Inflammatory Bowel Disease: Updates and Controversies

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Case 1

- 4 yr old female presented with 1 yr history of constipation, withholding behavior and hematochezia. Maintained for 1 year on MiraLax with no improvement in symptoms.
- Seen by PMD on numerous occasions; no rectal examination performed due to lack of cooperation/excessive anxiety and shyness.
- BMI centile had decreased from 83rd to 40th% during that time. Labs (cbcd, cmp, esr, celiac antibodies, tft's): normal

- PE: Exam normal with exception of multiple perianal tags; unable to visualize well due to poor cooperation.
- Next steps:
  - Continued stool softening
  - Topical therapy: sitz baths, Zn oxide, proctofoam
  - Psychology/child life consultation (to help with anxiety reduction related to stooling, examination, testing, etc)
  - Fecal calprotectin----elevated (178 ug/g)

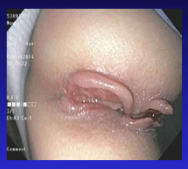
Q: What is the next BEST step in the evaluation?

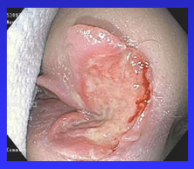
A: Examination under Anesthesia (colonoscopy with biopsy)

Severe perianal disease present with large ulcerated tags.

Aphthous ulcers noted in rectum and transverse colon; TI normal.

Biopsies: focal active colitis with scattered granulomas in TI and colon.





Perianal Crohn's Disease: How common is it?

- Occurs in up to 50% of children with Crohn's
- 3 Categories
  - tissue destruction (fissures, tags, deep ulcers lined with granulation tissue)
  - fistulae and abscesses
  - strictures

Perianal Crohn's Disease: Therapy

- Goals of therapy
  - Improve quality of life; minimize risk of incontinence
  - Avoid perianal sepsis
  - Avoid diversion/proctectomy
- General principles
  - control diarrhea (dietary changes/medication) to reduce perianal symptoms
  - cleansing to reduce itching/pain
  - barrier creams to protect perianal skin from excoriation

Q: What are therapy options for this patient's perianal Crohn's Disease?

- A. sitz baths
- B. antibiotic therapy (metronidazole/cipro)
- C. immunomodulator therapy
- D. biologic therapy
- E. surgical consultation

Case 2

- 14 yr old female s/p TAC and IPAA at age 10 yrs for treatment of refractory UC (growth failure, anemia, diarrhea) now presents with purulent drainage in underwear.
- Q: What is the differential diagnosis?

Additional History

- Patient not sexually active; has been having more loose stools over past 6 months despite increased fiber and anti-motility agents. Pain noted in perianal region.
- Exam: area of tenderness and erythema left of anal sphincter; no anal stricture on examination

Q: What is the next best step in the evaluation of this patient?

A. Laboratory studies (cbcd, cmp, esr)
B. Pouchoscopy with biopsy/EUA
C. Fistulography
D. CT of pelvis

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- Findings: chronic pouchitis (no dysplasia)
  focal active enteritis of neo-TI
- MRI pelvis: an intersphincteric fistula along the left lateral margin of the anus extending to the medial left gluteal cleft with small superficial abscess

Q: Next steps in management?

Case 3

- 17 yr old female with longstanding UC well controlled on infliximab (prior pancreatitis on azathioprine) presents for dysplasia screening.
- On the morning of colonoscopy, found to have + β HCG on protocol screening prior to test.

Q: Do you proceed with the colonoscopy?

A: yes

B: no

Q: The patient and her mother immediately express concern about fetal exposure to infliximab. What do you advise regarding medical therapy?

A. discontinue infliximab; no therapy currently needed

B. discontinue infliximab and start oral budesonide

C. discontinue infliximab and start methotrexate

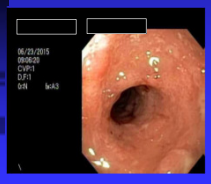
D. continue infliximab until 32 wks gestation, then discontinue until after delivery

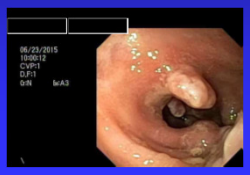
Case 4

- 19 yr old female with Crohn's disease diagnosed at age 10 yrs presents for her 2nd dysplasia screen.
- Dysplasia screen 2 yrs prior was negative; scattered pseudopolyps seen in ascending colon
- Receives infliximab infusions q 6 wks with good symptom control.

Colonoscopy findings

- 5 cm stricture (9mm luminal diameter) at rectosigmoid junction
- Pseudopolyps throughout colon
- Routine surveillence biopsies show low grade dysplasia in ascending colon; biopsies throughout with active inflammation





Q: What management do you advise?

A. Reassurance-patient asymptomatic and adenocarcinoma not identified

B. Escalate medical therapy; repeat surveillance in 3-6 months

C. Repeat colonoscopy in 6 months for stricture dilation with repeat surveillance biopsies

D. Surgical referral to address stricture

E. Surgical referral for colectomy

Case 5

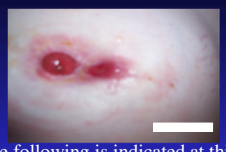
- 13 year old female newly diagnosed Crohn's disease has not had regular pediatric health maintenance exams for the last 3 years.

Q: Prior to consideration of immunomodulator or biologic therapy, what screening labs or immunizations should be considered?

Case 6

- A 17 year old male underwent colectomy with end-ileostomy 4 months ago for severe steroid-dependent colitis.
- Disease course complicated by persistent right hip pain (plain films negative) that started with onset of GI symptoms and only improves while on corticosteroids.
- He currently presents with complaints of ongoing right hip pain and pain around his stoma.

- On examination, you find the following:



Q: Which of the following is indicated at this time and most likely to improve this condition?

A. Change of ostomy adhesive/appliance
B. Nystatin powder
C. Oral antibiotic (cipro/metronidazole)
D. Topical and intralesional steroids
E. Stomal relocation

Q: What evaluation/management would be recommended with regards to the right hip pain?