How to Manage Silent Inflammatory Bowel Disease

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Introduction

- The incidence and prevalence of inflammatory bowel diseases (IBD), Ulcerative Colitis (UC) and Crohn's Disease (CD), are increasing worldwide.
- The pathogenesis of IBD is multifactorial and the disease has a pre-clinical stage where inflammation and damage progress to develop intestinal symptoms.
- Some patients in the pre-clinical stage of IBD may be identified on screening modalities.

Case Description: Patient 1

- An asymptomatic 47-year-old female without significant past medical history presented for screening colonoscopy.
- Colonoscopy revealed ileocecal valve stenosis with inflammation that prevented intubation beyond the valve but tissue sample of the ileum was obtained (Figure 1, A-B).
- Biopsies revealed focal active ileitis with mild glandular distortion and rare pseudopyloric glandular distortion.
- Magnetic resonance elastography (MRE) showed findings of the terminal ileum with marked bowel wall thickening, luminal narrowing, upstream dilatation suggestive of stricture and penetrating disease with enteroenteric and enterocolonic fistulas.
- Patient was classified A3/L3/B3.

Montreal Classification	
Age at diagnosis	A1, <16 years old
	A2, 17-39 years old
	A3, ≥ 40 years old
Location	L1, ileal
	L2, colonic
	L3, ileocolonic
	L4, isolated upper disease (can be added to L1-L3 when concomitant upper gastrointestinal disease is present)
Behavior	B1, non-stricturing, non-penetrating
	B2, stricturing
	B3, penetrating
	P, perianal disease modifier (can be added to B1-B3 when concomitant perianal disease is present)

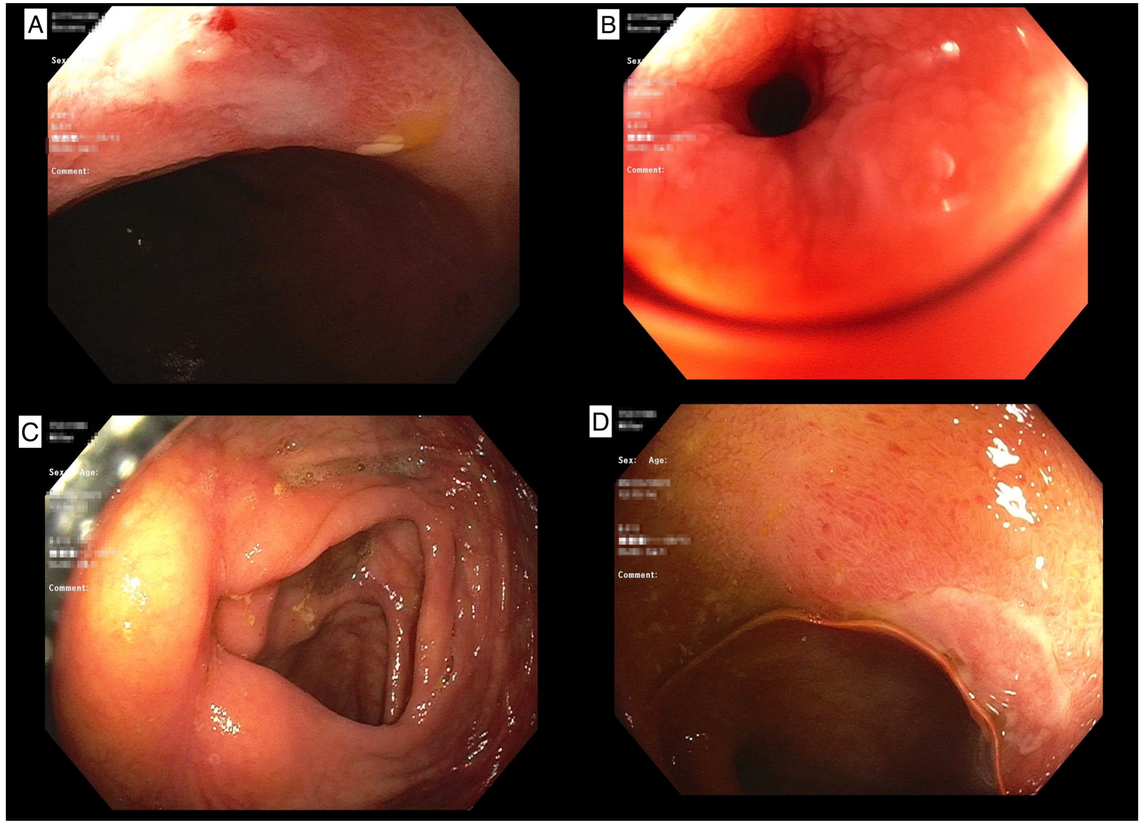

Figure 1. Screening Colonoscopy of Patients
A – Patient 1 Ileocecal valve
B – Patient 1 Stenosed Ileocecal valve unable to be traversed
C – Patient 2 Normal appearing ileocecal valve
D – Patient 2 Terminal ileum ulcer

Case Description: Patient 2

- An asymptomatic 51-year-old female with a past medical history of gastroesophageal reflux disease and anxiety presented for screening colonoscopy.
- Colonoscopy was noted to have a patchy, erythematous and ulcerated ileum, and distorted ileocecal valve (Figure 1, C-D).
- Biopsies revealed severe active ileitis with ulceration.
- Patient subsequently underwent further workup revealing positive anti-Saccharomyces cerevisiae antibodies (ASCA).
- Patient was classified as A3/L1/B1.

Conclusions

- Identifying pre-clinical IBD on screening modalities should not dissuade clinicians from appropriately managing moderate to severe cases of IBD.
- Clinicians can follow up with lower risk patients to monitor for symptoms like Patient 2, but asymptomatic complicated disease (fistulizing, stenosis) should be addressed and managed with medical or even surgical therapy to prevent future symptoms or complications.
- Awareness of the pre-clinical stage of IBD is important for providers who may encounter on colonoscopy or imaging and may allow for the necessary early interventions to prevent IBD-related complications. However, the therapeutic management discussion with patients who are asymptomatic still needs to be a shared decision model with all the available benefits and risk that may be associated with the treatment plan.
- We hypothesize that "ill" disease without colon involvement may be the reason why these patients remained "silent" and without symptoms, as colonic involvement leads to more specific primary symptoms like urgency, rectal bleeding, and diarrhea compared to nonspecific symptoms like abdominal cramping and early satiety from small bowel involvement.

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