REFRACTORY ULCERATIVE COLITIS
CASE PRESENTATION

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Demographic and clinical data

- 20 year-old female student
- Lives in the island of Limnos
- Tonsillectomy at 4 years
- Appendicectomy at 9 years; histology not available.
- Allergic rhinitis
- Non smoker
- FH: -ve for IBD
Ulcerative colitis

- **2004**: Ulcerative proctitis
  - mesalazine supp 0.5g bid – no maintenance treatment
- **→ 2005**: mild relapses of UP
  - Mesalazine supp (0.5g bid)

- **June 2005**: arthralgias (elbows/knees)
  - rofecoxib and omeprazole

- **15 days later**
  - acute bloody diarrhoea, abdominal pain, ↑↑ inflammatory indices, no fever.
  - (by phone) mesalazine, oral (1g tid) + rectal (4 g enemas nocte).
  - no improvement
  - came to Athens – total colonoscopy + bxs
  - extensive UC.
Ulcerative Colitis: C’d

- Oral (1g tid) plus rectal (4 g nocte) mesalazine
- Oral prednisolone 40mg/day; tapered by 5 mg/week.

- Improved clinically, but...
- Steroid-dependent: relapse when pred <20 mg.

- Admitted to a private hospital
- IV steroid regimen and aza- (2 mg/kg/d)

- Responded

- Discharged on oral pred-, aza-, oral and rectal mesalazine.
- Returned home. aza- safety protocol?
Ulcerative colitis: C’d

- 2 mo later
  - admitted with pneumonia
    - WBC 1500 (35% neutrophils).
  - Aza- was discontinued; IV antibiotics.

- Transferred to Athens - Joined consultation
  - Haematologist, lung specialist, gastroenterologist
  - Sagramostim daily for a week

- After 2 wk
  - Discharged on oral and rectal mesalazine.
  - WBC 4500 (60% neutrophils).
  - Sagramostim daily for another week

- Attended our Clinic

- Clinical + endoscopic remission for 18 m
  - Oral mesalazine (1g tid) and rectal mesalazine (4 g biw).
ULCERATIVE COLITIS: C’ed

- Oct 2006: ‘flu’ vaccine

- 15 days later
  - ≤3 bloody bowel motions daily
  - Tests for common pathogens, Cl. Dif, etc -ve
  - By phone: oral pred (20 mg), mesalazine enemas od, oral calcium, and vit. D supplements

- Symptoms worsened
- Oral prednisolone 40 mg/day

- No improvement within 1 wk
Physical Examination

- Admitted to our hospital
- Tired, pale, but otherwise well.
- BO 8-10/d (anchovy sauce).
- BP 100/70 mmHg, PR 95/min, T 37.5-37.8°C.
- Mild LIF pain and tenderness on deep palpation.
Laboratory tests

- Blood tests
  - WBC 13,500 (85% p-); ESR 56; CRP 4.5 mg/dl.
  - CMV-Ag/IgM-Ab/PCR-RNA: -ve.
  - pANCA+/ASCA-.

- Stool tests/culture negative (incl C. difficile)

- Supine abdominal x-ray
  - small bowel ileus; no ‘thumb printings’ or colonic dilatation.
  - no stools; diffuse colonic oedema.

- Chest x-ray –ve

- PPD test -ve

- Upper abdominal US: reported ‘normal’

- Flex-sigm with bxs
  - Severe diffuse colonic inflammation.
  - Histology: severe UC; negative for CMV inclusions.
Treatment

- TPN (2400 kcal/d)
- IV ciprofloxacin and metronidazole
- IV methyl-prednisolone
  - 60mg in 3 divided doses/day
- HC rectal drips (100mg/100ml water over 30mins bid)
- After 5 days
  - No improvement (clinical + lab. Indices)
Treatment: C’d

- Did not consent to IV CysA.
- IFX (5mg/kg).
  - 1st infusion: 5th hospital day
- 8th hospital day
  - Clinical deterioration
  - Leukocytosis; thrombocytosis; ↑ CRP
  - Abd. x-ray small bowel ileus
Treatment: C’d

- Emergency subtotal colectomy
  - uneventful
- Two stages Ileal pouch-anal anastomosis (IPAA)
Follow up

- Last week
- 1st episode of pouchitis
- iridocyclitis