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Case Review: Can You Crack This IBD Case?

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Ms. Orleck:
This is CE on ReachMD, and I'm Kim Orleck, physician assistant. Dr. David Rubin is here with me today, and we're discussing a case to help us explore IBD management.

Today's case is going to be similar to probably many patients we see. This is a 52-year-old female who presents with ongoing rectal bleeding and diarrhea. She was diagnosed with moderate left-sided ulcerative colitis 4 months ago, and her past medical history includes hypertension and obesity with a BMI of 30. She recently quit smoking.

At diagnosis, she was given a 6-week steroid taper and initiated on 4.8 grams of mesalamine orally, as well as nightly topical enemas. Despite several months of this therapy, she continues to experience active colitis symptoms, including frequent loose stools and intermittent rectal bleeding. Her baseline fecal calprotectin was 878, and at follow-up on therapy, it is 656.

Dr. Rubin, when a patient like this fails optimized 5-ASA therapy, how do you approach the next treatment decision?

Dr. Rubin:
Well, thanks, Kim. And as you said, this is not an uncommon problem. So the first thing I just want to point out is the clinical pearl that she's an ex-smoker. That's what we often will identify as a trigger in somebody who develops older-onset ulcerative colitis. So the fact that she quit smoking recently is likely what turned on this colitis in her. Whether she was always going to get UC and the smoking prevented it, or whether smoking set her up for it and the shift in her microbiome when she quit triggered it, is beside the point. What we have now is a woman who's suffering and needs to get treated.

The goals of treating ulcerative colitis are focused first on symptom improvement, and that's defined as normal stool frequency, formed stools, no rectal bleeding, and the absence of bowel urgency—really important there. And of course, we don't want her to have pain. But urgency actually is a more driving and uncomfortable symptom than even a little bit of bleeding. But we want to make sure we address that.

The second goal we have is to make sure that that symptom improvement is going to be durable. And in order to achieve that, you have to make sure that the disease itself is under better control. We measure that objectively by looking at blood counts, stool markers like the calprotectin that you mentioned, and after a bit of therapy, we'll look with a scope.

When someone doesn't reach the goals of therapy, and certainly if they're getting worse despite our first treatment option, it's really important that we move on to the next level of therapy. And fortunately, we have a lot of other treatments.

When I talk about remission, the last goal, which comes a bit later but is very important, is to think about functional remission. That means that there's no joint pain, that we're addressing and identifying if she has mental health problems, and we think about other things that are limiting her ability to function, to get on with her life. And so we think about all those goals, and in this case that you just described, she clearly hasn't achieved them yet, and it's time to move to a different therapy.

Ms. Orleck:
Do as you mentioned, Dr. Rubin—and thank you so much for that—as you mentioned, there's a lot of great options, thankfully. In this particular patient where I gave you her comorbidities that were only hypertension and obesity, will you give just a couple of pearls when it comes to classes that you would consider for this patient—if there's any that you would consider over certain classes and others that you might avoid?

Dr. Rubin:
Well, certainly. First of all, by virtue of her ongoing symptoms and the degree of those symptoms, but even her other markers like the stool inflammatory protein and not responding to 5-ASA that you correctly gave orally and rectally, we enter the options for advanced therapy.

And there's a whole bunch. We can talk about biological therapies, which include anti-TNF, anti-IL-23, and the anti-integrin therapy, which is vedolizumab, that targets the white blood cells on their way to the gut. And it also offers the opportunity to think about oral advanced therapies, including the S1P receptor modulator that prevents white blood cells from migrating through the lymphatic system, and the Janus kinase inhibitors, the JAK inhibitors, which are oral therapies that inhibit those enzymes.

And choosing the therapies are dependent on a lot of different factors we have to consider.

Ms. Orleck:
And I know you mentioned there's so many different factors, and of course, I wish I had more time with you, as always. But if you can give a real quick—kind of based on if this patient had extraintestinal manifestations, obviously knowing it could be joint, it could be ocular, it could be skin, how would that really impact which therapies you discuss with this patient?

Dr. Rubin:
Absolutely. The most common extraintestinal manifestation of ulcerative colitis is joint pain, and so we should always be asking about that. So we always ask about joints. A patient with ulcerative colitis and joint pain is somebody in whom I would most likely choose an anti-TNF or a JAK inhibitor. They're both excellent options for people with those problems. Doesn't mean you can't consider the other ones, but they may not address the joints very well.

Somebody who has skin problems, if she had coexisting psoriasis—remember that people who are obese may have psoriasis, as one of the risk factors for psoriasis is obesity—I might choose an IL-23 inhibitor as an excellent option because it'll work extremely well on her skin and on her bowel.

But the other factors that come into play have to do with her lifestyle and, of course, her insurance status and whether it will pay for or approve these options.

Ms. Orleck:
Thank you, Dr. Rubin. I know that was brief, but we hope you keep this case in mind when you see your next patient with moderate to severe ulcerative colitis. And thank you for listening.

Announcer:
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