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Gastroenterology & Hepatology
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Atypical Presentations of IBD

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Disclosures

Angela Gieseler, PA-C

- No financial relationships to disclose

Case Study #1

- 26-year-old male with a history of IBS, anxiety and chronic joint pain was referred to GI clinic by his rheumatologist. He has a 5 year history of joint pain that has progressively worsened over the past year. He has been seeing rheumatology for the past 6 months and the only significant finding in their evaluation was an elevated CRP at 37. His joint pain moves around and varies in intensity. It sometimes affects his wrists and hands, sometimes his knees. Some mild swelling in his hands at times. He has had fatigue for years. He has a history of anxiety but has not had significant issues with this since college.
- GI history: He reports a history of IBS, although he has never had a colonoscopy. He has had intermittent diarrhea for years. He can have anywhere from 3-6 stools a day. Usually soft loose stools, but sometimes watery. Some urgency at times. States he has good days and bad days. He attributes his bad days to stress at work or something he ate. He has some abdominal cramping at times that improves after a bowel movement. He has not noticed blood in his stool. His weight has been stable. No upper GI symptoms
- No medications. Did try ibuprofen for the joint pain but it upset his stomach, so he stopped them
- No other significant PMH or surgical history
- No FH of IBD or colon cancer
- Non-smoker
- Social use of ETOH
- Physical exam is unremarkable

Case Study #1

Differential Diagnosis?

Which tests/labs should be offered?

Case Study #1

Labs: CMP, CBC, TSH, TTG IGA, total IGA were all WNL

Stool studies: culture, O&P and *C diff* negative

EGD with duodenal biopsy unremarkable

Colonoscopy – moderate ileitis with a few small ileal ulcers without evidence of bleeding. Scattered areas of moderately congested, erythematous mucosa found in the ascending colon and cecum. Mild patchy erythema in the descending colon. Pathology from TI revealed chronic ileitis and path from ascending and descending colon revealed chronic active colitis.

Diagnosis?

Ileocolonic Crohn's disease

Case Study #1

Other testing?

- **MRE** mural thickening and hyperenhancement of the distal ileum at the ileocecal junction with adjacent mildly prominent lymph nodes, representing active superimposed on chronic inflammation
- **Calprotectin** elevated at 480
- **HBsAg** and **Quant gold** both negative

Treatment options?

Treatment Options for Crohn's Disease

- **5-aminosalicylates** (use of these is controversial, use only considered for mild CD with limited ileocolonic involvement)
 - Mesalamine
 - Sulfasalazine (a byproduct of 5-ASA, not for ileitis, the colonic bacteria must cleave the drug to release the active ASA)
 - Balsalazide
- **Glucocorticoids**
 - Prednisone
 - Budesonide
- **Biologic therapy**
 - Infliximab, adalimumab, certolizumab pegol (anti-TNF)
 - Vedolizumab (anti-integrin antibody)
 - Ustekinumab (anti-interleukin 12/23 antibody)
- **Immunomodulator**
 - Azathioprine or 6-mercaptopurine
 - Methotrexate (with folic acid)

Treatment Options for Crohn's Disease

Goal of treatment

To achieve steroid free remission, both clinical and endoscopic (histologic remission?)

Things to consider

- Severity of disease
- Patient's risk factors for severe disease
- Patient preference (injectable vs infusion)
- Age of patient
- Infection and cancer risk
- Access to an infusion center/transportation
- Compliance
- Prior therapies
- Other medications
- Insurance

Crohn's Disease: Assessing a Patient's Risk

- High risk patients with moderate-severe Crohn's disease may have the following features:
 - Diagnosis at a younger age (<30 years old)
 - Elevated CRP/fecal calprotectin
 - Extra-intestinal manifestations
 - Tobacco use
 - Deep ulcers on colonoscopy
 - Long segment of small and/or large bowel involvement
 - Perianal disease
 - History of bowel resection

Case Study #1

- After discussing options with the patient, he decided that adalimumab was the best option for him. His joint pain improved in 4 weeks and completely resolved after 8 weeks. His bowel movements improved to 2 soft, formed stools a day. His abdominal cramping resolved and his energy level improved. In 6 months, his CRP and calpro normalized.
- Other options to consider for more immediate treatment of joint pain
 - NSAIDs – (naproxen or celecoxib) Strong caution due GI side effects, potential for worsening IBD. If used consider adding a PPI
 - Sulfasalazine
 - Steroids/steroid injections
 - Methotrexate/azathioprine/6-MP (these can take months to work)
 - Physical therapy, rest, moist heat, ROM exercises

Patient Follow-Up

- Short-term plan
 - Follow up in the office in 2-3 months
 - Repeat labs and calpro in 6 months
 - If patient clinically improves and repeat CRP and calpro are normal, then a repeat colonoscopy is needed to evaluation for endoscopic remission
- Long-term plan
 - Once in remission, follow with office visit and labs every 6 months

Case Study #2

- A 33-year-old male presents to the ER. Two hours prior, he suddenly began slurring his speech and mumbling. This progressed and his mother call EMS. When EMS arrived at his home the patient was lying on the floor and unresponsive. Narcan was administered without effect. Patient was taken to the ED in respiratory distress.
 - EKG sinus tach
 - WBC 32.2, Hgb 10.5, MCV 88.1, Plt 643, CMP WNI except for glucose of 173, Ca 7.8, Trop < 0.015
 - CT Abdomen/Pelvis – chronic splenic infarcts, new left renal infarcts and severe pancolitis
 - CT angio brain/neck – revealed a basilar stroke and an aortic arch thrombus
- He was intubated and transferred to the ICU

Case Study #2

- PMH is obtained from his mother and EMR
 - 9/2017 – the patient (no prior PMH) started having blood in his stool and diarrhea.
 - 10/2017 – Colonoscopy showing sigmoid and rectal mucosal ulcerations. The remaining colon was normal to the cecum. Path consistent with Ulcerative Colitis. Started mesalamine 4.8g daily.
 - 2017/2018 – numerous hospitalizations with acute diarrhea, abdominal pain and hematochezia. Each time was treated with steroids and antibiotics. Mesalamine was continued. Starting biologic therapy was discussed but patient hesitant.
 - 7/2018 – Colonoscopy revealed severe ulcerative pancolitis. Path revealed moderate to severe UC
 - 8/2018 – Hospitalized with *C diff*, treated with vancomycin
 - 12/2018 – Started adalimumab. 72 hours after initial injections, he was admitted to the hospital with acute left sided abdominal pain, vomiting and bloody diarrhea. Hgb 6.8. Imaging showed multiple new splenic infarcts with continued severe pancolitis. TEE negative. Hematologic evaluation negative. No evidence of a cardiac source. Treated with IV steroids. His symptoms improved and he was discharged. He was not anticoagulated due to concern for GI bleeding
 - 1/2019 – Patient presented to the ER with AMS

Case Study #2

- Patient had emergent angiogram with mechanical thrombectomy, treated with heparin initially then switched to clopidogrel. His adalimumab was continued with steroids
- After 14 days, he was discharged to a rehabilitation facility. At discharge, he had difficulties ambulating. He used a walker for several months and after intensive rehab he was able to ambulate independently. He had numerous speech deficits that completely resolved after a year. He was able to wean off steroids 8 weeks after discharge and in 6 months his GI symptoms completely resolved and his labs/inflammatory marker normalized. He continued adalimumab every 14 days.
- After 12 months of adalimumab, he developed severe rapidly progressive pustular psoriasis on his hands. This was thought to be due to anti-TNF therapy. Adalimumab was stopped and he started vedolizumab. His psoriasis resolved. His IBD continued to be in clinical remission. He is planning to have a follow up colonoscopy early 2021 to evaluation for endoscopic/histologic remission
- He continues clopidogrel and follows with hematology. Extensive evaluation was negative for an inherited cause for his hypercoagulable state

VTE Risk and IBD

- Patients with IBD are at 2-3x increased risk for both venous and arterial thromboembolism
 - Increased risk for both hospitalized and ambulatory patients with IBD
 - Risk tends to occur in younger patients, is commonly recurrent and has higher morbidity and mortality.
- IBD hospitalized patient's absolute risk 37.5/1000 person-years versus 13.9/1000 person-years, IBD ambulatory patients with IBD flare 6.4/1000 person-years versus 0.4/1000 person-years¹
- VTE prophylaxis is underutilized in the inpatient setting, especially in IBD flares. It has been reported that only 50% of hospitalized patients get VTE prophylaxis

Symptoms of IBD

- We are all familiar with the common symptoms of IBD
 - Abdominal pain, diarrhea (with or without bleeding), fatigue, weight loss
 - Fistulas, perianal disease, abdominal abscess, SBO, peritonitis, malabsorption, anemia
- Less common presentations
 - Upper GI Crohn's disease
 - Mouth ulcers
 - Odynophagia/dysphagia
 - Epigastric pain, nausea, vomiting
- Extraintestinal manifestations of IBD
 - Arthritis/arthropathy – 20% of IBD patients
 - Uveitis/iritis/scleritis – 5% of IBD patients
 - Skin disorders – ex Erythema nodosum/pyoderma gangrenosum – 10% of IBD patients
 - Primary sclerosing cholangitis – 5% of CD, presents with elevated alkaline phosphatase

Other Atypical Presentations of IBD

- 43 year old female presented with primary complaint of vaginal/perianal ulcers. No GI symptoms other than bloating. Colonoscopy consistent with Crohn's disease. Symptoms resolved on adalimumab.
 - Up to 40% of patient with Crohn's disease can get perianal involvement at some point.
- 35 year old female presented with constipation, persistent bloating and obstructive symptoms. No history of diarrhea. No blood in her stool. Colonoscopy found ileal inflammation/stricture. Path consistent with Crohn's disease.
- 31 year old female was taken to the OR for planned sleeve gastrectomy and Nissen fundoplication for GERD and weight loss. Was opened up, the surgeon found a 9.9cm liver hemangioma, surgery cancelled. Several weeks later she was taken back to the OR and the hemangioma was resected. She was discharged and returned to the hospital 2 days later with abdominal pain. Was diagnosed with high grade small bowel obstruction at the ileocecal junction. Had a small bowel resection and path revealed Crohn's disease. She denies any history of diarrhea or abdominal pain; however, she does have 2 sisters with IBD.

Other Atypical Presentations of IBD

- A 46-year-old female with a PMH of anxiety and depression had elective laparoscopic sleeve gastrectomy. Surgery went well, she was discharged on post op day 2
- She returned to the hospital 1 week later with abdominal pain and found to have complete staple line dehiscence of the sleeve gastrectomy, esophageal leak and mediastinal fistula requiring multiple reoperations
 - She ended up having gastrectomy, blind-ending intrathoracic esophageal stump and jejunostomy
- The leak persisted, and she was given a spit ostomy in her chest and was fed through a J-tube
- In preparation for repeat surgery, she had a pre-op colonoscopy that showed rectal, sigmoid and cecal inflammation
 - Pathology was suggestive of Crohn's disease
 - Patient denied any history of GI symptoms
 - MRE negative for small bowel disease. Calpro 222. CRP normal.
- Follow-up colonoscopy with ileal intubation showed moderate inflammation in the cecum, proximal ascending colon and distal colon; normal ileum and normal mucosa in the transverse and proximal descending colon
- She started on infliximab and calpro normalized
- She eventually underwent takedown of her spit fistula and underwent esophageal reconstruction with jejunal conduit



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Q&A