A 23-year-old man with Crohn’s disease presented to clinic in September 2018 in remission on adalimumab 40 mg EOW. Drug levels can vary from one patient to the next. In a retrospective cohort study Van Steenbergen et al. identified 40 patients with Crohn’s who de-escalated adalimumab to every 3 week dosing. At a median follow-up of 24 months, 63% of patients maintained clinical response, and 35% needed dose escalation back to EOW because of relapse, low drug levels, or both. Our case is the first of a patient maintained in clinical remission, with detectable drug level and no antibody formation on adalimumab at intervals greater than 3 weeks. Given the economic burden of biologic therapy, prolonging the dosing interval of therapy is of interest. More studies are needed to investigate the effects of de-escalation in Crohn’s disease.

REFERENCE

2019 Coexistence of Lymphocytic Colitis in a Patient With Ulcerative Colitis

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INTRODUCTION: Microscopic colitis (MC) is an inflammatory condition of the colon that is histologically divided into two different conditions, lymphocytic colitis (LC) and collagenous colitis. Initially suspected to be unrelated to inflammatory bowel disease, a growing body of evidence now suggests a common pathophysiology between MC and IBD. We describe a case report of a patient presenting with both LC and UC.

CASE DESCRIPTION/METHODS: A 59-year-old Caucasian, nonsmoking female with a history of diabetes underwent a colonoscopy for evaluation of constipation which demonstrated significant colitis, consistent with UC. Her disease was managed with mesalamine however due to social restrictions, clinical follow up and management of her disease was limited. As part of age appropriate management, patient underwent routine screening colonoscopy 15 years after her initial diagnosis as an open access procedure. During the procedure patient was noted to have terminal ilium aphasia with Mayo score 2 pancolitis. Random biopsies taken during the procedure demonstrated focal acute inflammation. In follow up clinic visit, patient endorsed having 3-4 non-bloody, loose bowel movements daily but was otherwise asymptomatic. She was started on balsalazide capsules with improvement in stool consistency and reduction in frequency of bowel movements. Shortly after starting balsalazide patient lost insurance access and was unable to follow up as directed. Patient returned to gastroenterology clinic two years later endorsing 4-5 non-bloody, loose bowel movements every day. Fecal calprotectin at this time was noted to be 26.7 mg/kg (normal < 50 mg/kg) however due to ongoing symptoms balsalazide was restarted. Repeat colonoscopy was performed to evaluate for dysplasia and ongoing symptoms which demonstrated Mayo score 1 pancolitis. Random biopsies taken during the procedure demonstrated chronic active colitis with superimposed lymphocytic colitis. Patient was started on budesonide in addition to balsalazide with reduction in stool frequency and improvement in consistency.

DISCUSSION: In literature, coexistence of LC and UC is described in 12 cases, typically in patients with UC and LC suggestive of a common pathophysiology. We describe a case report of a patient presenting with both LC and UC. This case emphasizes the importance of looking for alternative causes of symptoms in patients with mild colonicoscopic findings.