Vedolizumab for the Treatment of Refractory Microscopic Colitis

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BACKGROUND: Microscopic colitis (MC) is a common cause of chronic watery diarrhea. It is more prevalent in women and typically manifests in the 6th-7th decade of life. The colon mucosa typically appears normal on endoscopy and biopsies reveal an increase in intraepithelial lymphocytes/IELs (lymphocytic colitis) or sometimes associated with a thick subepithelial collagenous membrane (collagenous colitis). Guidelines position budesonide as the first-line treatment for MC, however, relapse rate is high when budesonide is stopped. A subset of MC patients may be refractory or intolerant to budesonide, hence requiring a different treatment approach. We here present a case of severe and refractory MC that responded to vedolizumab, an α4β7 integrin monoclonal antibody.

RESULTS: Case presentation. The patient is an 84-year-old female, previous smoker, who presented to the GI clinic for chronic diarrhea. She was diagnosed with MC at age 65 and was treated with budeso- nide at the beginning. However, she stopped responding after 1 year. For the last 2 years, she stopped responding to any daily metronidazole and ciprofloxacin, which led to partial improvement of her symp- toms. She had a previous history of vascular aneurysm, hip fracture and cancer. She was started on vedolizumab with partial improvement of her diarrhea up to 8-10 times a day, with fecal urgency and incontinence. She was otherwise healthy, and the diarrhea and incontinence greatly affected her quality of life. Stool cultures were negative, and no drug-related side effects were noted, and she denied NSAIDs, PPI, and SSR1 use. Colonoscopy with exam of the terminal ileum and random biopsies of normal colon mucosa confirmed MC. She was intolerant to the drug. She completed 3 induction doses of vedolizumab with plan to reassess her long-term response and decide if maintenance therapy is needed.

Discussion: The treatment of MC consists of controlling the diarrhea and improving the patient’s qual- ity of life while minimizing potential side effects of the treatment drug. It is important to find effective and safe alternative to budesonide, in patients who become steroids dependent, refractory or intolerant. Immunomodulators and anti-tumor necrosis factor have been described as options for the treatment of refractory MC, however, they carry an increased risk of serious side effects in the elderly population. Ved- olizumab targets the α4β7 integrin monomolecular antibody that blocks the trafficking of inflammatory T cells to the gut. This mechanism of action should halt the increased IEL seen in MC, and the gut-selective action of vedolizumab makes it an attractive safe treatment option for patients with MC.

CONCLUSIONS: Study results show that vedolizumab in treating refractory MC and to determine the duration of treatment that is needed to achieve and maintain remission of MC.

Four Cases of Reoperative Pouch Surgery After Failed Minimally Invasive Pouch Creation

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Ucerative colitis (UC) treatment has evolved from an unknown disease process without effective diagnostic or therapeutic tools, to currently a vast field with biologic agents and creation of ileal pouch-anal anastomosis (IPAA). Modern surgical techniques for functional pouches that has become the standard of care for patients with UC and familial adenomatous polyposis. With a movement towards minimally invasive techniques, such as laparoscopy and robotic assisted operations, there has been an emergence of complications that were relatively rare in open ileo-pouch creation. We share 4 cases of reoperative pouch surgery where the mechanical complications after initial minimally invasive pouch creation led to pouch failure. Mean age was 29 (16-38) years old and mean body mass index was 22.9 kg/m^2 (17-24). All patients were female and underwent 3-stage laparoscopic pouch creation for medical treatment resistant ulcerative colitis. Mean number of bowel movements was 20 per day at the time of presentation. All patients were cre- ated a diverting loop ileostomy 3 months prior to redo pouch operation. Intraoperative results showed all 4 patients were diagnosed with retained rectums with 3 patients also having a concomitant pouch twist. Two pouches were excised and a new pouch created, while 2 pouches were able to be salvaged through pouch augmentation (video). All patients had diverting loop ileostomies placed at the time of pouch salvage. Re-operative pouch surgery is safe but requires multiple staged-procedures with proper timing and planning. These patients have a higher pouch salvage rate that allows the possibility of sub-optimal functional results. Since the trend in minimally invasive techniques has increased to encompass lap-pouch construction, there has been a resurgence of retained rectums and pouch twists that have caused pouch failure, which maybe secondary to a limited view with laparoscopic instruments. Special attention should be paid to avoiding leaving remnant rectum behind and mesenteric twist during minimally invasive pouch surgery.

P-025
Young Investigator

Metastatic Crohn’s Disease of the Vulva: A Diagnostic Challenge

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BACKGROUND: Metastatic Crohn’s disease of the vulva is an extraintestinal cutaneous manifestation that occurs less commonly than fistulizing Crohn’s disease. It can be a diagnostic challenge as it presents in a similar fashion to other infectious and non-infectious diseases of the vulva. We present a patient with a long history of Crohn’s disease complicated by enteropathic arthropathy, who presented to the dermatology service with a 2-week history of a tender, erythematous, indurated mass with a central ulceration. The patient was noted to have decreasing C-reactive protein (CRP) values and persistent pyrexia. The patient underwent endoscopic examination, which showed normal appearing small and large intestines. A skin biopsy was performed and presented to gynecology clinic with vulvar lesions of one month duration. The patient had a history of hypertension, depression and recurrent pulmonary embolisms. Past surgeries included laparoscopic proctocolectomy, ileostomy and cholecystectomy. The patient is a ex smoker and presented personally to gynecology clinic with vulvar lesions of one month duration. The patient had a history of hypertension, depression and recurrent pulmonary embolisms. Past surgeries included laparoscopic proctocolectomy, ileostomy and cholecystectomy. The patient is a ex smoker. She has not been sexually active for the past 10 years. She reported painful bilateral nodular vulvar lesions that increased in size and eventually started to discharge despite use of cephalexin prescribed in urgent care. She feels otherwise well since her last gastrointestinal surgery 3 years ago. She denied diarrhea, bleeding per rectum, abdominal pain, weight loss, nausea or vomiting. On physical exam she was obese and had normal vitals. IELsctomy was intact. There were tender nodular lesions associated with clear dis- charge as well as few small sized ulcers on the mons pubis and labia majora. Rest of exam revealed no abnormal findings. Complete metabolic panel, coagulation profile and C-reactive protein were within normal limits. Cultures from lesions showed growth of Citrobacter freu- dii complex sensitive to trimethoprim-sulfamethoxazole. Cultures for MRSA and screening for human papilloma virus, syphilis, chlamydia and gonorrhea were negative. Due to the unresolved concerns, the patient continued taking multiple antibiotics with several visits to gynecology and referral to infectious diseases and gastroenterology clinic. Her ulcers never improved. Absence of an extravascular manifesta- tion of Crohn’s disease was ruled out, so a skin biopsy was performed. Vulvar skin showed florid granulomas in addition to dilated cystic follicles, some containing keratinous debris, with surrounding lymphoplasmacytic infiltrate. The patient was referred to rheumatology for further workup. Possible diagnosis of hidradenitis suppurativa was suggested by pathologist. Patient was referred to Medical Center for Vul- var Disease, where biopsy results were reviewed. The expert opinion was more of a Metastatic Crohn’s disease. She was started on adalimumab and topical steroids. On follow up one month later, the patient reported significant improvement of her symptoms. Discussion: Metastatic ulcerative Crohn’s disease is very uncommon, there also appears to be some degree of overlap between Crohn’s disease and large vessel vasculitides. It is characterized by the presence of noncaseating granulomas in the vulva and should be differentiated from other etiologies of granulomatous vulvar lesions. There is probably an association between Crohn’s disease and hidradenitis suppurativa, while both can co-exist, which makes distinguishing between them more difficult.

CONCLUSION(S): Metastatic Crohn’s disease of the vulva can be misdiagnosed as hidradenitis suppurativa. Fortunately, treatment of both conditions can be similar (antibiotics and anti-TNF alpha). Possible common immunopathological pathways need further clarification.

P-026
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A Rare Case of Crohn’s Disease–Associated Aortitis

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RESULTS: A 33-year-old woman with history of Crohn’s disease complicated by enteropathic arthrop- athies presented with symptoms of complete gastrointestinal obstruction. She had history of ongoing depression despite therapy with cerulimumab. Due to persistent obstruction symptoms, she underwent an unsuccessful diagnostic laparoscopy. She continued to present with intermittent obstructive symptoms that were refractory to medical treatment. A course of intravenous antibiotics and high-dose corticosteroids were administered without improvement in symptoms. She then presented with chest pain and dyspnea. A chest CT revealed ascending aortic disease, which was later confirmed with MR angiography. The patient was placed on high-dose corticosteroids and ultimately transitioned to infliximab (5 mg/kg) and infliximab. Crohn’s disease with aortic disease was negative. Total IgG and IgG2 noted to be elevated with normal IgG4 levels. Interferon release assay for tuberculosis (TST) was positive. Pulmonary symptoms and fever resolved with cessation of IFX. Due to persistent fever, the patient was started on adalimumab and topical steroids. On follow up one month later, the patient reported significant improvement of her symptoms. Discussion: Metastatic ulcerative Crohn’s disease is very uncommon, there also appears to be some degree of overlap between Crohn’s disease and large vessel vasculitides. It is characterized by the presence of noncaseating granulomas in the vulva and should be differentiated from other etiologies of granulomatous vulvar lesions. There is probably an association between Crohn’s disease and hidradenitis suppurativa, while both can co-exist, which makes distinguishing between them more difficult.

CONCLUSION(S): Metastatic Crohn’s disease of the vulva can be misdiagnosed as hidradenitis suppurativa. Fortunately, treatment of both conditions can be similar (antibiotics and anti-TNF alpha). Possible common immunopathological pathways need further clarification.

References: