CASE-BASED WORKSHOP

The Mother with IBD (based on a true patient case)

A 23-year-old female from Israel has moved to Canada. You are seeing her for the first time. She has a history, well documented endoscopically and histologically, of colitis diagnosed at age 19 years. However, on review of the translated pathology and endoscopic reports you notice that there was some ileal inflammation on biopsy and that the pathologist reading the biopsy in Israel concluded this could be indeterminate colitis.

Interestingly, past history is also positive for a diagnosis in Boston, during a summer vacation, of pseudotumor cerebri that was attributed to mesalamine (the only medication she was on at the time, age 21). You read the literature and confirm 2 case reports of pseudotumor cerebri.1,2

Today, she tells you that her previous doctor in Boston said the pseudotumor cerebri has resolved off mesalamine and never to take it again. Clinically she has been in remission and off all medications for 18 months.

However, now she is having 3 to 4 bowel motions per day with occasional blood. She is also 28 weeks pregnant. She does not want any invasive gastrointestinal investigations.

Decision Node 1

- What investigations would you propose, if any?

The following investigations were carried out:

- Hb 106 g/L
- MCV low at 79 fl/red cell
- Iron low at 5 µmol/L
- Ferritin low at 9 pmol/L
- Platelets elevated at 401 x 10^9/L
- CRP elevated at 35 mg/L
- Fecal calprotectin 434 µg/g
- Stool culture and ova and parasites negative
- PCR C. difficile toxin assay negative

Decision Node 2

- Given the above investigations would you proceed to endoscopy? Discuss why and why not.3
- Are there any other investigations or consultations you would want to get and why?4
She does not want any therapy that will harm the baby. She is seen by a high-risk obstetrician and by an ophthalmologist who confirms there is no evidence of pseudotumor cerebri. After a long discussion with her and her husband, she is started on oral iron therapy and agrees to a flexible sigmoidoscopy to define if this is rectal disease or more diffuse disease. Sigmoidoscopy demonstrates loss of vascular pattern, granularity and friability up to the extent of the sigmoidoscopy at the mid descending colon. There are no deep ulcerations. Additional active disease can be seen proximally.

**Decision Node 3**

- What is your therapeutic approach at this point?
- Would you try mesalamine with careful ophthalmologic follow-up?

She is seen a few days after the sigmoidoscopy. She is now having 6 to 7 bowel motions daily and 25% with blood.

Again, after much discussion, she and her husband are not keen on advancing to biologic therapy. She is started on prednisone 40 mg tapering by 5 mg each week to 20 mg, then by 2.5 mg each week to zero as an outpatient. She has frequent ophthalmologic follow-up arranged while on the prednisone.

One week later she calls your office and tell you that her symptoms are not improving. She tells your staff that she does not want the doctor to put her on biologic therapy.

**Decision Node 4**

- What is your next therapeutic approach? Discuss the use of antibiotics, probiotics, immunosuppressants and biologics at this point.

Given the complexity of the case and the progression while on corticosteroids she is admitted to hospital directly from your office for treatment with intravenous methylprednisolone 20 mg IV q12h, steroid enema, ciprofloxacin 500 mg bid, and azathioprine 2.5 mg/kg/day. Her diarrhea and blood subside over 5 days to 1 to 2 bowel motions per day with no blood. She is discharged home on tapering prednisone and azathioprine 2.5 mg/kg/d for maintenance therapy.
She delivers a healthy baby and remains on azathioprine 2.5 mg/kg/d as maintenance therapy.

**Decision Node 5**

- What do you advise about breastfeeding? Do you have any advice for the infant’s care?\textsuperscript{6,7,8}

**References**