INS AND OUTS OF IBD

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Crohn's & Colitis Center

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Non-IBD Colitis

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Disclosures

David H. Kerman, MD:

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Outline

- Review presentation, diagnosis, and management of IBD mimickers
  - Infectious Colitis
  - Checkpoint inhibitor colitis
  - Drug-induced colitis

Case 1

55 year old male with metastatic lung cancer presents with persistent diarrhea.
Treatment: carboplatin, pemetrexed, pembrolizumab

Symptoms began about 6 weeks *after* his 3rd cycle
Family history: Anal cancer and prostate cancer. No IBD

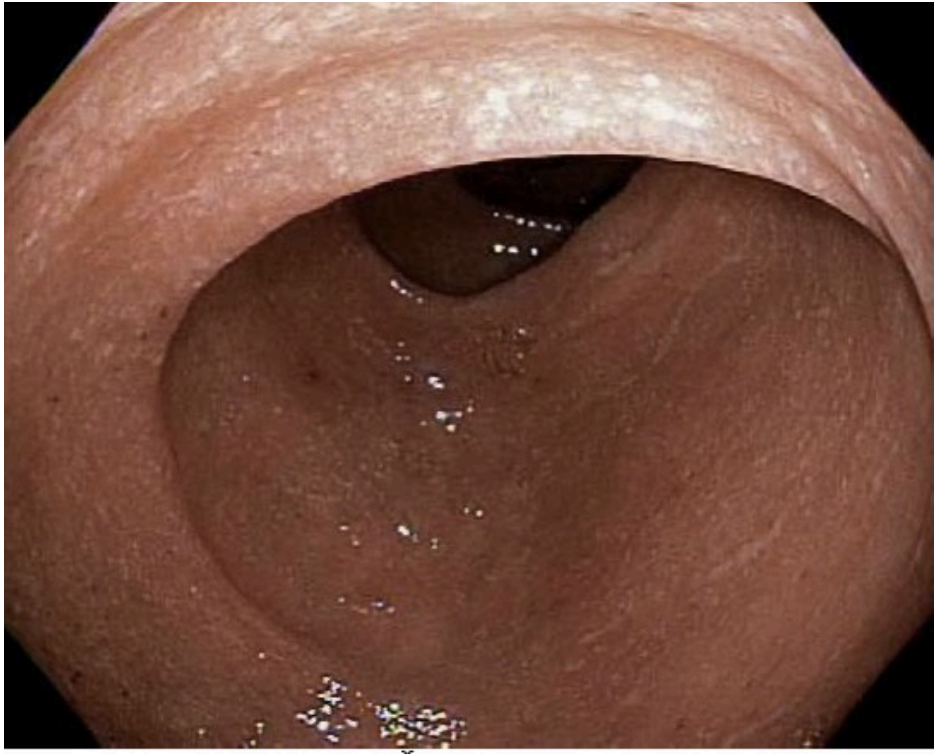
Stool studies: negative
Started on prednisone, no significant improvement

Current medications:

- Meclizine
- Allopurinol
- Omeprazole
- Losartan

Colonoscopy

- Continuous inflammation
- Erosions, erythema, decreased normal vascular pattern



Pathology

- Colonic mucosa with:
  - Architectural distortion
  - Increased lymphoplasmacytic infiltrate in lamina propria
  - Cryptitis
  - Crypt abscesses
  - Erosion
  - Fibrinopurulent exudate

What Is the Most Likely Diagnosis?

Check point inhibitor colitis

- Rule out infection + (lower likelihood) GI mets
- Diagnosis: Colonoscopy with biopsy
- Typically involves the colon
- Most commonly presents 5-10 weeks after 2nd or 3rd dose

Management of Checkpoint Inhibitor Colitis

- Step 1:
  - Determine severity
- Step 2:
  - Appropriate intervention based on severity
- Step 3:
  - Escalate if inadequate response
- Step 4:
  - Stop treatment for CIC with complete response
  - ?Restart cancer therapy

Severity of Checkpoint Inhibitor Colitis

Colitis	Signs/Symptoms	Diarrhea (number over baseline)
Grade 1	Asymptomatic	Increase by < 4 stools/day
Grade 2	Abdominal pain, bloody stool, mucus	Increase by 4-6 stools/day
Grade 3	Severe pain with peritoneal signs and fever	Increase by ≥ 7 stools/day
Grade 4	Life threatening complications	Life threatening complications
Grade 5	Death	Death

Treatment for Checkpoint Inhibitor Colitis

Grade of Colitis	ICI	Monitoring	Medical Therapy
Grade 1	Continue ICI (or hold temporarily)	Signs/symptoms of dehydration	Consider anti-diarrheal
Grade 2	Hold	Consider: Labs Stool studies Colonoscopy	Oral prednisone
Grade 3	Hold	Labs Stool studies Colonoscopy May require hospitalization	Oral prednisone IV steroids Biologic therapy
Grade 4	Permanently discontinue	Labs Stool studies Colonoscopy May require hospitalization	Oral prednisone IV steroids Biologic therapy

Treatment: Biologics

- Start if no improvement with high dose steroids in 3-5 days

Options:

- Infliximab 5mg/kg Q2 weeks; can continue at standard IBD dose
  - Reassess
- Vedolizumab standard IBD dosing schedule

(Ongoing RCT comparing the two)

Consider Resuming ICI When…

- Corticosteroid dose <10mg/daily
- Symptoms return to ≤ Grade 1

*No known effective measures to prevent relapse

Case 2

60 year old female with PMH significant for hypertension presents to clinic for further evaluation after hospitalization following completion of a half marathon with subsequent development of left sided abdominal pain and hematochezia. She was told to follow up with an IBD physician for further management of her “colitis.”

Past medical history: hypertension, IBS-D

Family history unknown, adopted.

Home medications:

Amlodipine

PRN Imodium

Case 2 Evaluation

- Imaging:
  - CT A/P with contrast shows left sided colonic wall thickening
- Colonoscopy report
  - Left sided colonic inflammation
- Pathology slide review
  - Colonic mucosa with lamina propria hyalinization, focal crypt drop out, and acute inflammation

What Is the Most Likely Diagnosis?

Ischemic colitis

Ischemic Colitis

- Who?
- Where?
  - Why?
- How (to manage)?

Who Is at Risk for Development?

- Cardiovascular disease
  - Heart disease, hypertension, hypotension
- COPD
- GI
  - IBS, diarrhea, constipation
- DM
- Systemic rheumatologic disorders
- Certain prior surgeries
- Medications
  - Constipation inducing medications
  - Immunomodulators
  - Illicits

Who Is at Risk for Worse Outcomes?

- Male sex
- Hypotension (SBP < 90mmHg)
- Tachycardia (HR > 100bpm)
- Abdominal pain without rectal bleeding
- BUN > 20mg/dl
- LDH > 350 U/l
- Na < 136 mEq/l
- WBC > 15 x 10^9 cmm
- IRCI

Where and Why?

- Segmental
  - Vascular anatomy
- Isolated Right-sided Colonic Ischemia (IRCI)
  - Think embolic
  - Worse outcomes

Disease Severity

	Mild	Moderate	Severe
Diagnostic Parameters	Typical symptoms No risk factors	Up to 3 of the following: • Male sex • Hypotension • Tachycardia • Pain without rectal bleeding • BUN > 20 • Hb < 12 • Na < 136 • LDH > 350 • WBC > 15 • Ulcers on colonoscopy	More than 3 of criteria for moderate disease –OR- *any* of the following: • Peritoneal signs • Pneumatosis or portal venous gas on imaging • Gangrene on colonoscopy • Pancolonic ischemia • Isolated right sided ischemia
Management	Supportive Care	Supportive care Broad spectrum antibiotics Consider surgical evaluation	

Management

- Labs
- CT abdomen pelvis
  - PO/IV contrast
  - Consider CTA in IRCI
- Early colonoscopy for confirmation*
- Additional therapy based on degree of severity:
  - Mild: Supportive care
  - Moderate: Broad spectrum antibiotics
  - Severe: High level of care, antibiotics, +/- surgical intervention

  - *Of note, if evidence of vascular occlusion urgently address*

Case 3

- 63 year old female presents to your office complaining of 5 months of watery diarrhea, particularly worse after eating. She is having approximately 10-12 bowel movements per day with urgency and incontinence. She has occasional nocturnal stools. She has lost about 7 pounds, and is having significant concomitant joint pains. She has not seen blood in her stool

- Past Medical History:
  - Acid Reflux
  - Arthritis

- Current Medications:
  - Omeprazole
  - Prn ibuprofen

Case 3 Evaluation

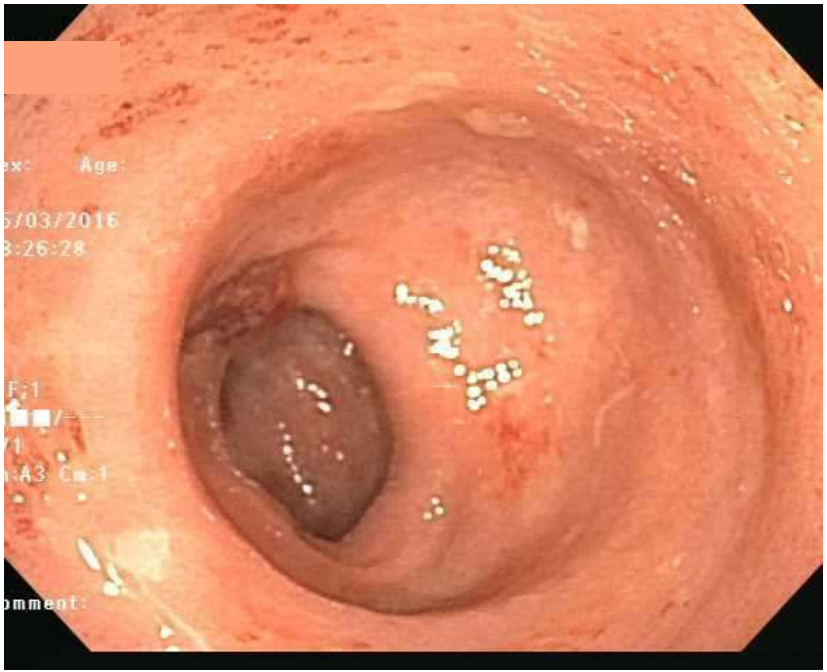
Labs:

- Normal CBC, CMP
- Negative TTG-IgA, normal IgA level
- Slight elevation in ESR
- C diff, stool PCR panel, ova & parasites negative

Proceed with colonoscopy…

Colonoscopy

- Mild scattered erythema + friability
- Few erosions



Pathology

- Mononuclear cell infiltration of lamina propria
- Thickened submucosal collagen band measuring approximately 13 micrometers in diameter

What Is the Most Likely Diagnosis?

Microscopic colitis, specifically collagenous subtype

Microscopic Colitis

- Two classes
  - Lymphocytic colitis
  - Collagenous colitis
- 2.3 to 16 and 2.0 to 10.8 per 100,000 per year, respectively
- Typically ≥ 65 y/o

Microscopic Colitis: Presentation

- Chronic, watery diarrhea
  - Typically insidious onset
- Active disease
  - ≥ 3 stools or ≥ 1 watery stool per day
  - +/- nocturnal
- Symptoms can become severe

Microscopic Colitis: Pathogenesis

- Unknown
- Medications implemented
  - NSAIDs, PPI, H2 blockers, SSRIs
- Smoking
- Associated autoimmune conditions
  - DM 1
  - Celiac disease
  - Autoimmune thyroiditis

Microscopic Colitis: Diagnosis

- Rule out infection
- Biopsy

Collagenous colitis: Colonic subepithelial band > 10 micrometers in diameter

Lymphocytic colitis: ≥ 20 intraepithelial lymphocytes (IEL) per 100 surface epithelial cells

Microscopic Colitis: Treatment

- Removal of offending agent
- Mild diarrhea
  - Symptom management
- More significant*
  - Budesonide taper

*Rare, but some with refractory disease require immunosuppression

Refractory Disease

Limited data

- Small case series:
  - AZA/6MP
  - IFX
  - ADA
  - VDZ
- Surgery

Summary

Not all colitis is IBD colitis

- Take a thorough history
- Rule out infection
- Take biopsies

THANK YOU!