

Introduction

Acute severe ulcerative colitis (ASUC) is a life-threatening condition that may lead to complications such as toxic megacolon, infection, perforation, or hemorrhage.

Current medical therapy has a high failure rate with approximately a third of patients requiring colectomy.

Moreover, this can lead to higher costs for care of IBD patients.

Case Report

HPI: A 60-year-old South Asian man with a three-year history of ulcerative proctitis controlled on mesalamine therapy was admitted to the hospital for worsening diarrhea, abdominal pain, and hematochezia.

He was on 40 mg of oral prednisone and rectal budesonide foam for the past month as outpatient. He quit smoking recently.

ROS: arthralgias and malaise but no fevers, chills, shortness of breath, nausea, vomiting, rash

Vital signs on admission were normal.

Labs showed WBC of 12.5, Hgb of 10.6, platelet count of 530, albumin of 2.7, CRP of 143.2, ESR of 75, and fecal calprotectin of 1860. *C. difficile* testing was negative.

CT scan of the abdomen and pelvis was remarkable for mild colonic wall thickening.

He was started on IV methylprednisolone 60 mg/daily and underwent a colonoscopy which showed severe (Mayo Score 3) pancolitis with negative CMV on biopsies.

Images

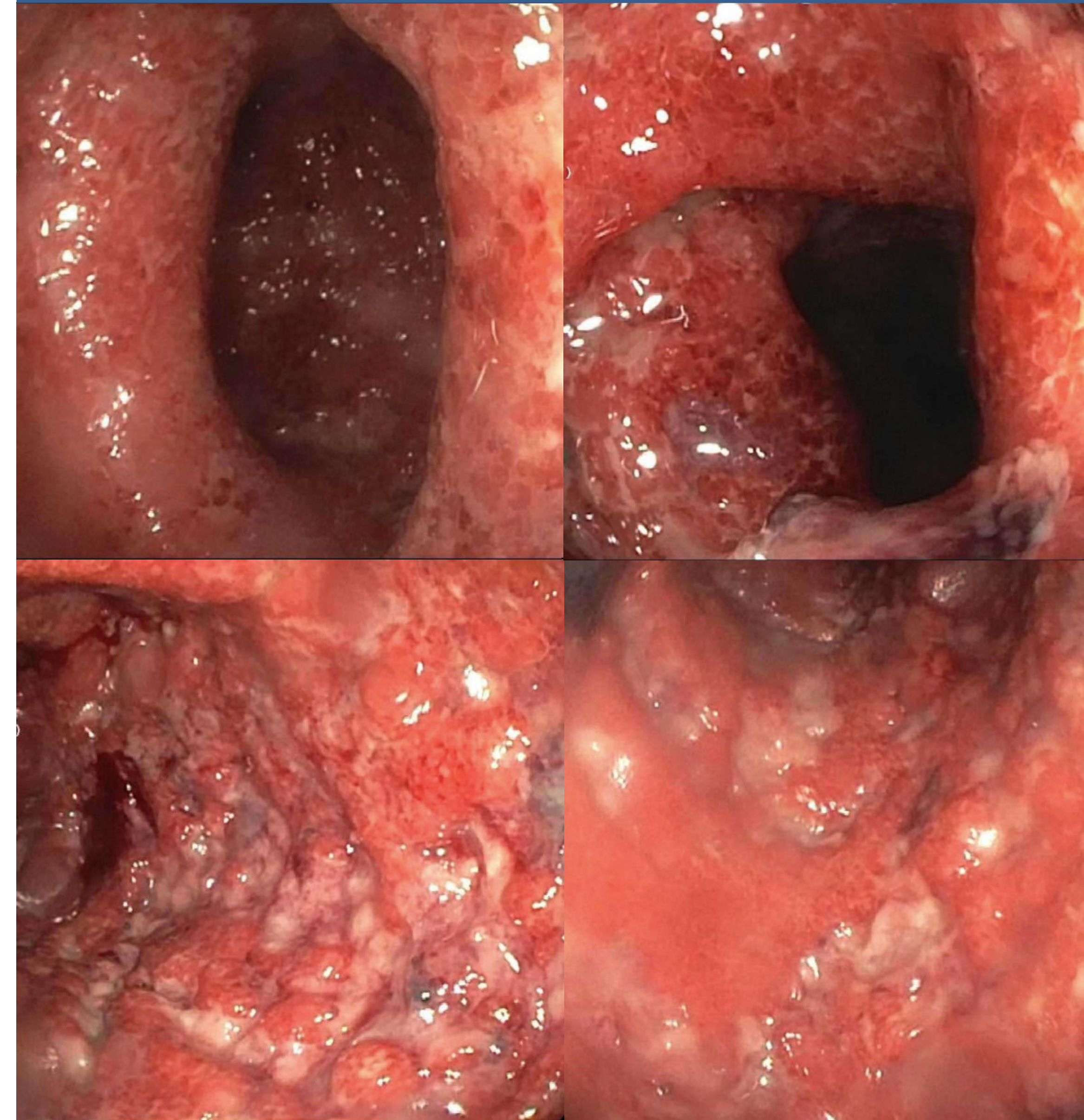


Image 1. Upper images of rectum and lower images of sigmoid colon show marked erythema, loss of vascular pattern, submucosal hemorrhages, erosions, and ulcerations. The sigmoid colon is notable for deep serpiginous ulcerations along with an area of spontaneous bleeding on the bottom left image.

Conclusions

- Steroid refractory disease is a marker of severity of inflammation
 - Surgery is often a great option
- Delay in surgery may increase the risk of having poor surgical outcomes

Clinical Course

Surgery was consulted after he failed after five days of IV steroids, and he required several blood transfusions. Due to the unavailability of Infliximab for inpatient use in our institution, he was started on Adalimumab and received 160 mg dose with no improvement, followed by another 160 mg injection a week later.

Patient refused to undergo colectomy until all medical therapies exhausted. Recent data for Tofacitinib prompted 10 mg three times daily dosing for 5 days. CRP declined initially but quickly worsened. Patient then decided to transfer care to another tertiary center for colectomy, but unfortunately developed brisk lower GI bleeding, requiring ICU transfer and emergent exploratory laparotomy with subtotal colectomy and an end ileostomy, three weeks after his hospitalization.

Discussion

Data to support rescue tofacitinib has been through retrospective case-control study with several limitations including small sample size, predominantly Caucasian patients, lead-in effect from outpatient biologic initiation, and a single-center experience with a non-randomized cohort of patients.

As many patients who are refractory to high-dose IV steroids may ultimately require colectomy, one should be cautious delaying a definitive surgical intervention for this very sick population. Fortunately, our patient had an uncomplicated post-op course and was discharged to rehab in ten days.

Contact

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References

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