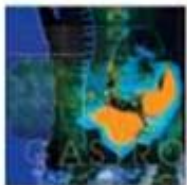


Recurrent attacks of IBD

Similar symptoms,
different triggers?

Amir Waizbard, M.D

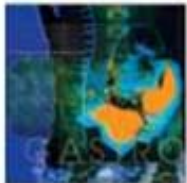


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Background

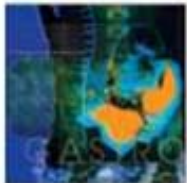
- TS, 17 years old, male
- Past medical history:
 - Healthy
 - Oral aphthous ulcers since age 15
- Smoker
- Cousin: celiac disease
- No medications or drugs



Admission 2009

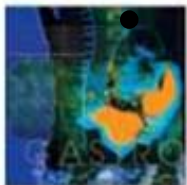
- Fever (39.5c)
- Abdominal pain, watery diarrhea (x6/day), weight loss, dysphagia
- Low back pain, sacroiliitis, anterior uveitis

- Treated out of hospital:
 - amoxicillin, etodolac, steroid eye drops –no improvement
- Physical examination-within normal limits

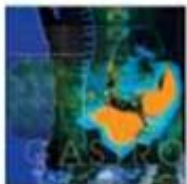
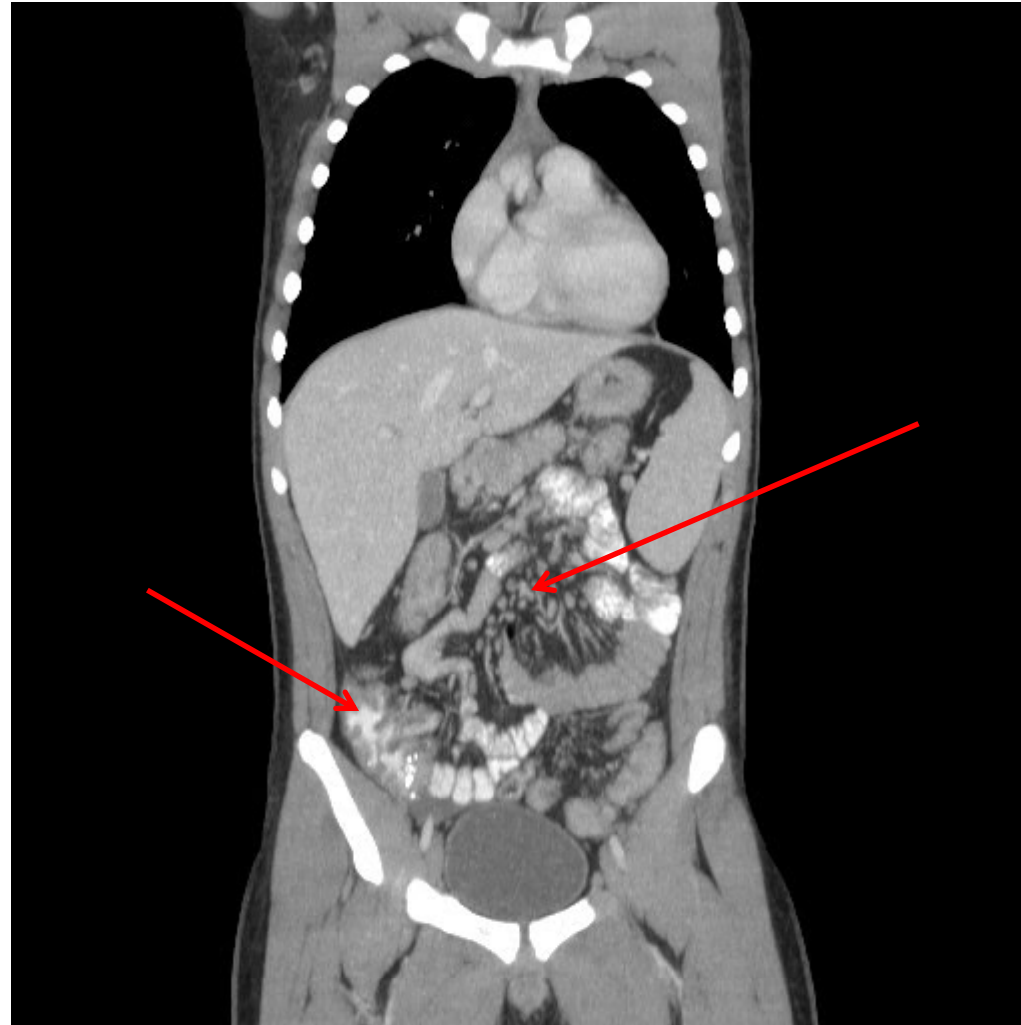


Investigation

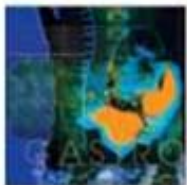
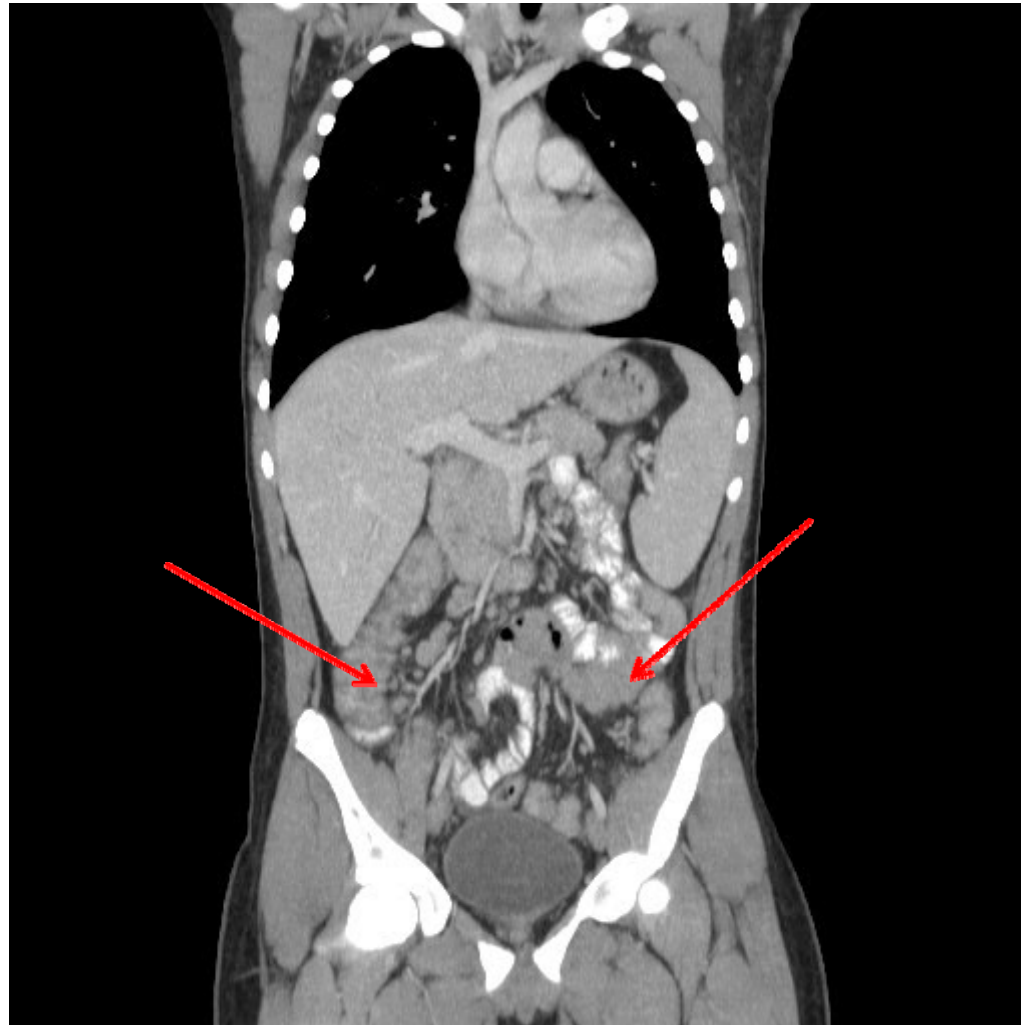
- Stool cultures: negative
- Blood work:
 - Hb – **11.3** g/dL (MCV 79 fL) , WBC – **11.9** (PMN 77%),
 - CRP – **161** mg/L, Albumin – **32** g/L, Iron – **20** mcg/dL,
 - LFT – normal, TSH – normal
 - Normal IBD serology
- EBV, CMV, HAV, HBV, HCV, Brucella, Coxackie, Q fever, Borrelia, Rickettsia VDRL, HIV: **all negative**
- C3/C4, ANCA, HLA B27, ANA, RF: **within normal limits**
- TTG, EMA: **negative**, normal IgA



2009 – Admission - CT 1



2009 – Admission - CT 2



2009 – Admission - Gastroscopy



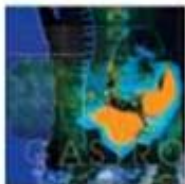
Distal esophagus



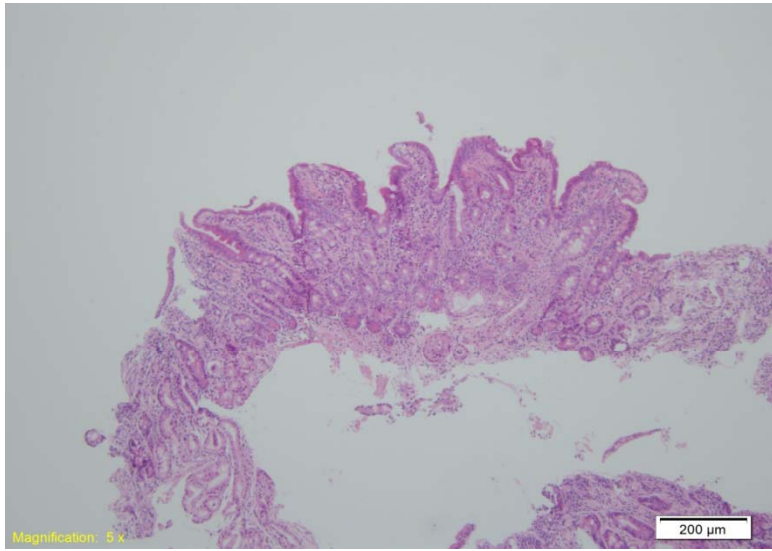
Mid esophagus



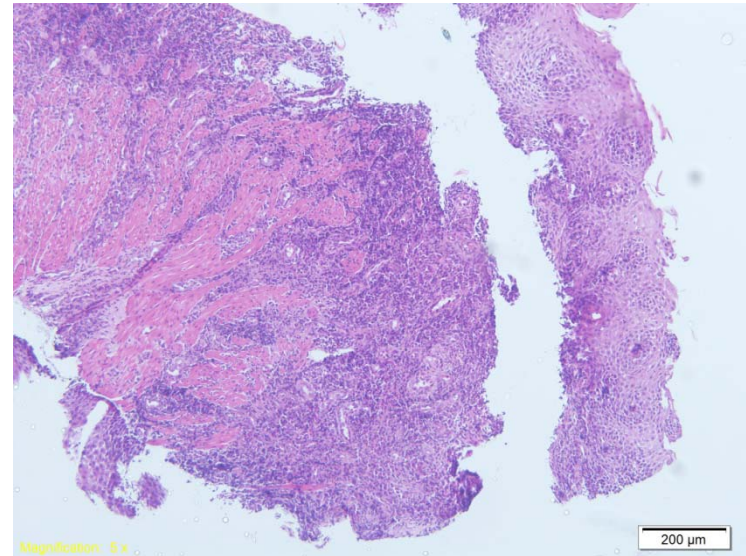
Duodenal bulb



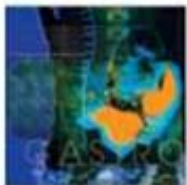
2009 – Upper GI - Histology



Duodenum – 2nd part



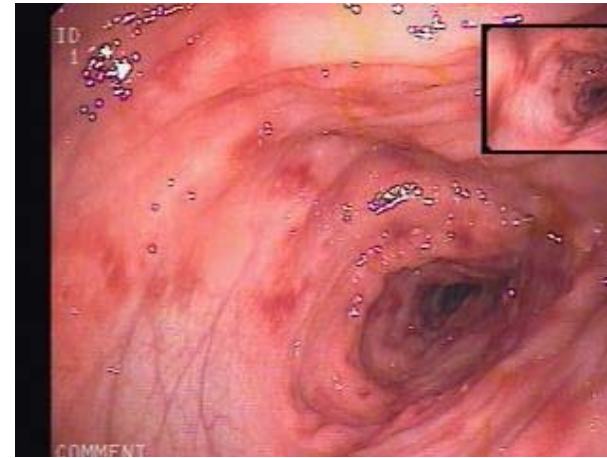
Esophagus - lower 3rd



2009 – Admission - Colonoscopy



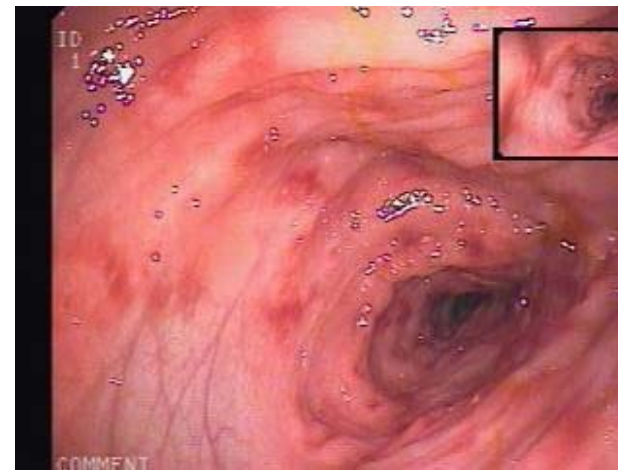
Ascending Colon



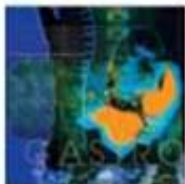
Transverse colon



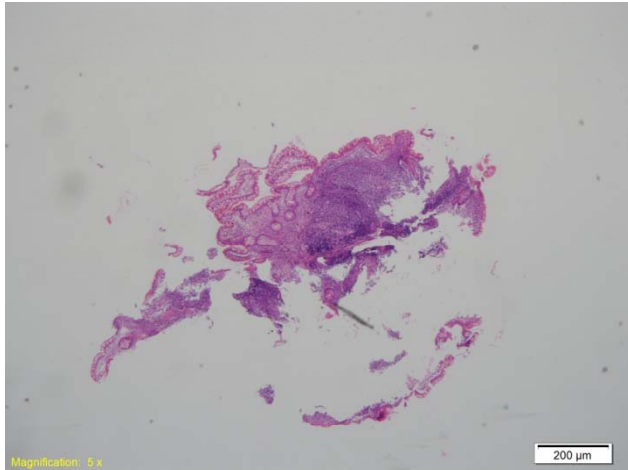
Terminal ileum



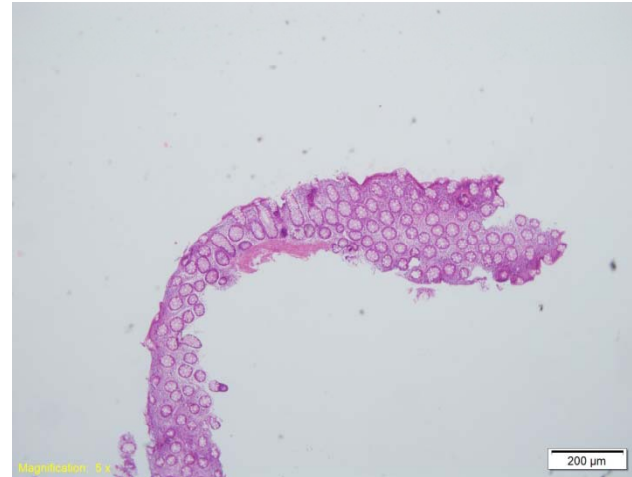
Descending colon



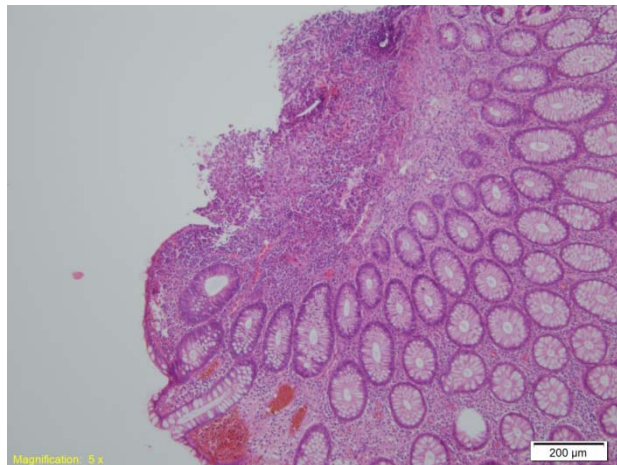
2009 – Lower GI - Histology



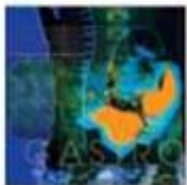
Terminal ileum



Right colon

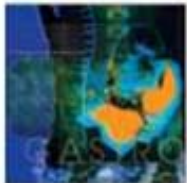


Transverse colon



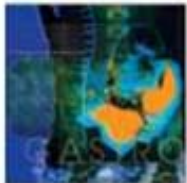
Summary

- 17 Y/O
- Fever, EIM (oral, eye, joints)
- Dysphagia, abdominal pain, diarrhea
- IDA, elevated CRP, negative infectious workup
- Negative IBD/celiac serology
- Endoscopic involvement : UGI, LGI
- Non significant pathology in lower GI histology
- CT : Colonic inflammation, mesenteric lymphadenopathy



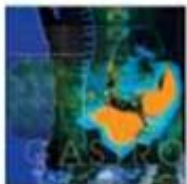
Improvement...

- Treated with systemic steroids and antibiotics
 - Resolution of abdominal pain, dysphagia, diarrhea, myalgia and arthralgia
 - Weight gain
 - CRP : 101->53->0.5
 - Albumin : 32->37
 - Hb : 11.3->12.5->14.2



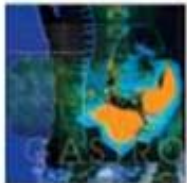
2009 – Follow up

- Steroid Tapering (Lumbar osteopenia)
- 6-mercaptopurine-> Elevated ALT/AST x 5 -> stopped
- IM MTX + Folic acid, 5ASA



Deep remission...

- Clinical and laboratory remission, normal CRP, normal laboratory tests
- 2010: Normal colonoscopy
- 2012: Therapy stopped after 24 months (August)
 - Calprotectin: 55 mcg/g (December)
 - Referred to colonoscopy: normal (December)
Histology : unremarkable small and large bowel mucosa



Flare up (January 2013)

- Abdominal pain, bloating
- Watery diarrhea X5/d
- Single episode of rectal bleeding
- *Mild anterior uveitis*

- *Lab : ESR/CRP normal, Hb-14.3, negative stool cultures and C.diff. **Calprotectin- 794***

- ***Two courses of antibiotics, partial improvement***
 - Oral 5ASA -> symptoms resolved (4W)

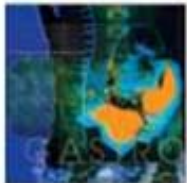


Case summary

- 1st Event (2009)
 - Presentation at age 17
 - Symptoms: Diarrhea, abdominal pain, anterior uveitis, sacroiliitis
 - Inflammatory markers
 - Involvement of upper and lower GI (endoscopy and CT, minimal histologic changes of colon)
 - Steroid responsive disease

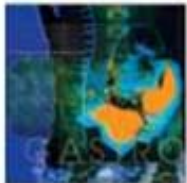
Clinical, laboratory and mucosal remission
~ 3 years

- 2nd Event (2013)
 - 2 weeks post a normal colonoscopy and histology
 - In parallel to a stressful and increased smoking period
 - Normal CRP/ESR yet increased calprotectin (794)
 - Symptom resolution with 5ASA



Food for thought

- Cause of trigger:
 - Crohn's disease flare up?
 - Smoking/stress/no treatment
 - Other inflammatory/infectious disease?
 - Colonoscopy induced flare?
- Role of Calprotectin as a biomarker of disease activity:
 - Consistent with endoscopic findings?
 - Predicts disease flare up?



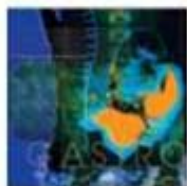
Colonoscopy induced flare

- Does Colonoscopy Cause Increased Colitis Symptoms?

Conclusions: out of 51 quiescent UC patients, 1 in 8 subjects had UC relapse by SCCAI immediately post colonoscopy, and 1 in 10 subjects required an increase in their 5-ASA medications.

Clinicians should be cognizant of this effect of colonoscopy in patients with UC.

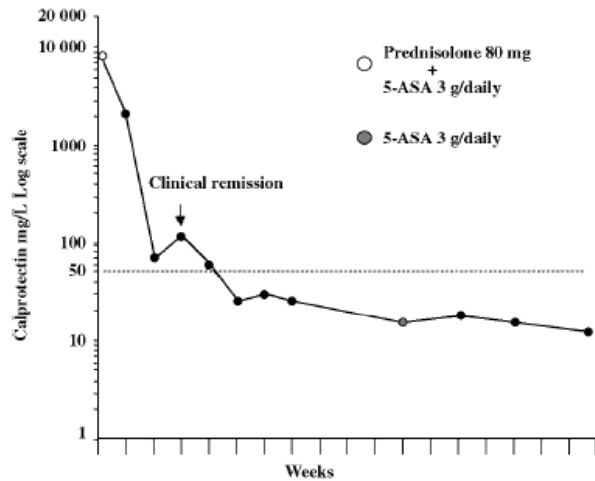
Stacy Menees, MD,* Peter Higgins, MD,† Sheryl Korsnes, MA,† and Grace Elta, MD†
Inflamm Bowel Dis 2007;13:12–18



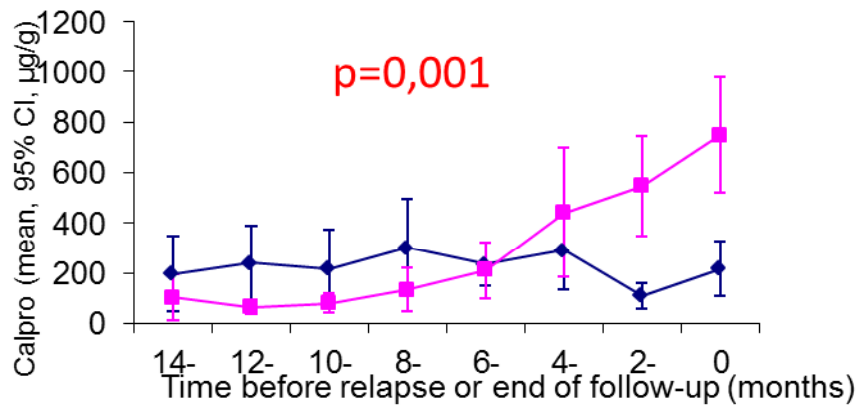
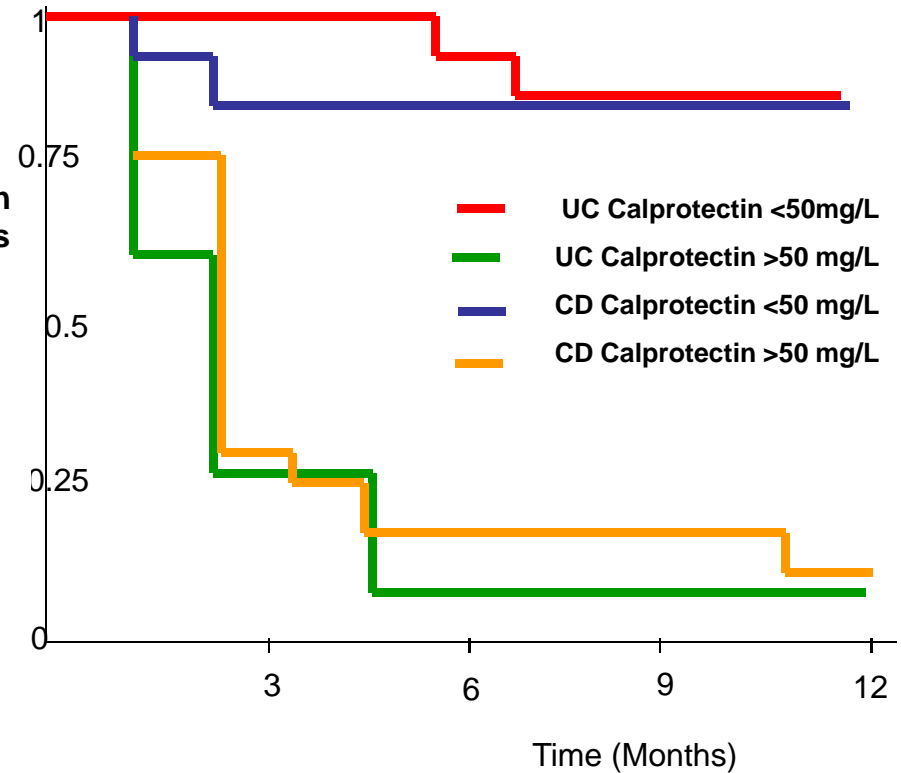
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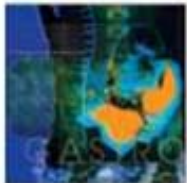
Calprotectin



Proportion of patients without a relapse



Roseth A et al Scand J Gastroenterol 2004; 39: 1017-1020
Tibble Gastroenterology 2000
Louis E DDW 2012





Thank You

