SESSION 4

RHEUMATOLOGICAL MANIFESTATIONS IN IBD

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Up to 20% of patients with inflammatory bowel disease (IBD) have associated spondyloarthritis (SpA) which can be classified as axial or peripheral. Distinguishing SpA from non-inflammatory musculoskeletal pain (e.g., fibromyalgia, mechanical back pain) and other immune-mediated inflammatory disorders (e.g., drug induced lupus) requires a careful history, physical exam, appropriate laboratory investigations and imaging.

The presence of SpA introduces new therapeutic considerations and challenges in the treatment of IBD. For peripheral SpA, immunomodulators (conventional synthetic DMARDs in the rheumatological literature) including methotrexate and sulfasalazine are often used, albeit with limited evidence to support their efficacy. For axial SpA, conventional DMARDs have no demonstrated efficacy. Anti-TNF therapy is generally the first-line biologic therapy, given its established efficacy in IBD and both peripheral and axial SpA. In patients who fail anti-TNF therapy, the preferred therapy is less certain. Combination biologic therapy with anti-TNF therapy and the gut-selective vedolizumab has been used with good effect and acceptable safety profiles in small case series. New oral small molecules (e.g., tofacitinib) show promise for both Crohn's disease and SpA. Corticosteroids (both systemic and intra-articular) and nonsteroidal anti-inflammatory drugs (NSAIDs) are useful short-term treatments in select situations for peripheral SpA and sacroiliitis, although the latter are limited by concerns over worsening of IBD.

This presentation will review the clinical presentation, diagnosis and treatment of common rheumatologic conditions in patients with IBD, focusing on practical aspects for the gastroenterologist, and highlighting the importance of shared care between rheumatology and gastroenterology.

Key References

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