓, Zn ↓
- Albumin ↓ (malabsorption, protein losing)

Diagnosis

- Stool: Steatorrhea (mild), WBC in stool, Increased calprotectin
- Disturbed Liver function tests (Alk. P- PSC, TA- inflammation)

Diagnosis

- Determine anatomic involvement
- Determine nature of involvement (UC Vs CD Vs others)

Diagnosis

- Endoscopic examinations:
  Rectosigmoidoscopy- rectum? Mucosal morphology? (ulcer type, skip areas)
  Colonoscopy- Same + disease extent + terminal ileoscopy

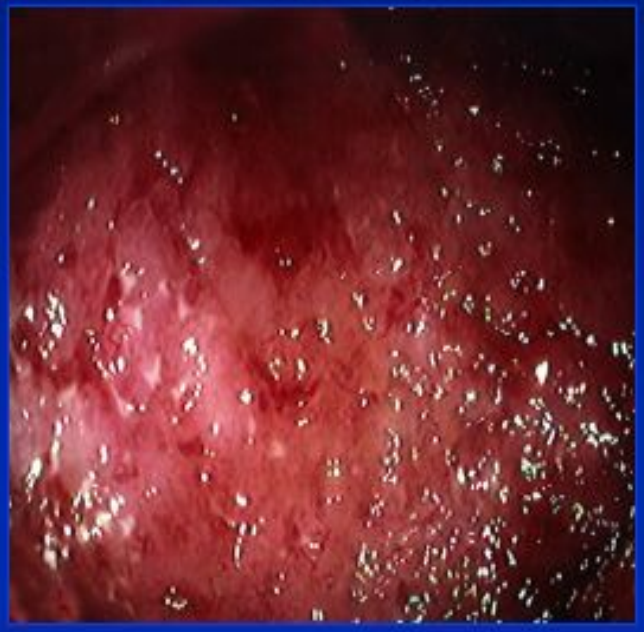
- Pathologic examination: biopsies
  (granulomas in 10-25 % of cases), other features less specific

UC - Spectrum of Disease

Normal

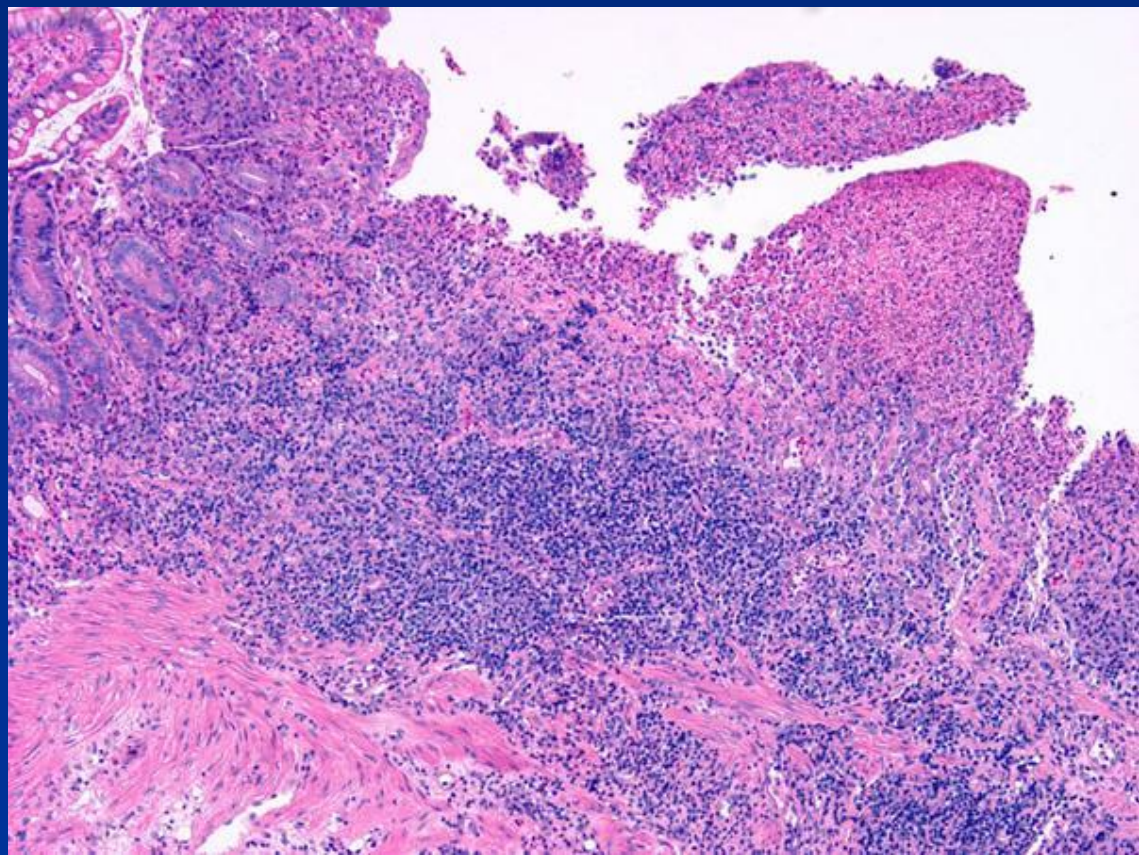
Mild

Moderate



Severe

- Tissue inflammatory infiltration by lymphocytes, plasma cells, and neutrophils with large lymphoid aggregates
- Cryptitis and crypt abscesses
- The lymphoid aggregates in the mucosa and submucosa, (could be located throughout the bowel wall)



CD


aphthae


stellate ulcer

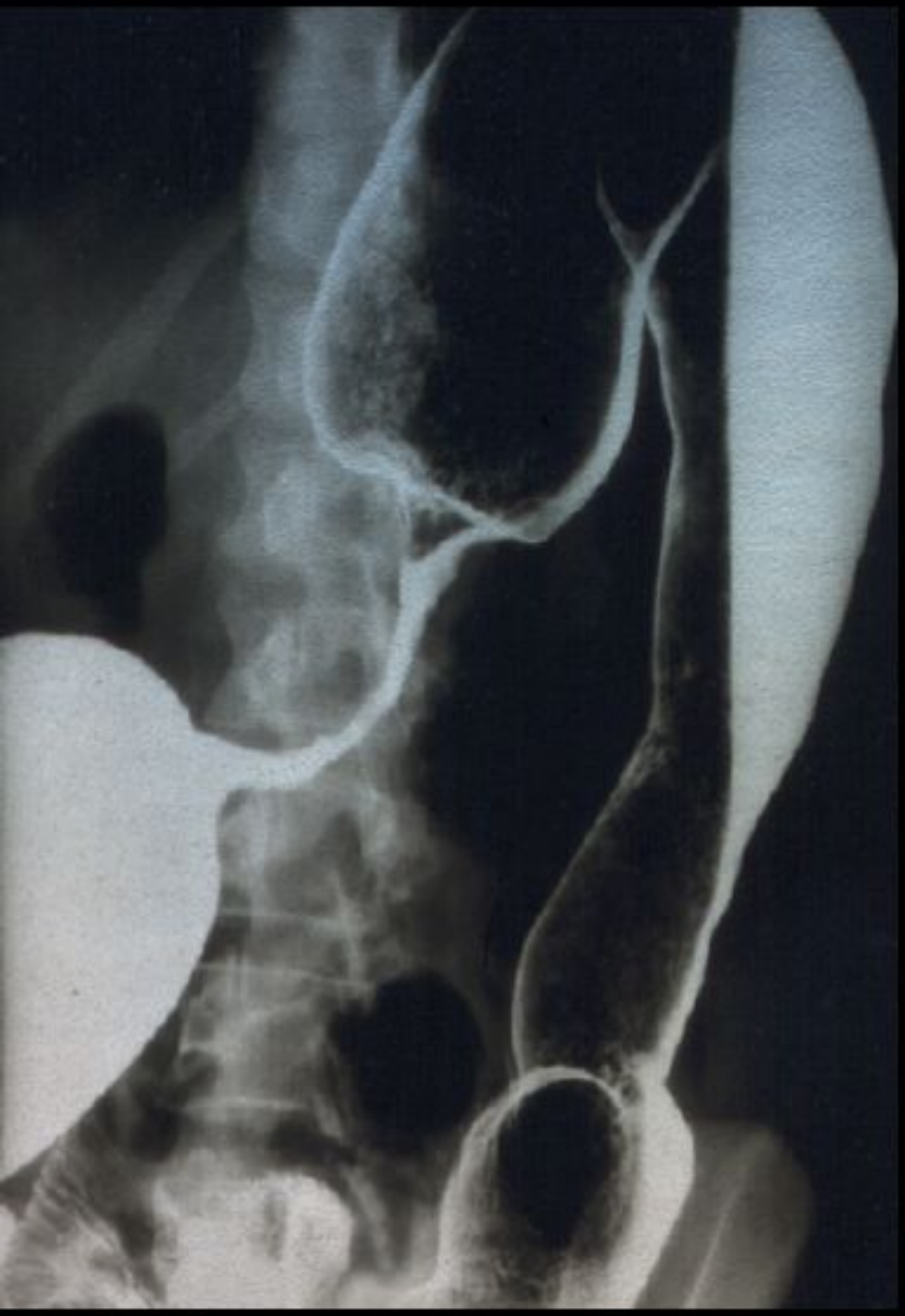

longitudinal ulcer


Macroulcerations and pseudoplyps

Diagnosis Radiology

- Barium enema:
  fistula, sinus tract, stricturing (not used today)

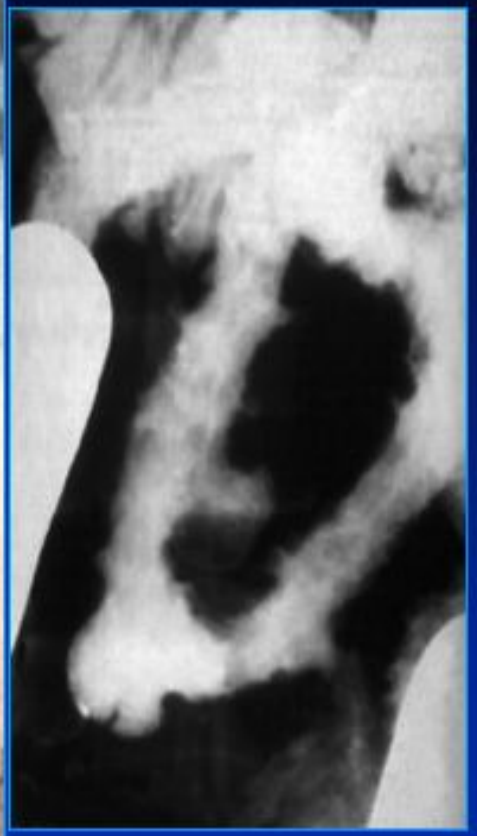
- Small bowel follow through- small bowel anatomy and involvement, strictures, fistula (rarely used today)



CD

marked edema and nodularity in addition to ulceration

narrowing and spasm



deeper ulceration+ mesenteric sinus tract formation

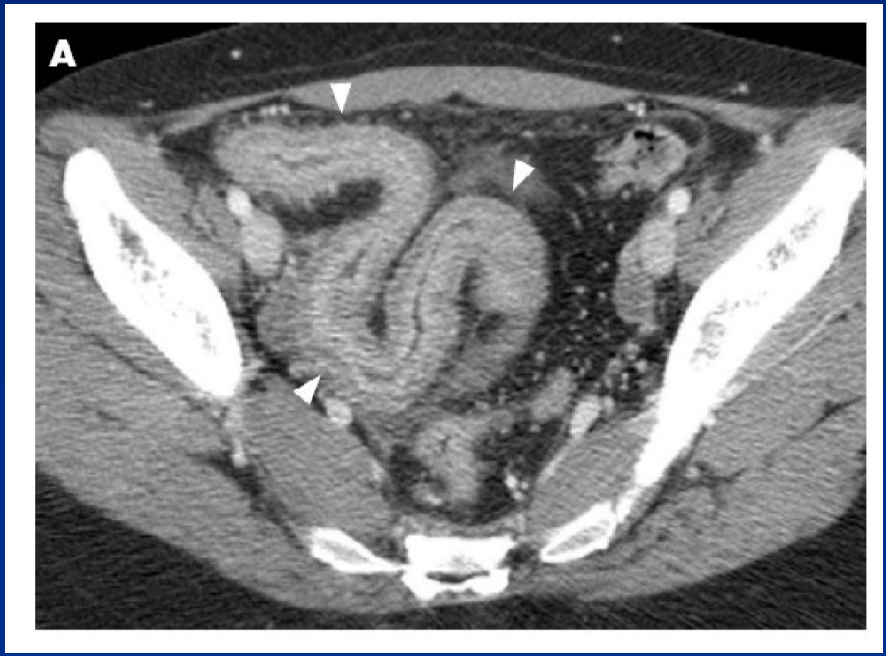
Diagnosis

- CT – replaced SBFT, allows for detection of extramural complications
  (abscess, fistula, retroperitoneal disease)

- MRI: MRE – replaces CT?
  - MR for pelvic CD

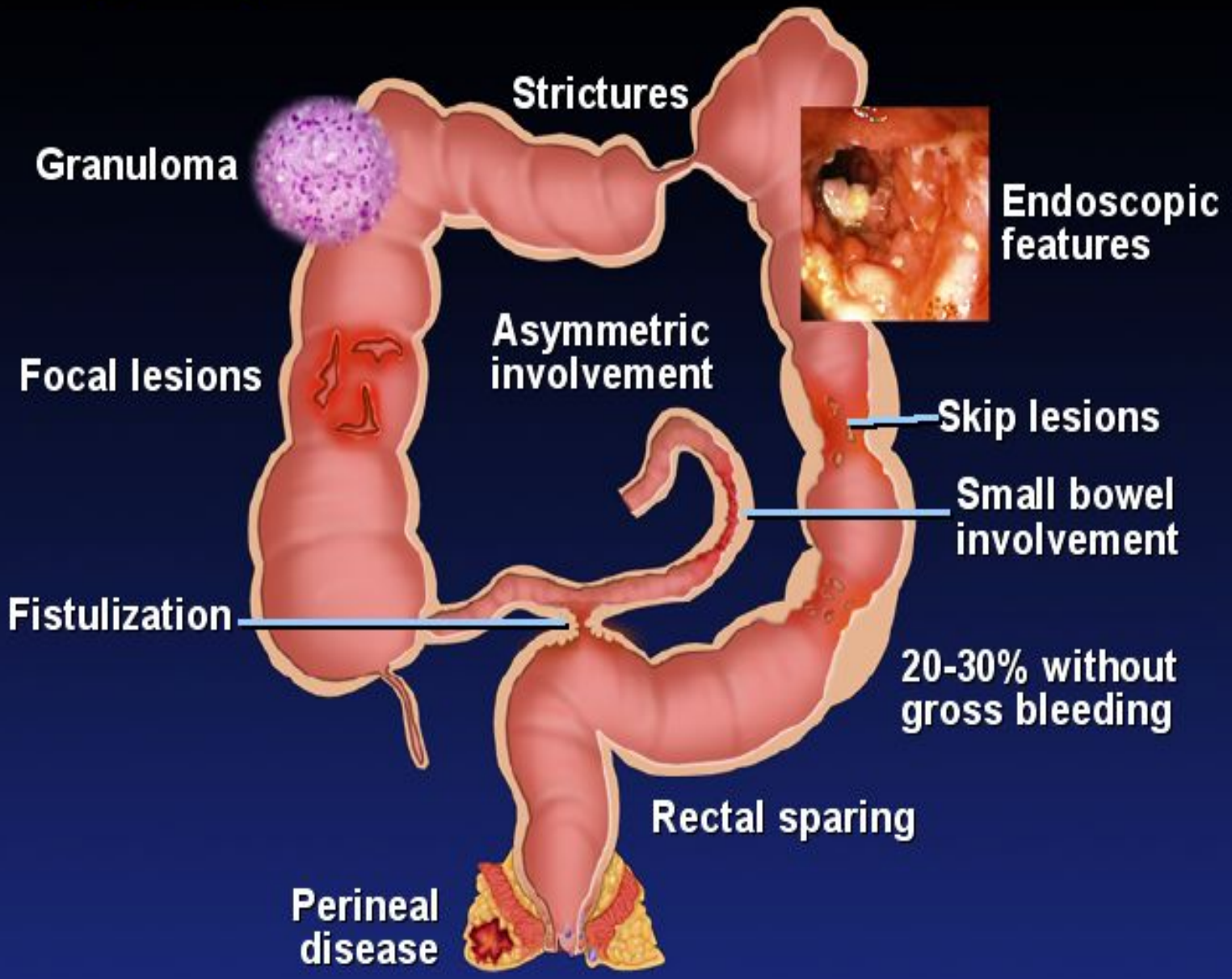
- EUS- pelvic CD, biliary disease

Abdominal CT in IBD Diagnosis



CT can asses inflammation, bowel wall thikening, fat, strictures and fistula

CD - Distinguishing Features



Goals of Therapy

- Induce clinical remission
- Maintain remission
- Enhance quality of life
- Avoid long-term toxicity

Conventional Drug Therapies

Aminosalicylates
- Sulfasalazine
- Mesalamine
- Olsalazine
- Balsalazide

Corticosteroids
- Prednisone / Prednisolone
- Budesonide
- ACTH

Supportive agents
- Antidiarrheal
- Bile sequestrants
- Bulk formers
- Antidepressants
- Pain management
- Anti-spasmodics

Antibiotics
- Metronidazole
- Quinolones
- Other

Immunomodulators
- 6MP/Azathioprine
- Methotrexate
- Cyclosporine / tacrolimus
- Anti-TNF

Biologics
- Anti- TNF
- Anti-cytokine
- Anti Migration

Sulfasalazine

Sulfapyridine
(SP)

5 - Aminosalicylic acid
(5-ASA)

Aminosalicylates

Sulfasalazine

Oral preparations

Mesalamine
- Acrylate coated
- Ethylcellulose encapsulated

Balsalazide — Inert vehicle

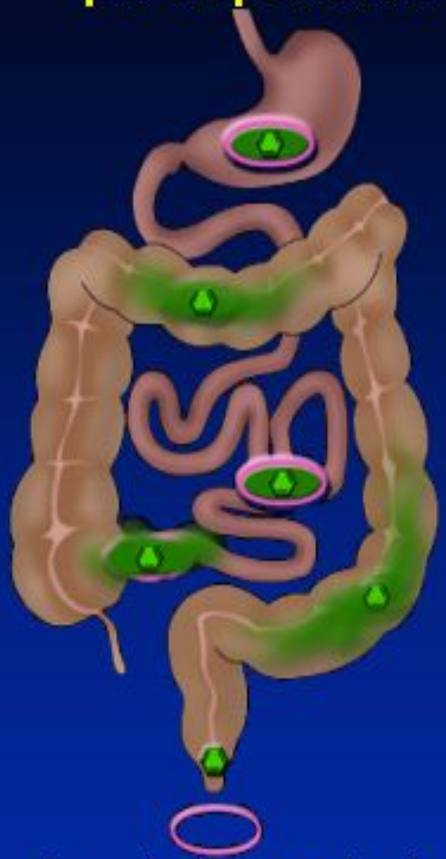
Olsalazine — 5-ASA dimer

Rectal preparations

Mesalamine

IBD - Oral Aminosalicylate Delivery

pH-dependent



Acrylate-coated mesalamine

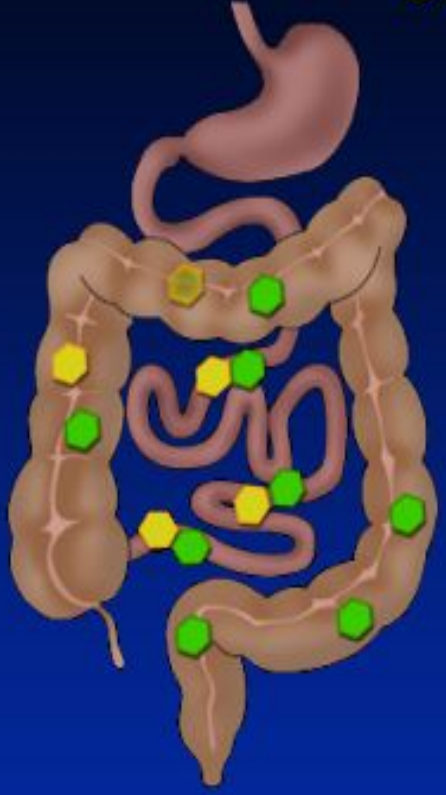
Asacol®, Claversal®, Salofalk®, Raffersal®

Time release

Ethylcellulose-encapsulated mesalamine

Pentasa®

Bacterial cleavage



Azobond - linked 5-ASA

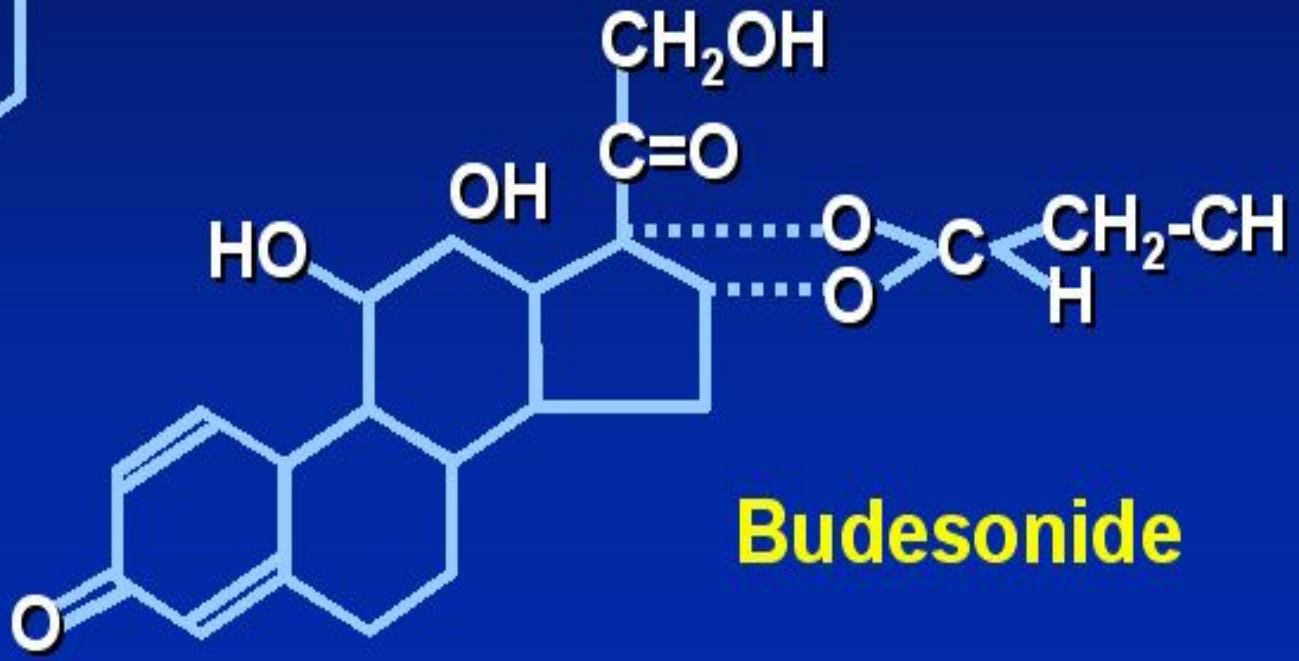
Sulfasalazine - Azulfidine®

Olsalazine - Dipentum®

Balsalazide - Colazal®

Systemic / Topical

Hydrocortisone



Budesonide

Corticosteroids in IBD

- Role
  - Induction of remission in CD and UC
- Toxicity
  - Metabolic
  - Musculoskeletal
  - Gastrointestinal
  - Cutaneous
  - Neuropsychiatric
  - Ocular
  - Growth failure (pediatric)

Immuno-suppressors in IBD

- Azathioprine, 6-Mercaptopurine
- Methotrexate
- Cyclosporin
- Tacrolimus

Table I. Thiopurine-related adverse drug reactions (ADRs)

ADRs	Frequency
Dose-dependent ADRs	
Haematotoxicity	
pancytopenia	0.4–2%[50,53,57]
leukopenia	3.8% and 11.5%[57,58]
thrombocytopenia	1.2%[57]
anaemia	Rarely[59]
Liver injury	0.3–9.9%[50,53,58,60]
Dose-independent ADRs	
Pancreatitis	1.2–4.9%[50,53,56,58,61]
Gastrointestinal disturbances, e.g. nausea, vomiting, diarrhoea[a]	4.6%[50]
Flu-like symptoms, e.g. fever, headache, rash, arthralgia, myalgia, malaise[a]	2–6.5%[50,53,58]
Rare complications	
pneumonitis	Seven cases[62]
acute interstitial nephritis	Single case[63]
veno-occlusive disease of the liver	Single case[64]
nodular regenerative hyperplasia	Four cases[65]
Infections	7.4–14.1%[53,58]

a Commonly termed as 'azathioprine intolerance'.

Side effects thiopurines (cont.)

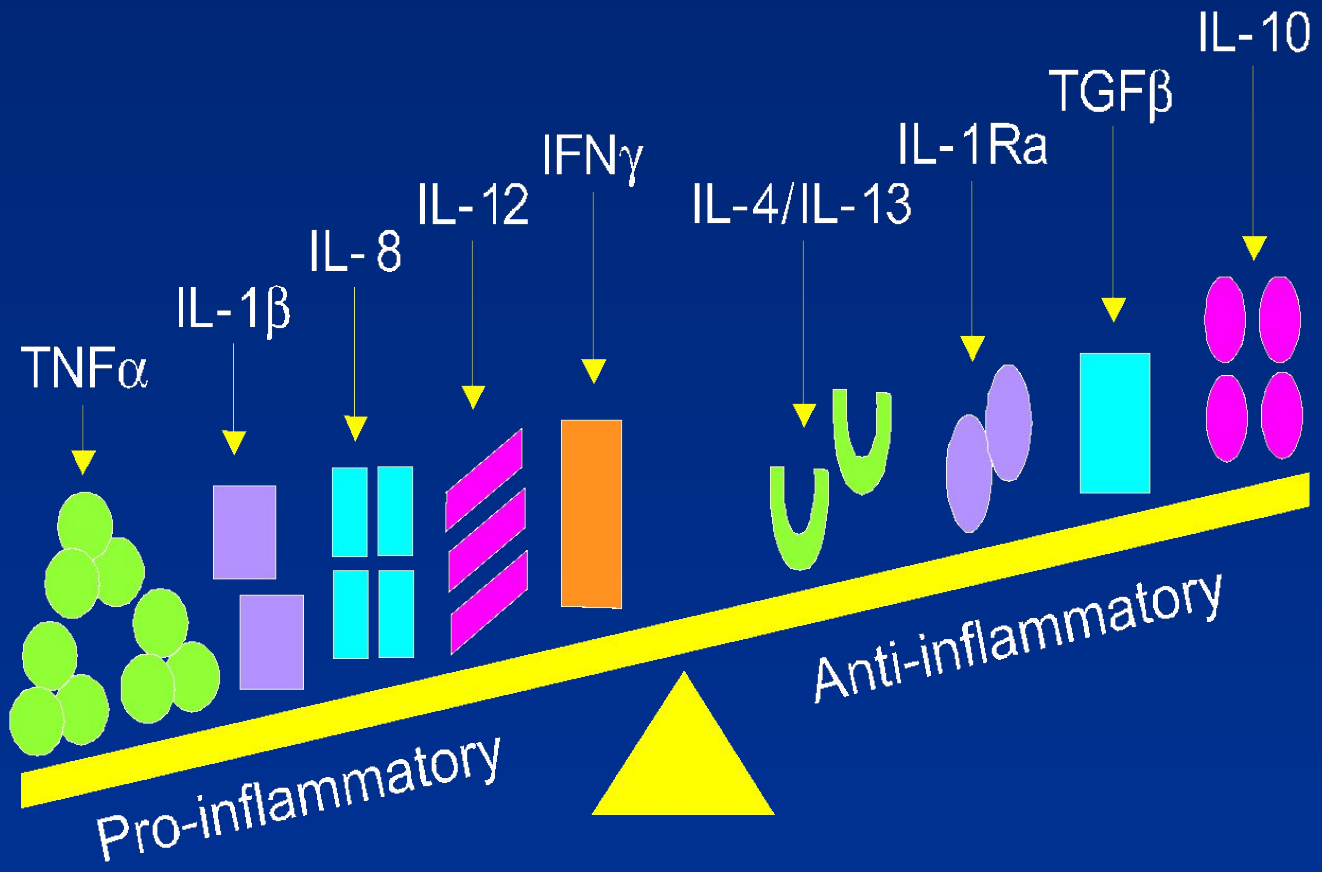
- Small increased risk of developing lymphoma
- Increased risk of non- melanoma skin cancer

Toxicity of Cyclosporine in IBD

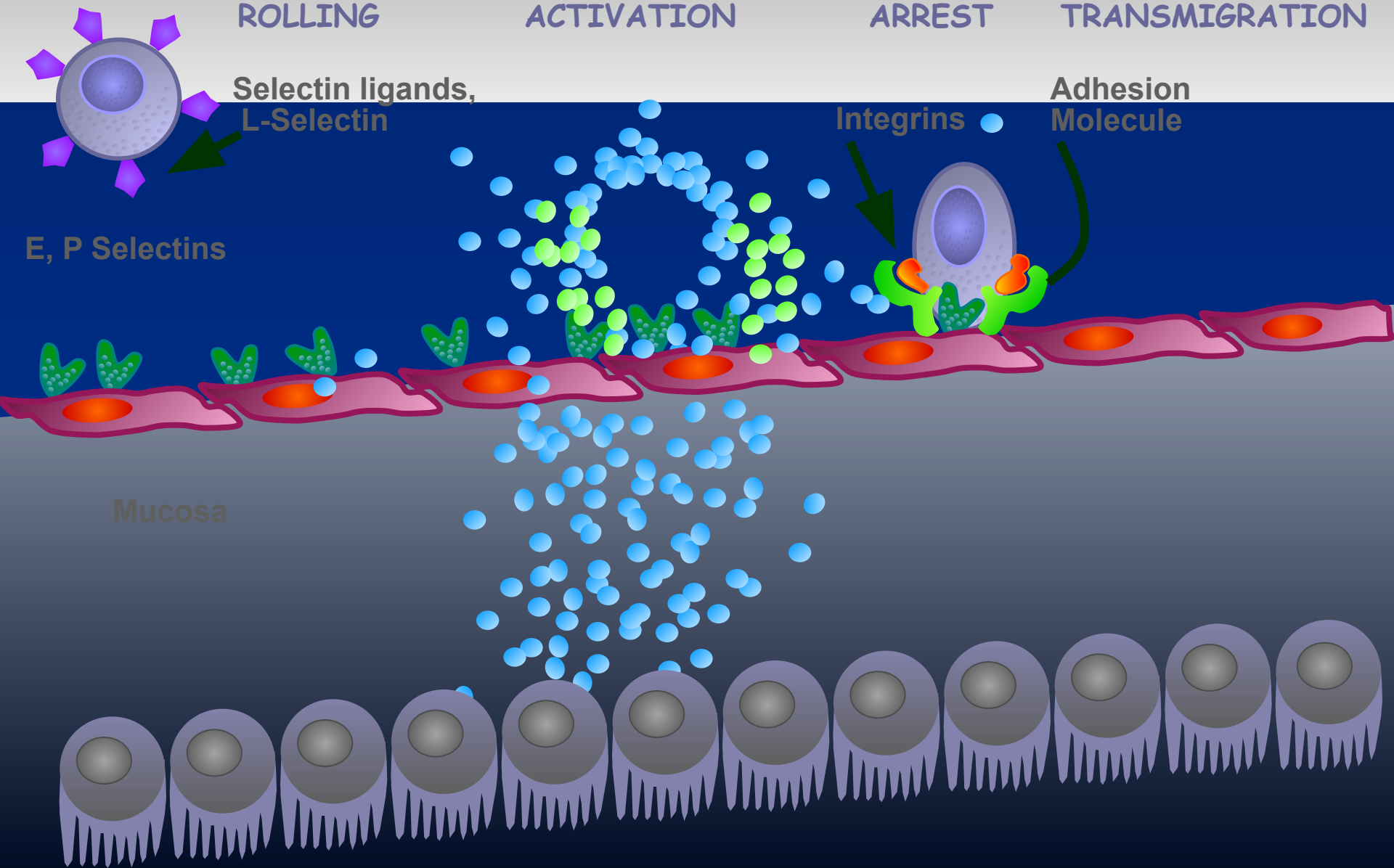
Major		Minor	
Nephrotoxicity	24%	Paresthesias	51%
Infection	20%	Hypertension	39%
Seizure	4%	Hypertrichosis	27%
Anaphylaxis	1%	Hypomagnesemia	20%
DEATH	2%	Hyperkalemia	13%

Sternthal M et al. Gastroenterology 1996; 110:A1019

Chronic Inflammation: Imbalance Between Mediators



Migration of Cells into Tissues



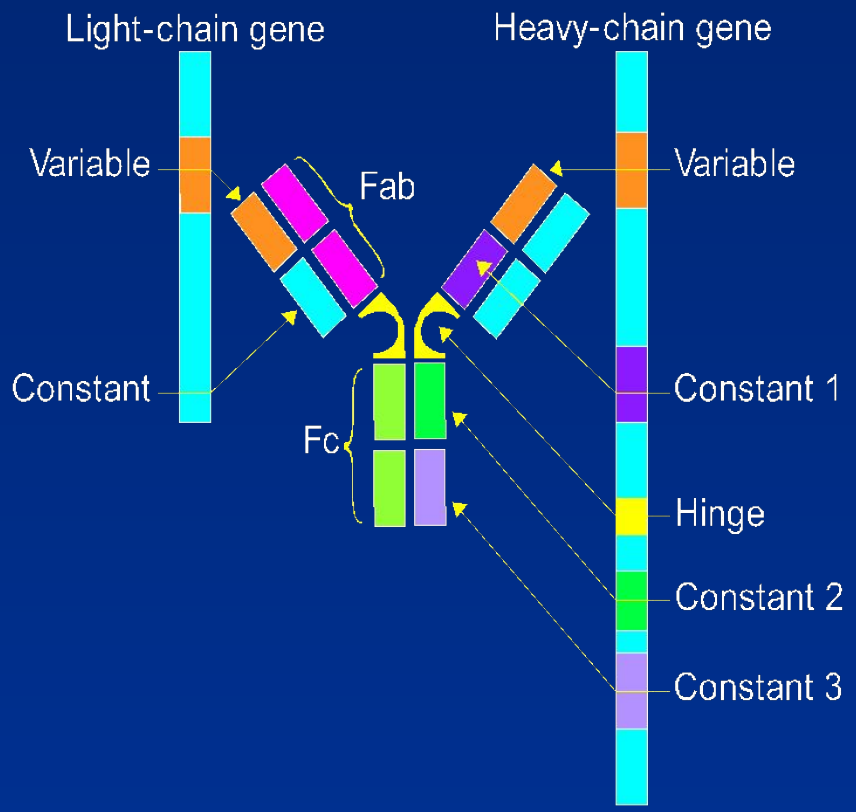
Biologicals

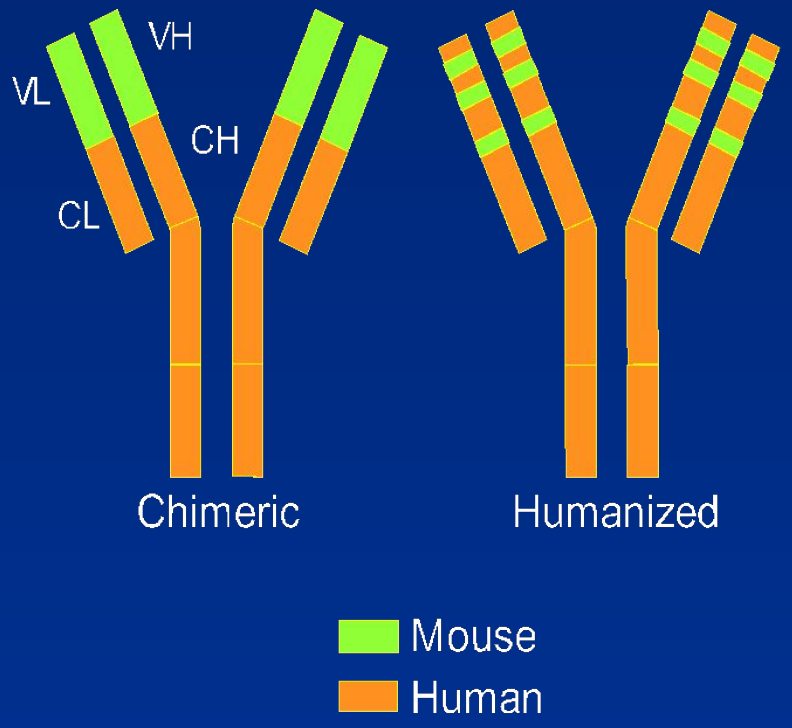
- Anti TNF agents:
  - **Infliximab** (Remicade), **Adalimumab** (Humera), Golimumab (Simponi)

- Anti migration:
  - Natalizumab
  - **Vedolizumab**

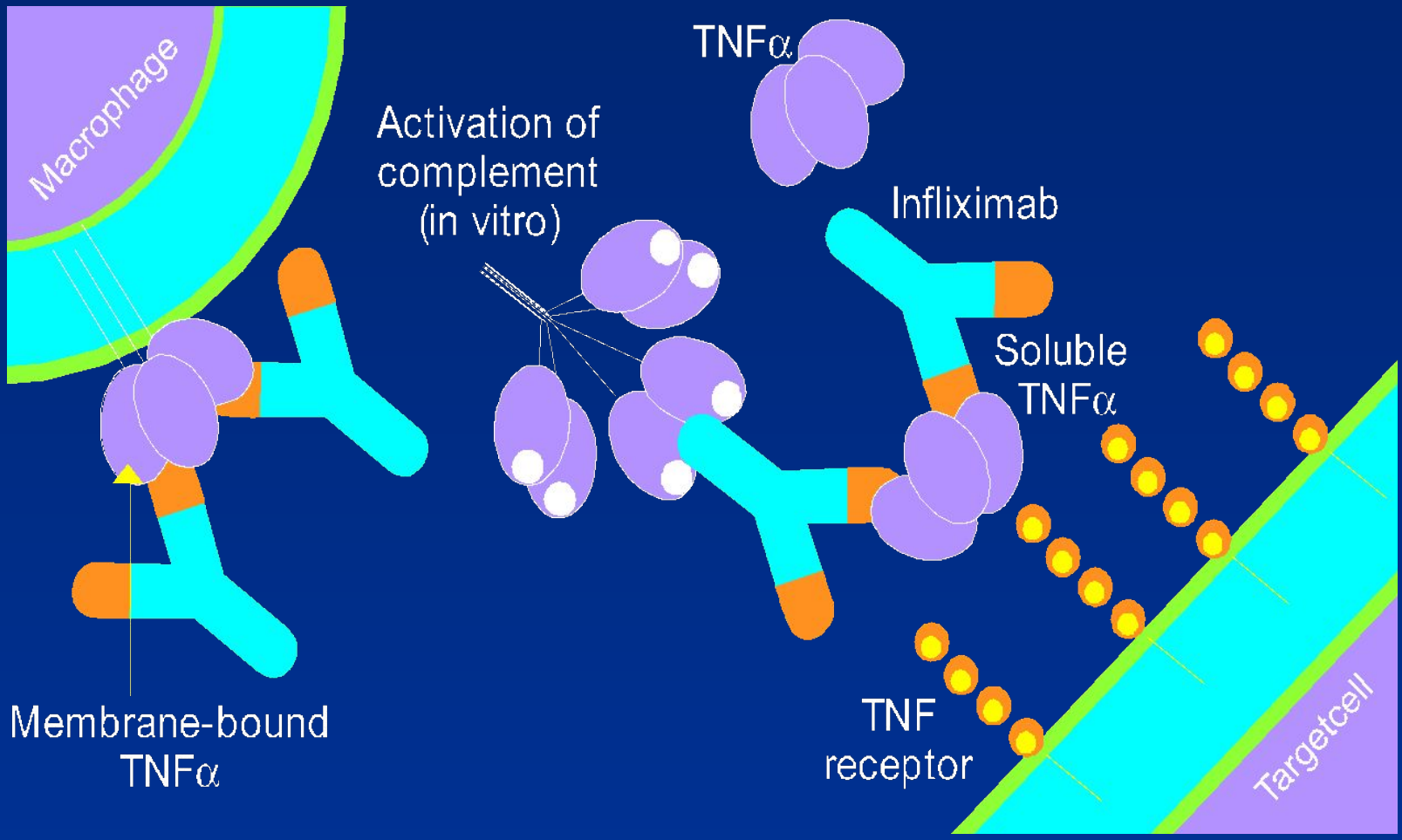
    Binds $\alpha_4\beta_7$-integrin heterodimer, inhibits the pathologic effects of CD4 T-cell

Chimerized and Humanized Antibodies

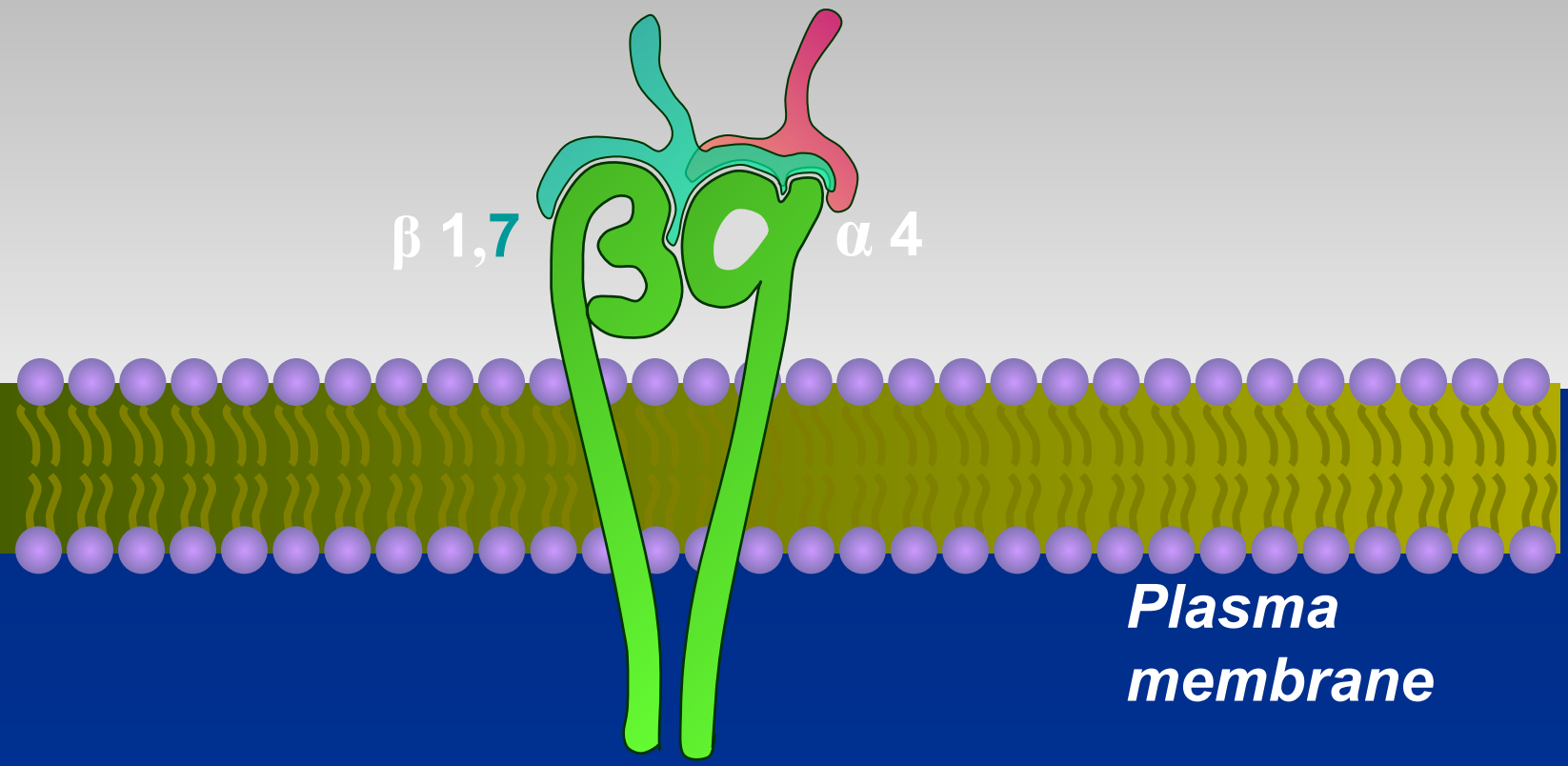




Infliximab Mechanism of Action



Integrin Structure



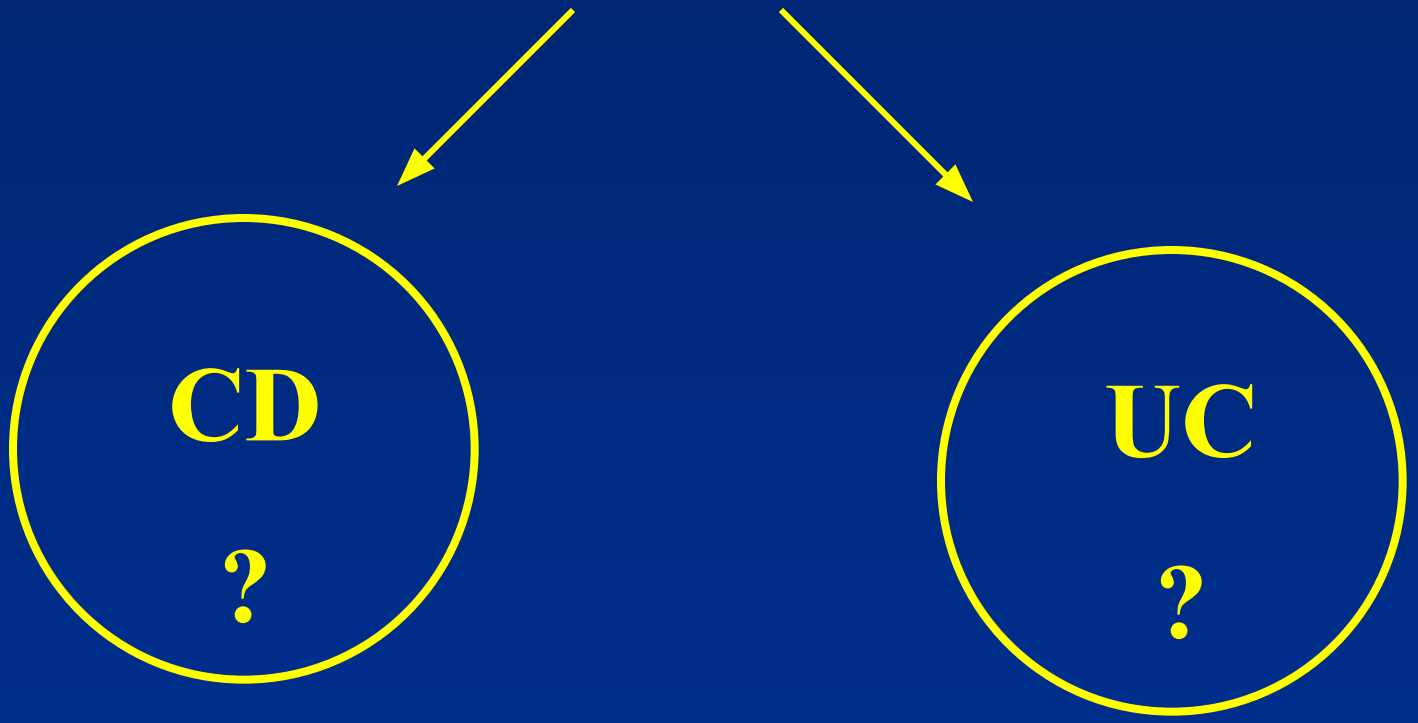
Adverse Effects of Infliximab

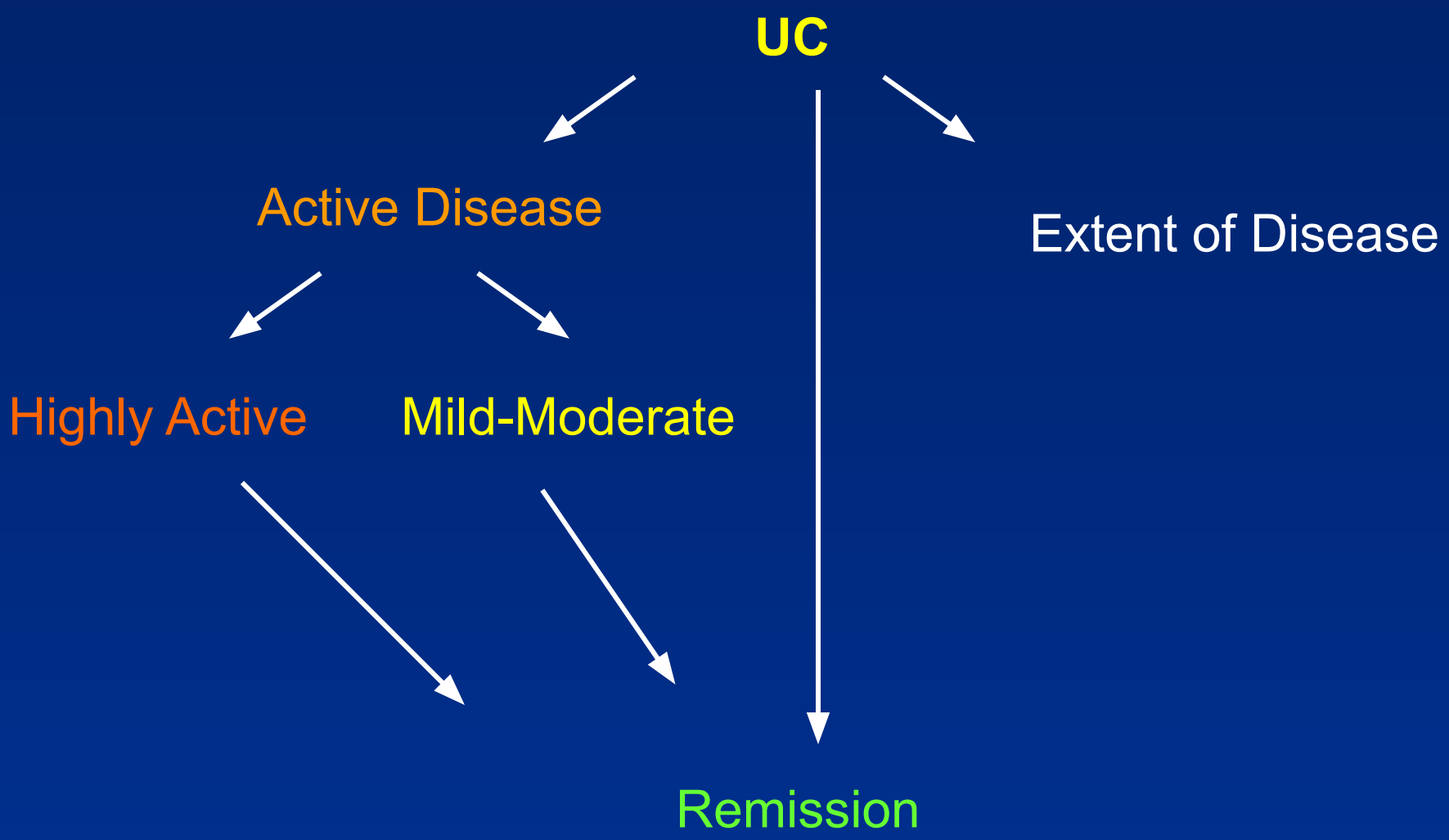
- Immediate infusion reactions
  - Headache, flushing, rash, fever, abdominal pain, chest pain, wheezing, anaphylaxis
- Serum sickness-like syndrome
  - High human anti-chimeric antibody titers
- "Lupus-like" syndrome
- Infection
  - URI, peri-rectal abscess, reactivation TB
- ? Worsening of strictures
- ? Risk of cancer

Biologicals: Pre-therapy preparations

- TB exposure: Skin test/quatiferon + Rx
- HBV, HIV, Varicella exposure
- Immunize: Pneumovax, Influenza (HBV, varicella)

Diagnosis




UC
Active Disease
Extent of Disease
Highly Active
Mild-Moderate
Remission

Main clinical points to address

Factors that affect treatment choice:

- Disease distribution (proctitis, left sided, extensive)
- Disease behavior (frequent relapse?)
- Response to previous medications
- Side effects
- Extraintestinal manifestations

Patient assessment

- Exclusion of infectious agents:

  STD in proctitis
  Bacterial (including C. Diff) and parasitic infections
  CMV- in the context of immune suppression (biopsy)

- Endoscopic evaluation:

  Infectious?
  Crohn's?
  Mucosal prolapse?
  IBS & haemorrhoidal bleeding ?

Outpatient assessment of the severity of active UC:

T&W- Important not to miss severe progressive disease

	Mild	Moderate	Severe
Bloody stools/day	**<4**		**≥6**
Pulse	**<90bpm**		**>90bpm**
Temperature	**<37.5ºC**	**In between**	**>37.8ºC**
Hb	**>11.5g/dL**		**<10.5g/dL**
ESR	**<20mm/hr**		**>30mm/hr**

or

or

or

- Easy to remember, easy to apply, defines severe attacks

UC - Mild to moderate activity

- 5-ASA/SZP:
  Both induction of remission and maintenance
  Dose – dependent
  Combine topical & systemic

  If Failure:

- Steroids:
  <u>Induction of remission only</u>
  Combine topical & systemic
  Start high does and taper

UC - Left sided & Pan colitis
Mild to moderate activity

If steroid dependent:

- Azathioprine/ 6-MP

If non responsive:

- Infliximab
  Can be used to induce & maintain remission

  Note: Role of Adalimumab & Methotrexate not formally established for UC

Severe UC

- Prevalence ~ 20% for first and recurrent attacks
- Severe active UC with systemic toxicity →hospitalize
- Usually IV, hydrocortison 100 mg X 3 for 5 days
- Lower doses – less effective, > 7-10 days – no benefit
- Systematic review 32 trials (1991 pts) [2]: Response 67%
  Colectomy 29%
  Death 1%

Severe UC

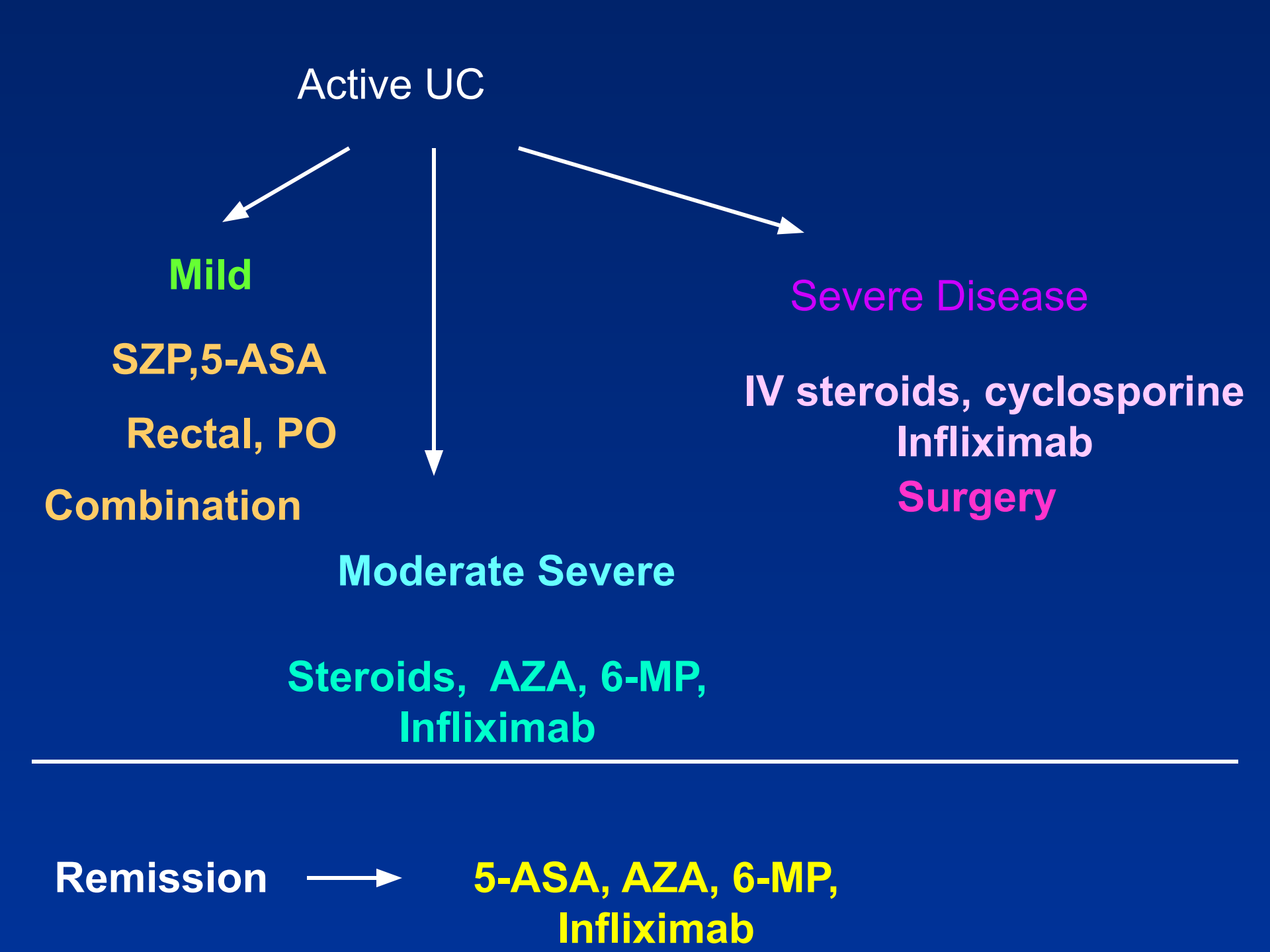
- Correct:
  Hypokalemia, hypomagnesemia (toxic dilatation ↑)
  Hemoglobin
  Nutritional support
  (complications enteral Vs parenteral 9% Vs 35%)[1]
  Withdraw anticholinergics, antidiarrheals, NSAID, opiod
  Abx – only if infection suspected or preoperative

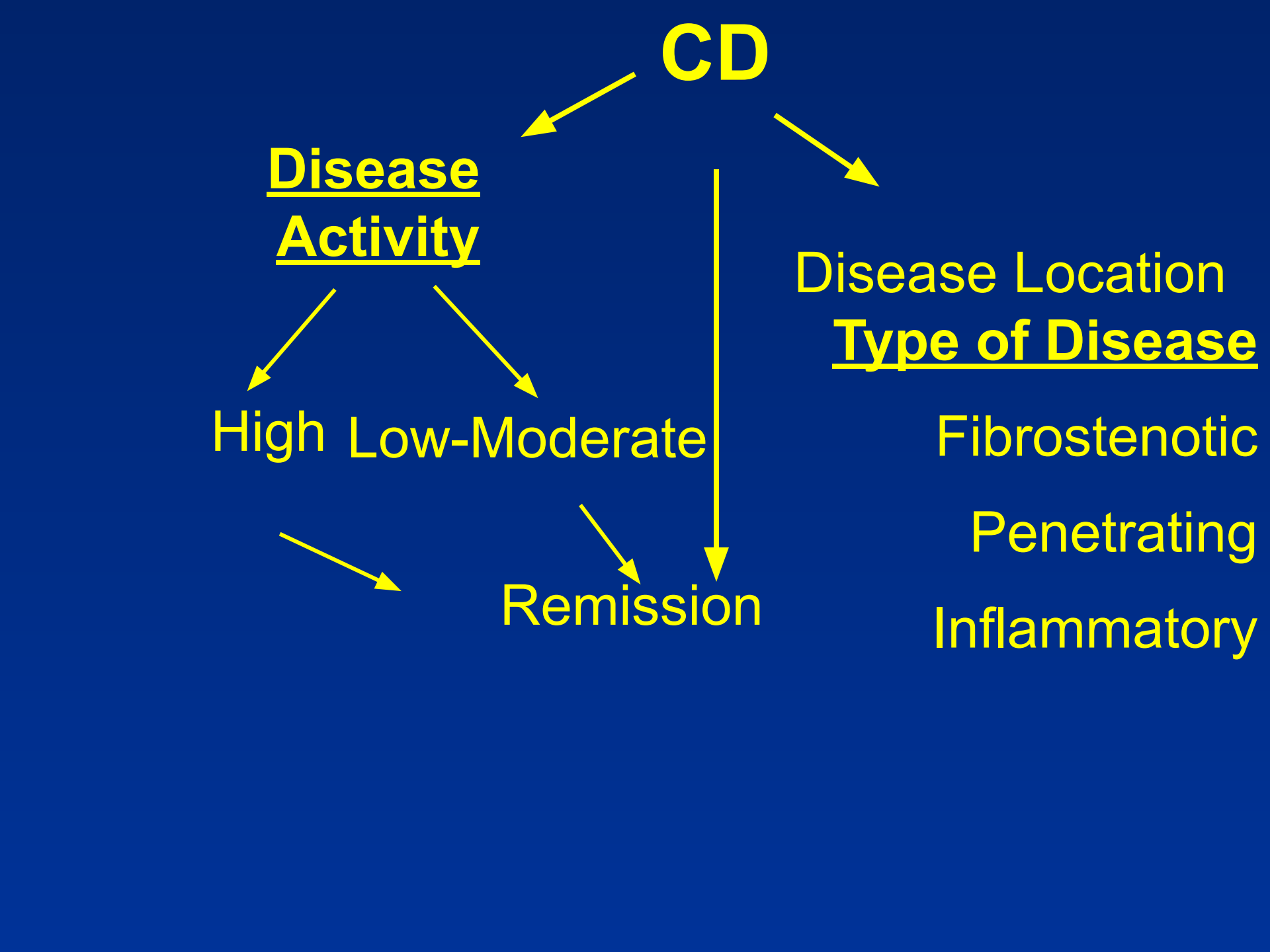
- Cyclosporin monotherapy = 40 mg Methylpredinsolone use in steroid intolerant

Ulcerative Colitis

INDICATIONS FOR SURGERY

- Exsanguinating hemorrhage
- Toxicity and/or perforation
- Suspected cancer
- Significant dysplasia
- Growth retardation
- Systemic complications
- Intractability


Active UC
Mild
SZP,5-ASA
Rectal, PO
Combination
Moderate Severe
Steroids, AZA, 6-MP,
Infliximab
Severe Disease
IV steroids, cyclosporine
Infliximab
Surgery
Remission
5-ASA, AZA, 6-MP,
Infliximab


CD
Disease Activity
High
Low-Moderate
Remission
Disease Location
Type of Disease
Fibrostenotic
Penetrating
Inflammatory

CD- Colon Mild -Moderate

- SZP-/5-ASA for colonic disease only
- Side effects: paradoxical diarrhea, nausea, vomiting, headache, hypersensitivity
- Need to check renal function
  Allowed in pregnancy

CD-Small Bowel

- **Steroids**:
  Generally try to avoid due to side effects
  - Controlled trials show definite efficacy
  - Use steroids with less side effects

- **Budesonide:** 90% first pass effect
  - TI & RT colon
  - Similar effect to prednisone less SE
  - Need to FU: Bone density, glucose levels allowed during pregnancy

CD – Moderate Activity

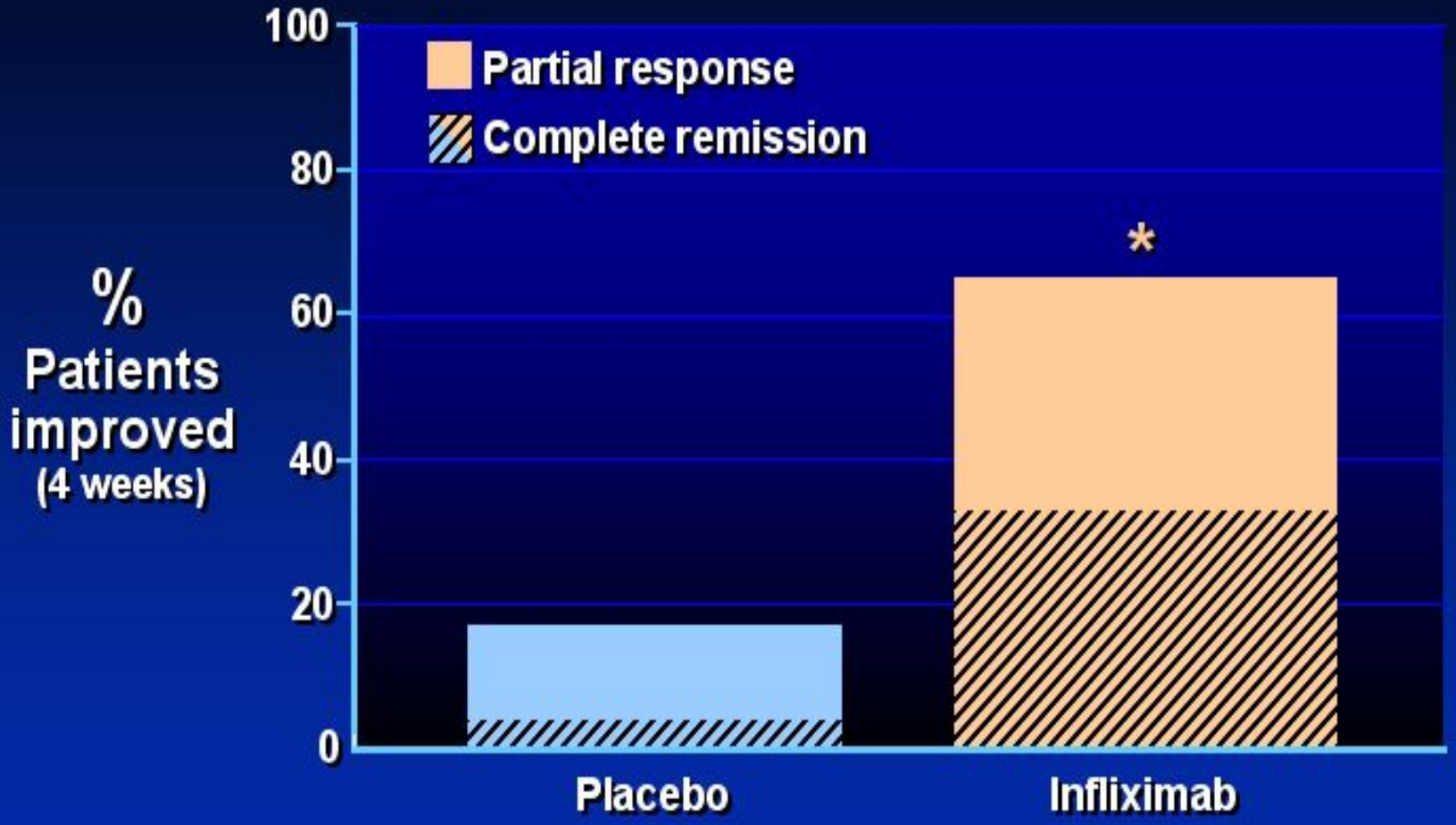
- Immunosuppressive agents
- Azathioprine, 6 MP
- Steroid dependent or resistant disease
  Steroid sparing
- 30-60% response
- Up to 6 mo to initial effect, most start earlier
- FU: CBC, LFT, Pregnancy OK

CD-Moderate Disease

- Methotrexate

- IM - 40% efficiency for 16 wks
- Reduced Steroid use
- Max efficiency - 6 wks
- SE: leukopenia, nausea, vomiting, diarrhea
  Possible liver fibrosis
- FU: CBC LFT
- Contraindicated in pregnancy

Anti TNF therapy in Crohn's disease



Targan SR et al. N Engl J Med 1997; 337:1029

Biologicals

- No difference between Infliximab and Adalimumab for efficacy
- Different modes of administration
- Loading, scheduled therapy
- Loss of response:
  Dose escalation/switch
- Antibodies formation

CD- Severe Disease

- Hospitalization
- IV steroids
- If abscess, fistula- drain, consider TPN
- Anti TNF Abs

CD- Effect of Disease Type

- Perianal & fistula:
  Antibiotics
  Azathioprine/6 MP
  Infliximab

- Surgery

- Treatment sequence: Image, classify, drain sepsis – medical treatment

CD- Effect of Disease Type

- Fibrostenotic disease
  - Need to differentiate inflammation/scare
- If scare: surgery
- Medical therapy as inflammatory

CD- Maintenance of Remission

- **Not Steroids !**

- 5-ASA: low efficiency (1:13), SE ↓
- May benefit post surgical
- Not good for remission post medical Tx
- Chemopreventive?

CD- Maintenance of Remission

- Immunomodulatory drugs
- Azathioprine/6MP: efficient regardless of therapy mode

- MTX: Good for pts that entered remission with MTX

- Anti TNF agents

Active CD

Mild Disease

Colon:
5ASA/SZP

SB: Budesonide

Moderate/Severe

Steroids

Prednisone/Budesonide

Immunomodulatory agents

AZA/6MP

MTX

Infliximab

Surgery when indicated

CD in Remission

Post Surgical -5ASA /AZA+MTZ/INFX

Medical

Immunomodulation

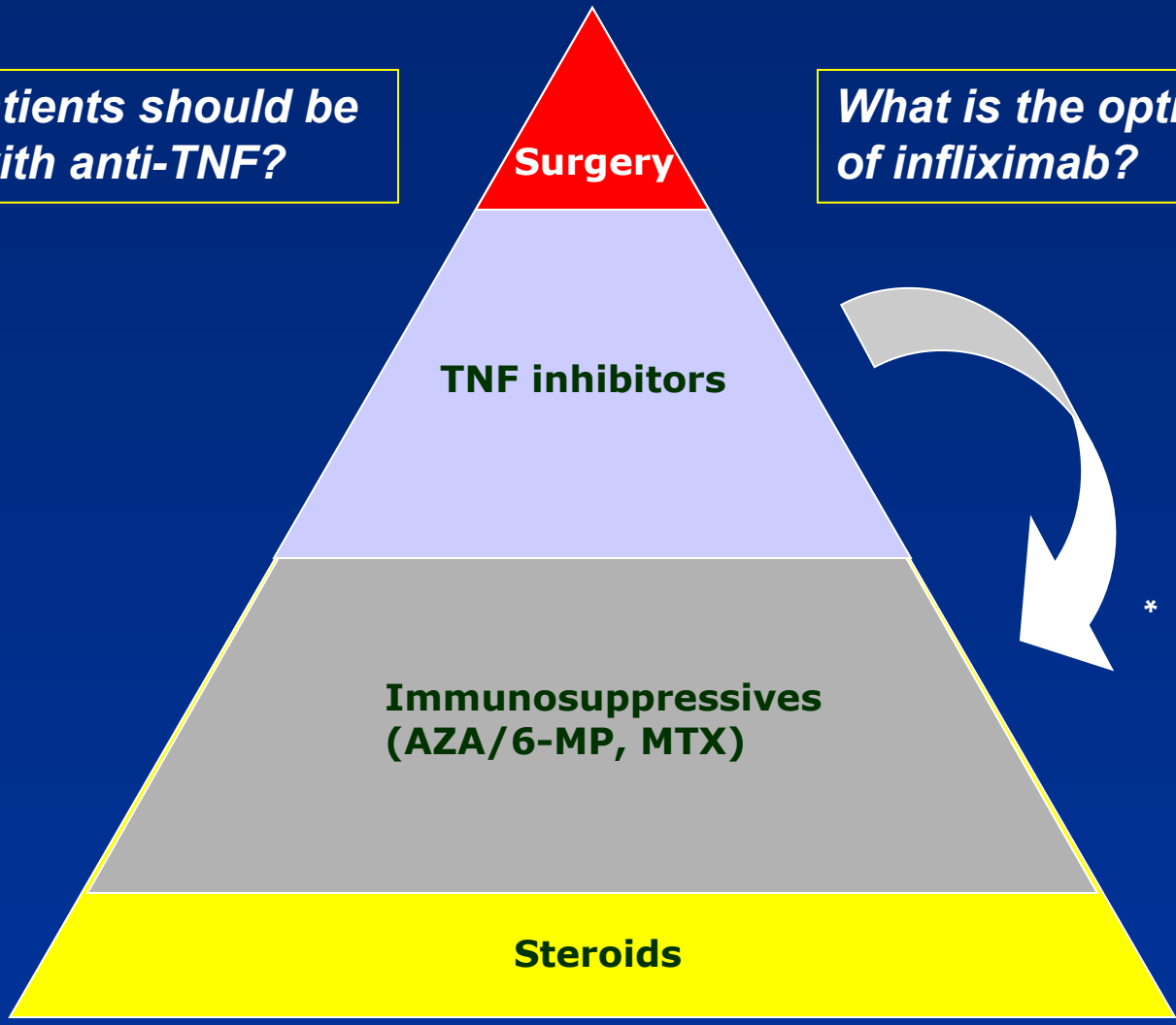
AZA/6MP/MTX

Infliximab

The evolution of therapy: Should we invert the pyramid?

Which patients should be treated with anti-TNF?

What is the optimal use of infliximab?



Future evolution

- Should we aim for mucosal healing?
- Should we perform early surgery?
- Risk / benefit analysis of treatments and outcomes

Case Study

30-year-old woman was admitted with a 4-week history of increasing bloody diarrhea and abdominal pain; she had lost 3kg in weight. She smoked 1 pack of cigarettes a day. On examination, she was not clinically anaemic and, apart from a temperature of 37.8°C and some tenderness over the right iliac fossa, there were no abnormal physical signs.

The perineum was normal but sigmoidoscopy to 15cm showed a red, granular mucosa with aphtous lesions and contact bleeding. Laboratory investigations showed a low haemoglobin (10.8g/l) with a raised CRP (67 mg/l) but a normal white-cell count. Urea and electrolytes, serum vitamin B_{12}, folate, iron, ferritin and iron-binding capacity were normal. Her total serum proteins were 5.4g/l (NR 6.2-8.2) with a serum albumin of 2.9g/l (NR 3.5-5.0). Faecal examination and culture revealed no ova or Campylobacter. Clostridium difficile toxin was negative

Case Study

The rectal biopsy : many crypt abscesses were present. The lamina propria contained a heavy infiltrate of lymphocytes, plasma cells and macrophages. Two non-caseating granulomas were present.

A CT and a colonoscopy were performed to assmall-bowel barium infusion s the extent of disease. Inflammatory strictures were seen at a number of separate sites (skip lesions) in the ascending and transverse colons. She was treated with corticosteroids and a 3-month course of metronidazole with symptomatic improvement. She was strongly advised to stop smoking.

י.ע. 9/2011

- בת 54, מזה כחודש וחצי סובלת משלשולים רבים, יציאות דמיות וריריות לסירוגין, ירידה במשקל של כ-5 ק"ג בתקופה זו. אירועים מעירים משינה, מלווים בכאבי בטן.
- לפני כשבועיים בוצעה קולונוסקופיה: פאן קוליטיס.
- טופלה בפנטסה ופלג'יל ללא שיפור משמעותי.

י.ע. 9/2011

- אושפזה בפנימית להמשך בירור וטיפול.
- בקבלתה הוחל טיפול בסטרואידים ורפסל.במהלך אשפוזה שיפור ניכר בתלונות.
- לאחר 3 ימי טיפול ללא כאבי בטן, 3-4 יציאות ליממה ללא דם, CRP ירד לנורמה.
- בתשובת פתולוגיה ממצאים מתאימים לIBD מסוג Active UC.
- בהמשך הועברה לטיפול פומי בסטרואידים.

י.ע. 18/10/2011

- באשפוז הקודם הותחל גם טיפול גם בMP-6. שוחחתי ארוכות עם החולה ובעלה אודות הסיכונים שבטיפול זה והצורך ההדוק במעקב.
- החולה תמשיך חפיפה עם סטרואידים ותגיע בעוד כחודש לביקורת.

י.ע. 18/10/2011

- הגיעה לביקורת, טופלה עד כה בפרדניזון עם ירידה הדרגתית וסיימה לפני שבועיים.
- בנוסף הותחל טיפול גם ב MP-6 (פורינטול) אך הפסיקה לפני שבועיים. למרות ההמלצות בשחרור לא נוטלת כרגע פורינטול או רפסאל!!! מקבלת פוליקס. אסימפטומטית לחלוטין.
- לויקופניה 4350, נויטרופניה של 670, Hb 8.8. עקב הירידה בלויקוציטים, במיוחד בנויטרופילים, ובהמוגלובין – לא מחדש בשלב זה טיפול בפורינטול.
- ממליץ: לתת רפסאל 2 גראם פעמיים ביום, לחזור על CBC.

י.ע. 26/12/2011

- שני אשפוזים בפנימית: פעם אחת בשל החמרה שטופלה בסטרואידים, פעם שניה בשל מחלת ריאות משנית לטיפול ברפסל.
- כאשר הפחיתה לפרדניזון 10 מ"ג השלשולים נשנו.
- בתחילת דצמבר אנמיה Hb 10, לויקופניה גבולית 4920 ותרומבוציטופניה.
- תלוייה בסטרואידים, ASA-5 אינן באות בחשבון בשל התפתחות פנאומוניטיס מסכנת חיים, ולכן האופציה הבאה היא התחלת טיפול בפורינטול או אימוראן (אם Plt וWBC יהיו תקינות) במינון הדרגתי.
- במקביל פרדניזון 30 מ"ג ולרדת בהדרגה.
- יהיה צורך במעקב CBC ואנזימי כבד ולבלב.
- דיברנו על סיכון קטן ללימפומה.

י.ע. 23/7/2012

- מזה 4 ימים עלייה בתדירות היציאות, 6-7 ליום, חלקן עם דם. כאבי בטן מטרימים.
- התלקחות של UC בדרגה בינונית, לאחר טיפול במינון מספק של פורינטול ולמשך זמן מספק.
- ננסה טיפול בחוקני בטנזול
- לשמירה על רמיסיה ננסה אם כך טיפול ברמיקייד. לפני כן יש לשלול שחפת ישנה.

י.ע. 17/06/2013

- אושפזה עקב החמרת UC והוחל שוב טיפול בסטרואידים.
- כעת רמיקייד כל 6 שבועות, הפסיקה ליטול פרדניזון לפני שבוע.
- עושה רושם שכעת ע. ברמיסיה
- 8/9/13: כעת על פרדניזון 25 מ"ג ליום, העלינו מינון רמיקייד לאחת ל-4 שבועות (מינון כפול)
- 8/10/13: כעת ברמיסיה, עדיין ב"זנב" הטיפול בפרדניזון. תמשיך טיפול ברמיקייד כל 4 שבועות.