İnflamatuar Bağırsak Hastalıkları

Dr. Yusuf Erzin

Cerrahpaşa Tıp Fakültesi

Gastroenteroloji Bilim Dalı

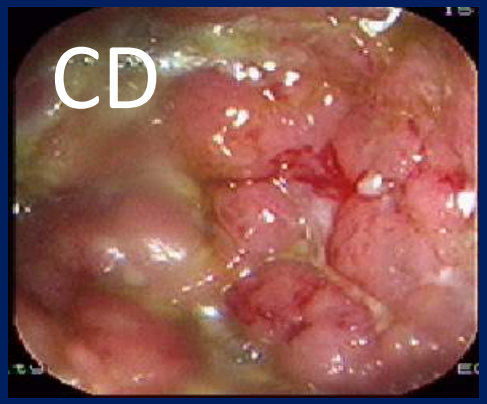
Haver Online Toplantı – 30.05.2023

İBH

- Ülseratif Kolit
- Crohn Hastalığı
- İndetermine Kolit %10

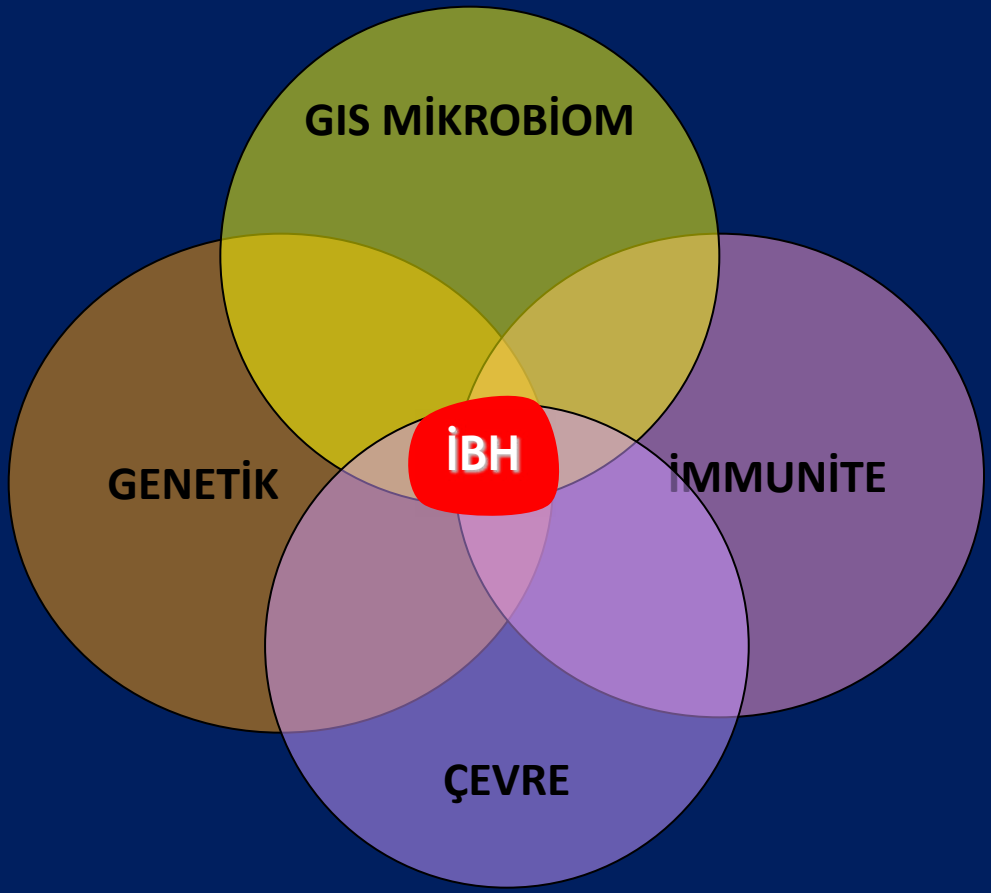
İBH AYIRICI TANI

- İNFEKSİYÖZ KOLİT
- ANTİBİOTİK KOLİTİ
- İSKEMİK KOLİT
- RADYASYON KOLİTİ
- PERİDİVERTİKÜLER KOLİT



- GİS Tbc
- GİS BEHÇET
- NSAID ENTEROPATİSİ
- GİS LENFOMA
- YERSİNİA ENTEROKOLİTİ

İBH ETYOLOJİ



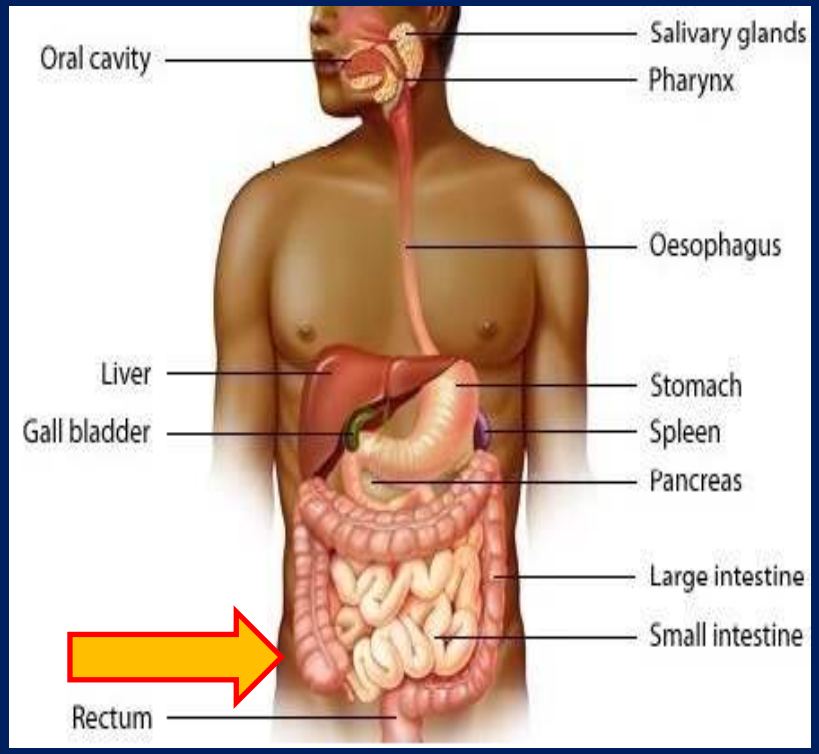
SON YÜZYILDA İBH'DA ARTIŞ - GENETİK??

- MONOZİGOTİK İKİZ CROHN <%50
- MONOZİGOTİK İKİZ Ü.KOLİT <%10

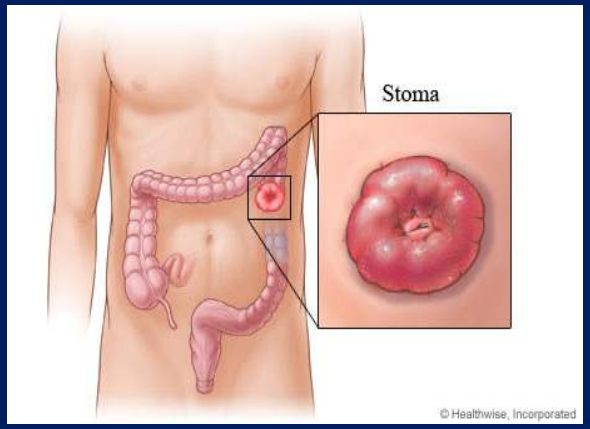
- GENETİK HAVUZ DEKADLARLA DEĞİŞMEZ.

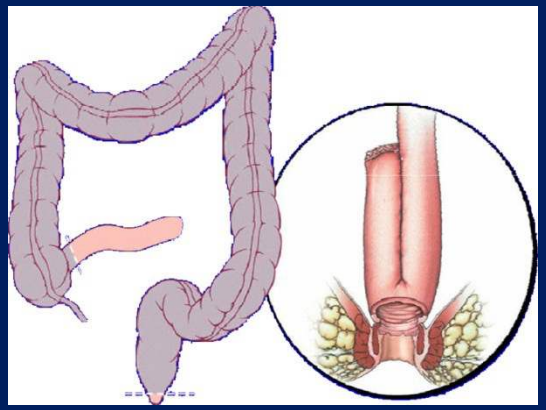
GİS MİKROBİOM
İBH NERELERİ DAHA SIK TUTAR??

- DUODENUM< 10^5 /ml
  (ANAEROB YOK)
- JEJENUM < 10^5 /ml
  (ANAEROB YOK)
- İLEUM < 10^8 /ml
- KOLON < 10^{11} /ml



FEKAL AKIM YOKSA KOLİTTE YOK





Harper PH. *Gut* 1985; **26**: 279–84.
D'Haens GR. *Gastroenterology* 1998; **114**: 262–7.

HASTALIKTA VE SAĞLIKTA GI MİKROBİOM

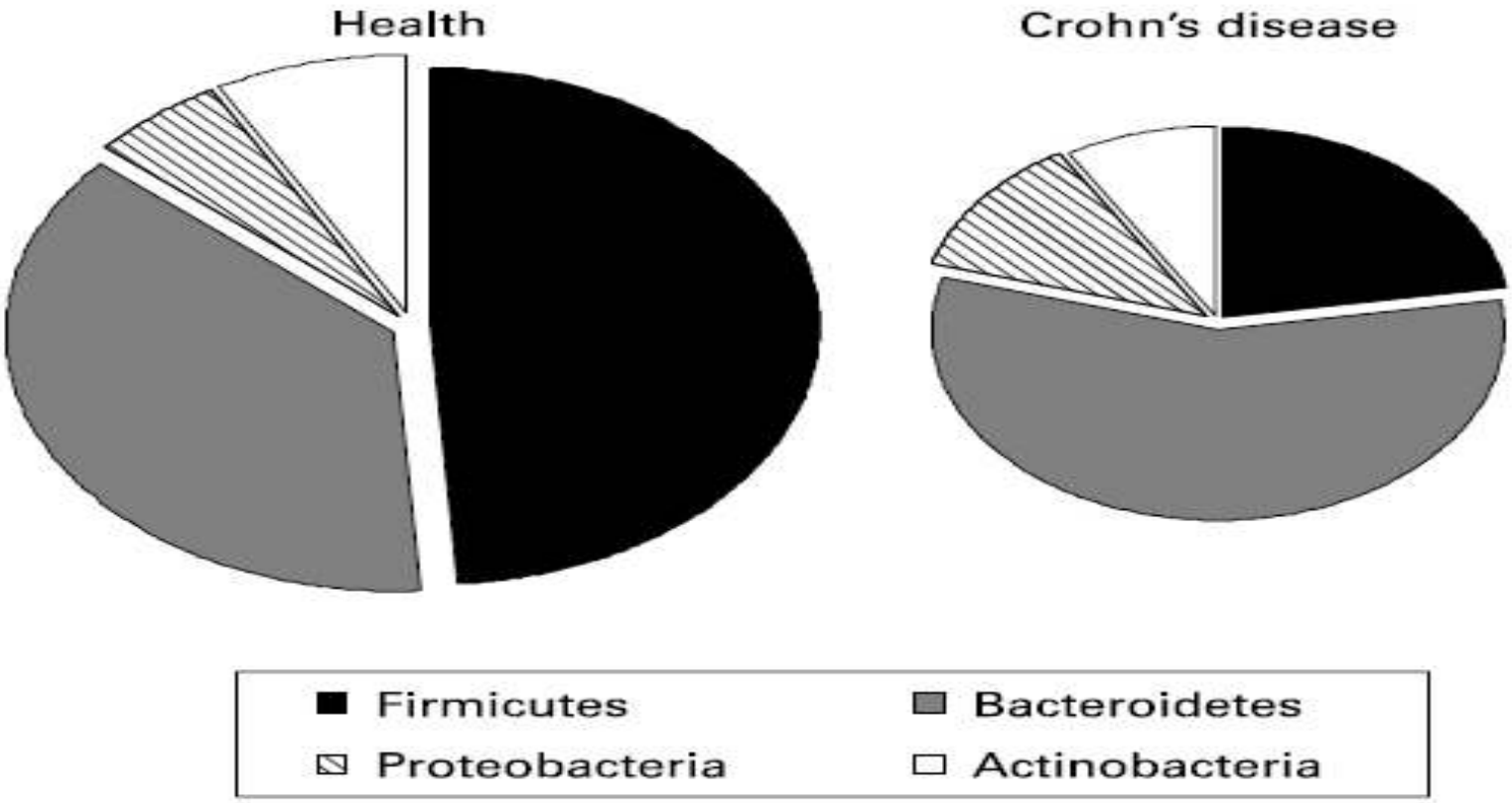


Fig. 1. The faecal microbiota of patients with Crohn's disease contains a reduced proportion of Firmicutes. The graph shows data from Manichanh and coworkers (ref 18) and represents number of phylotypes per division in 6 healthy persons and 6 patients in clinical remission.

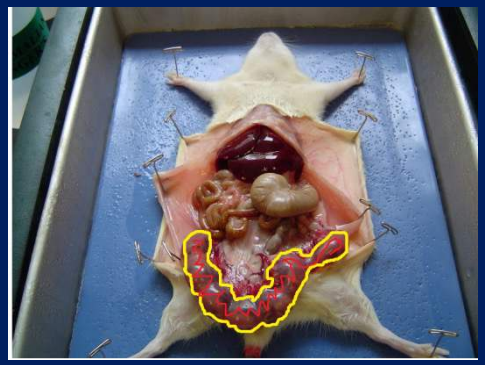
Manichanh C. *Gut* 2006; **55**: 205–11.

INFECTION AND IMMUNITY, Nov. 1998, p. 5224–5231 Vol. 66, No. 11
0019-9567/98/$04.00+0

Resident Enteric Bacteria Are Necessary for Development of Spontaneous Colitis and Immune System Activation in Interleukin-10-Deficient Mice

RANCE K. SELLON,[1] SUSAN TONKONOGY,[2] MICHAEL SCHULTZ,[3] LEVINUS A. DIELEMAN,[3] WETONIA GRENTHER,[1] ED BALISH,[4] DONNA M. RENNICK,[5] AND R. BALFOUR SARTOR[3]*

IL-10 -/-
ENTERİK BAKTERİ VAR



KOLİT VAR

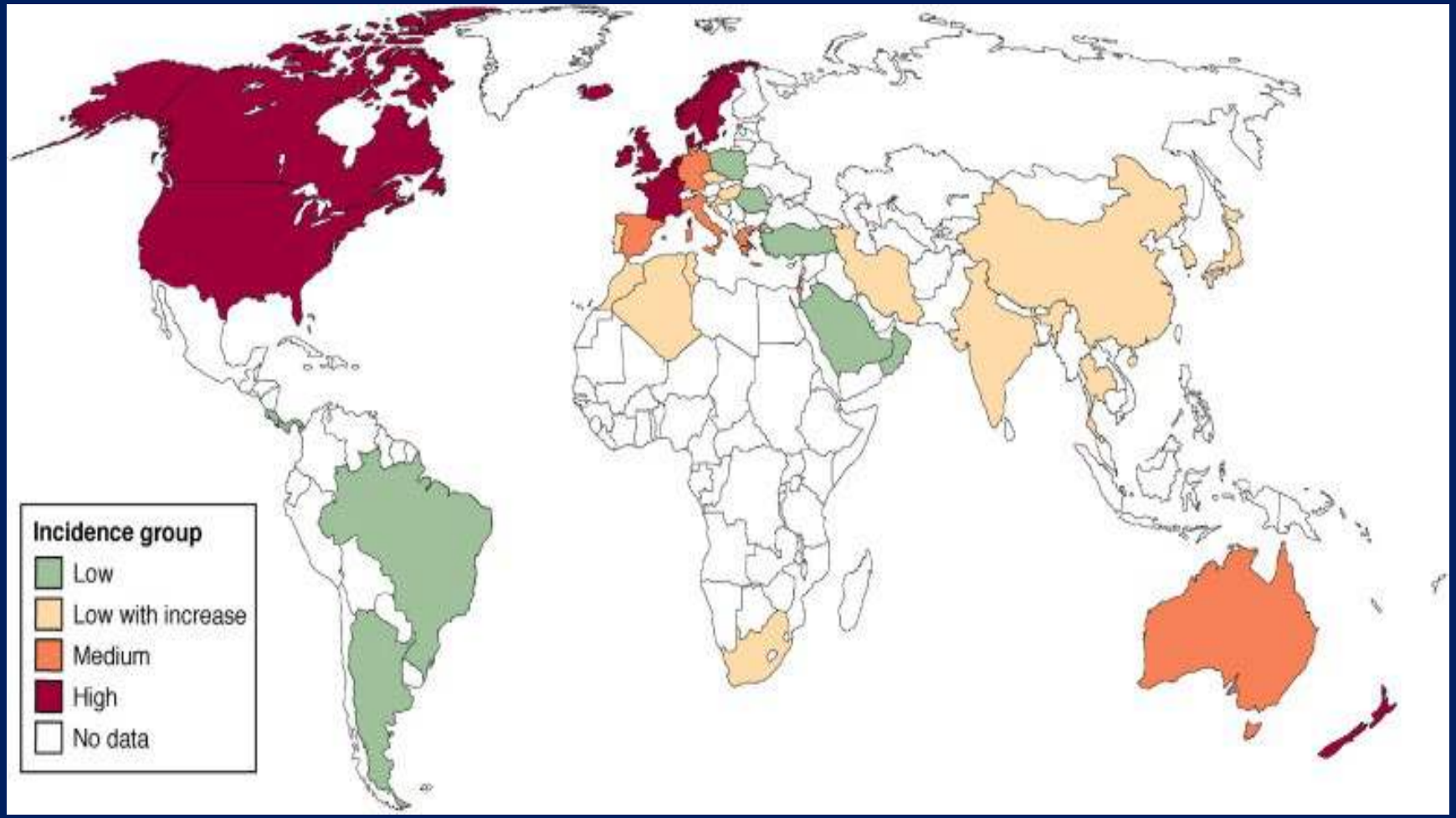
IL-10 -/-
ENTERİK BAKTERİ YOK

KOLİT YOK

İBH GELİŞİMİNDE SUÇLANAN ÇEVRESEL FAKTÖRLER

- SİGARA
- APPENDEKTOMİ
- HİJYEN FAZLALIĞI
- DİYET
- İLK YAŞ ANTİBİOTİK KULLANIMI
- NSAID
- GÜNEŞ IŞINI AZLIĞI
- ANNE SÜTÜ AZLIĞI
- STRES

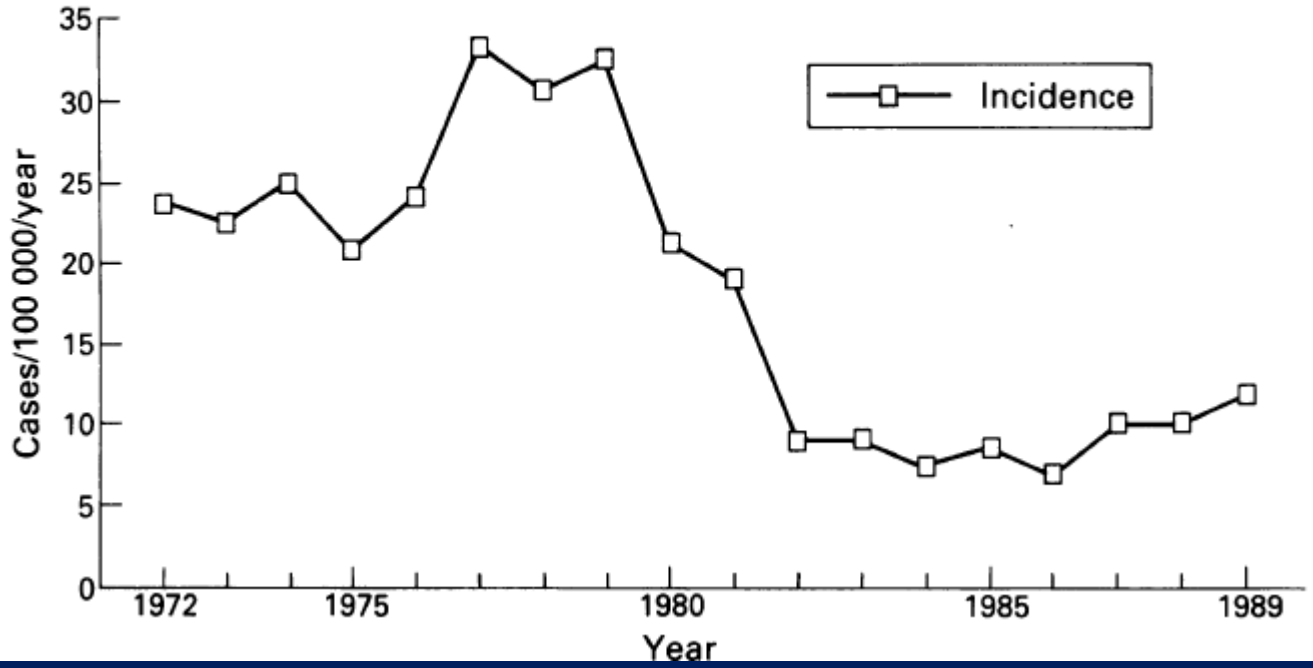
İBH – EPİDEMİYOLOJİ



Gut 1992; **33**: 1085–1088

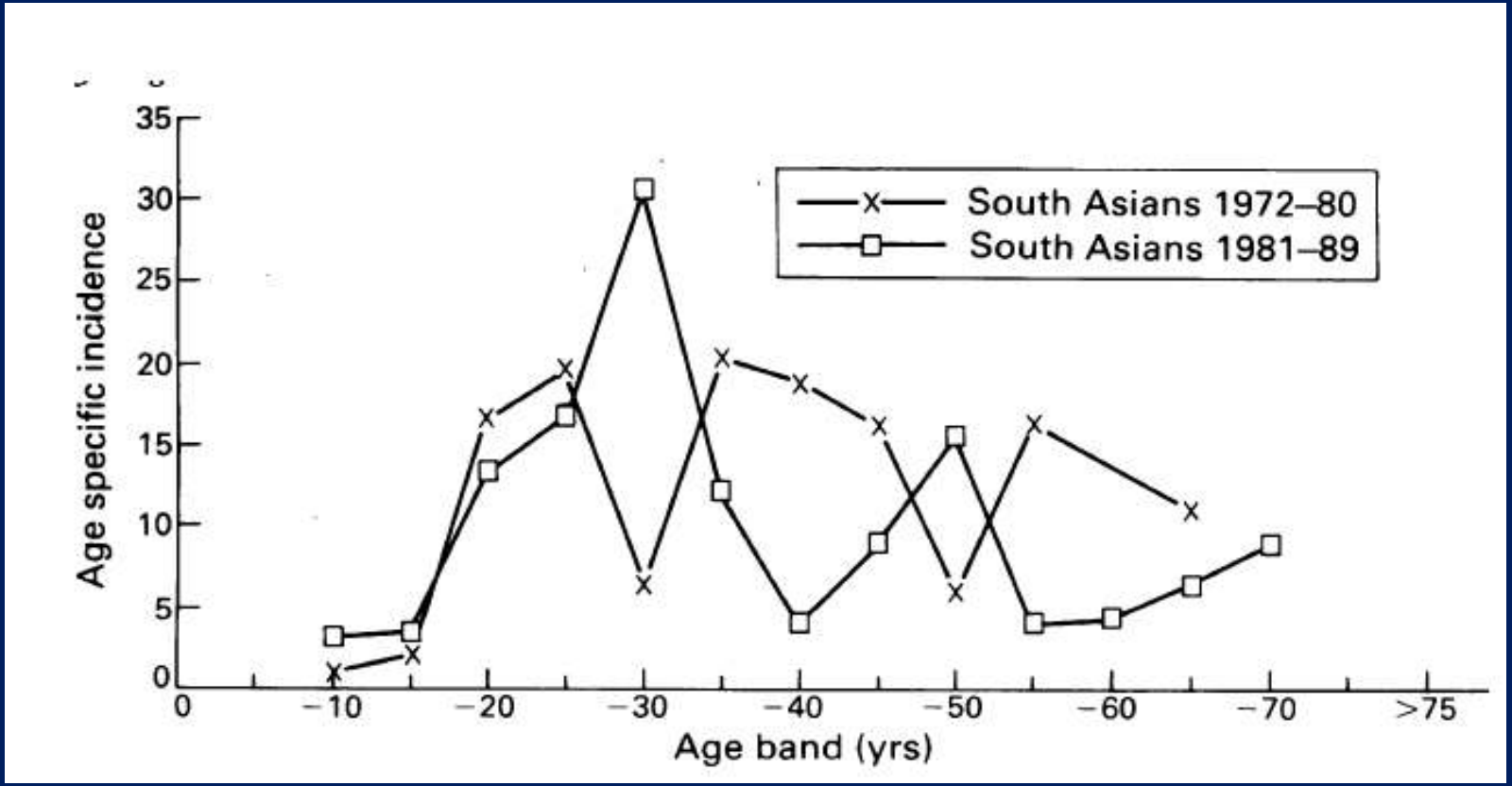
Epidemiological study of abdominal tuberculosis among Indian migrants and the indigenous population of Leicester, 1972–1989

C S J Probert, V Jayanthi, A C Wicks, D L Carr-Locke, P Garner, J F Mayberry



Hintli göçmenlerde azalan GI Tb insidansı

GENÇ GÖÇMENLER – GI Tb

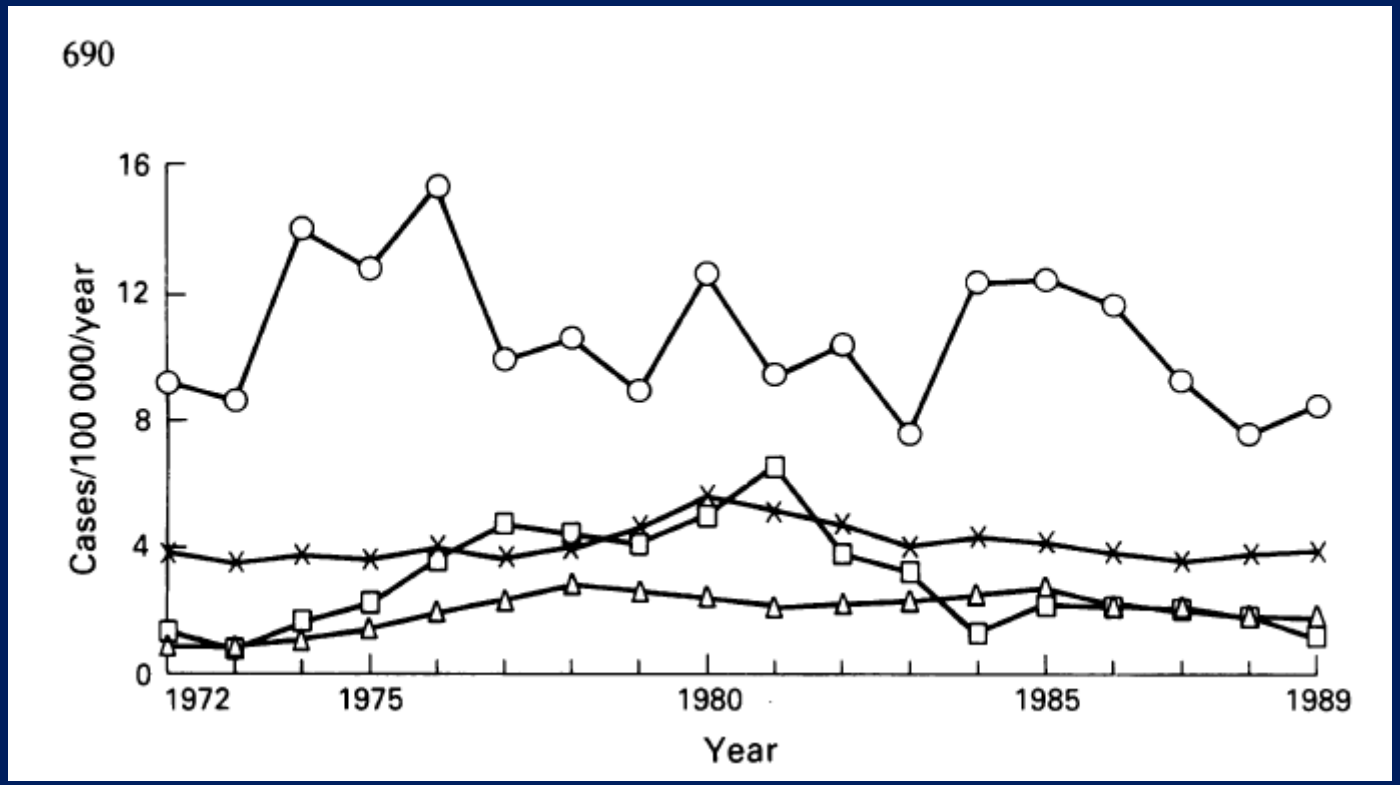


Gençlerde GI Tb sıklığındaki düşüş daha dramatik

Gut, 1992, 33, 687–693

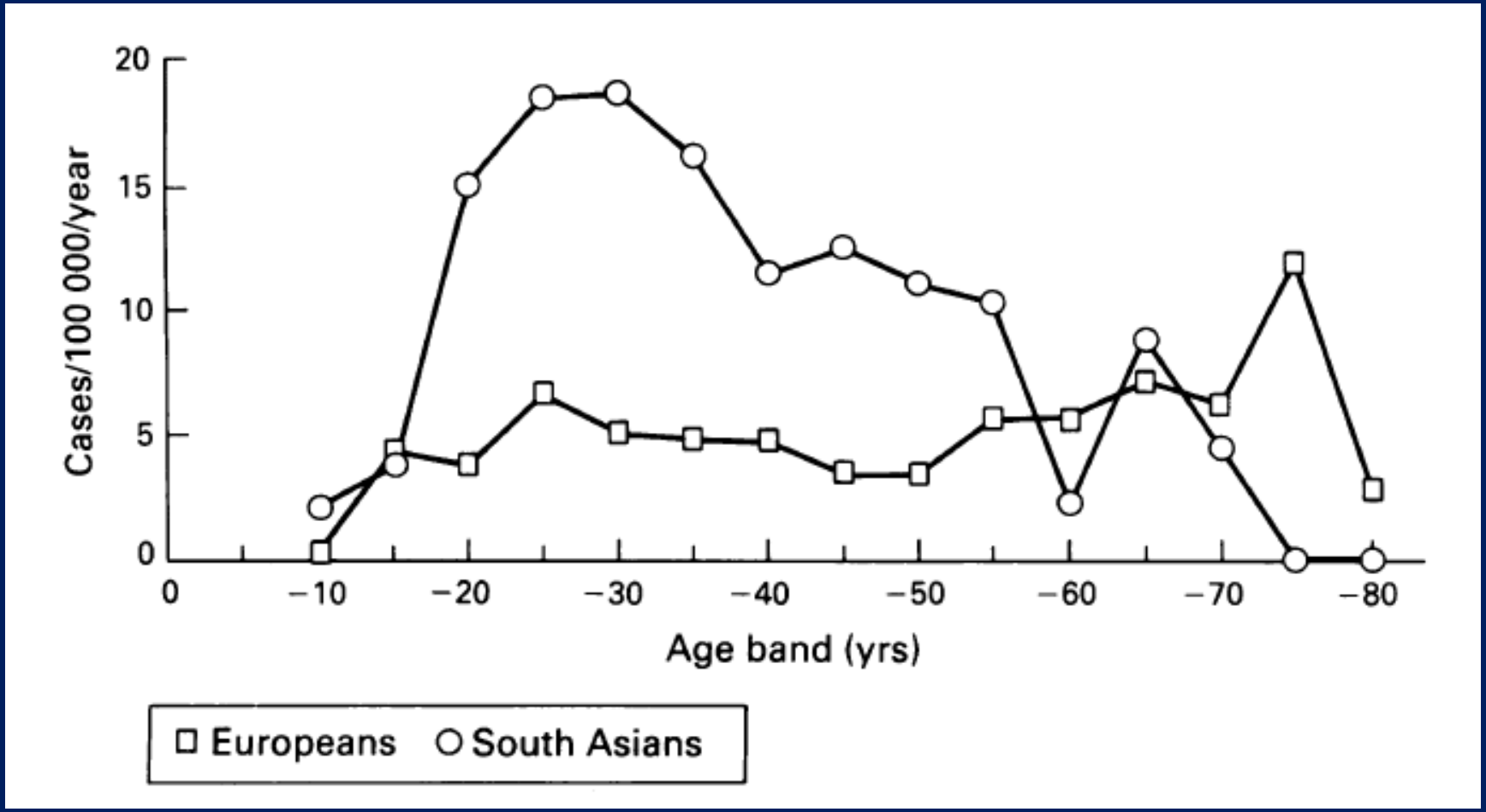
Epidemiological study of ulcerative proctocolitis in Indian migrants and the indigenous population of Leicestershire

C S J Probert, V Jayanthi, D Pinder, A C Wicks, J F Mayberry



Göçmenlerde ÜK sıklığında artış

GENÇ GÖÇMENLER – ÜK

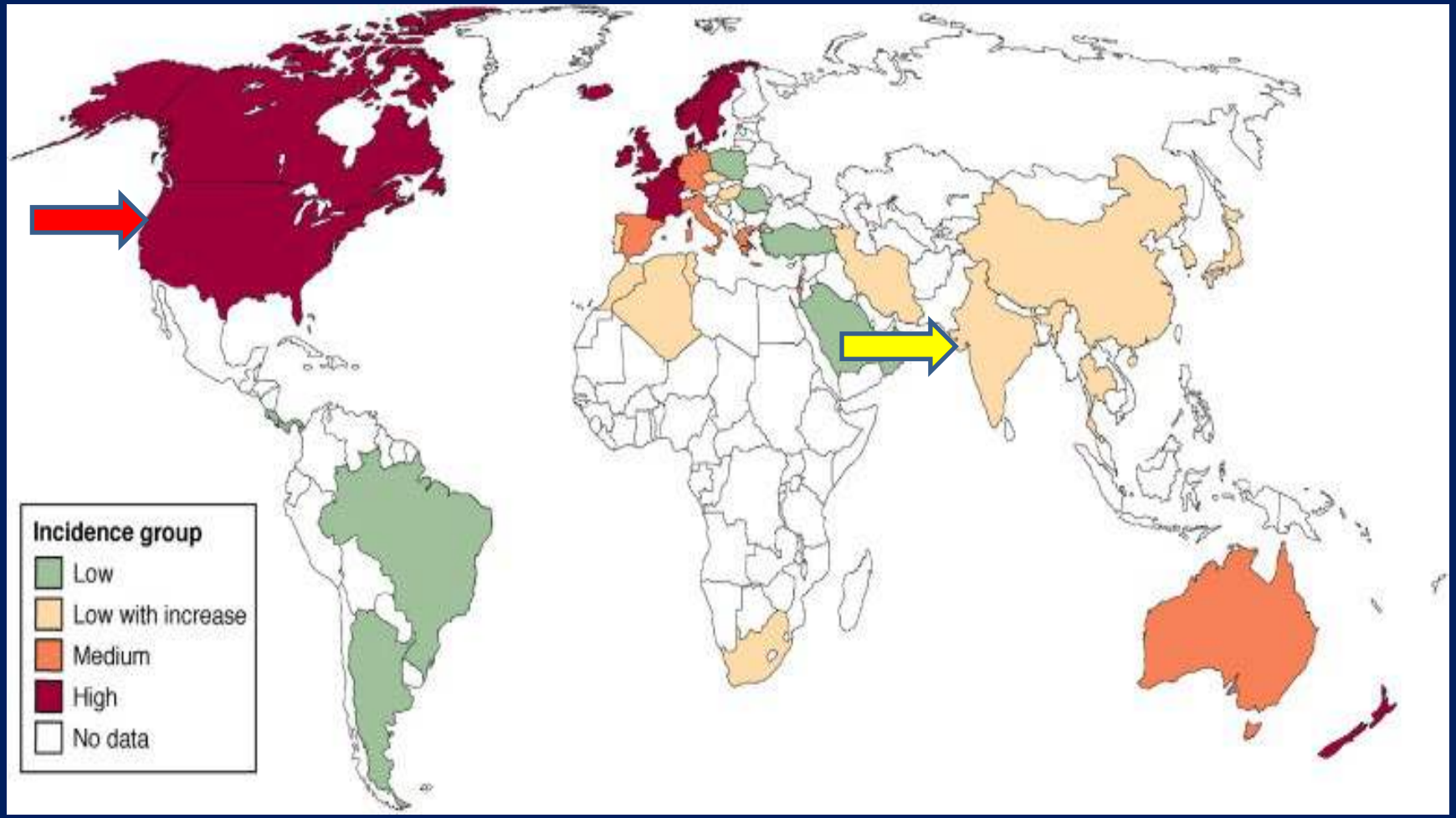


Genç göçmenlerde ÜK sıklığında dramatik artış

İBH – GÖÇMEN ÇALIŞMALARI

- 1. Genetik yatkınlık olmalı.
- 2. Bölgede çevresel faktör(-ler) olmalı.
- 3. Çocukluk çağında çevre daha belirleyici.

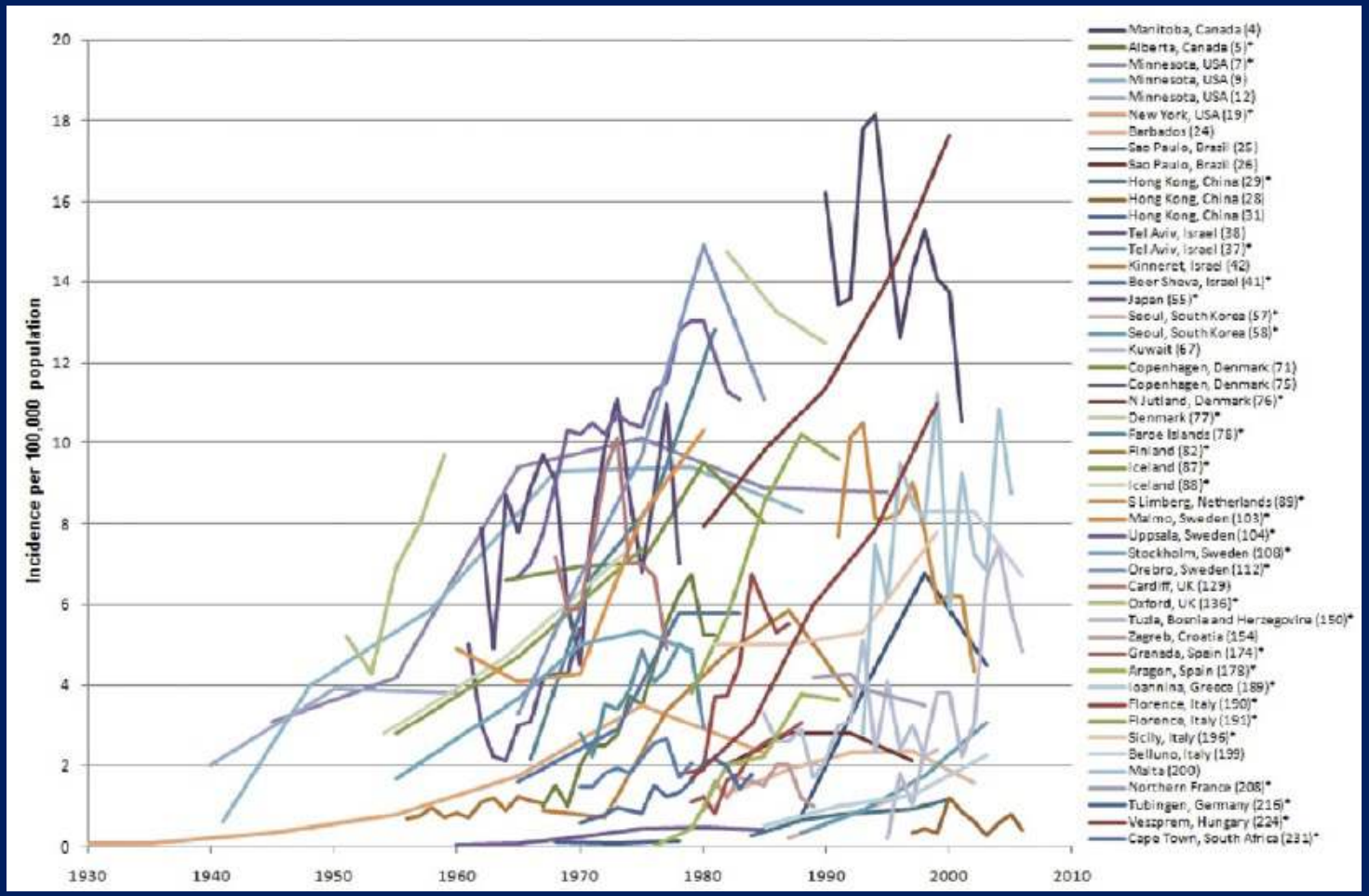
İBH – EPİDEMİYOLOJİ



ÜLSERATİF KOLİT

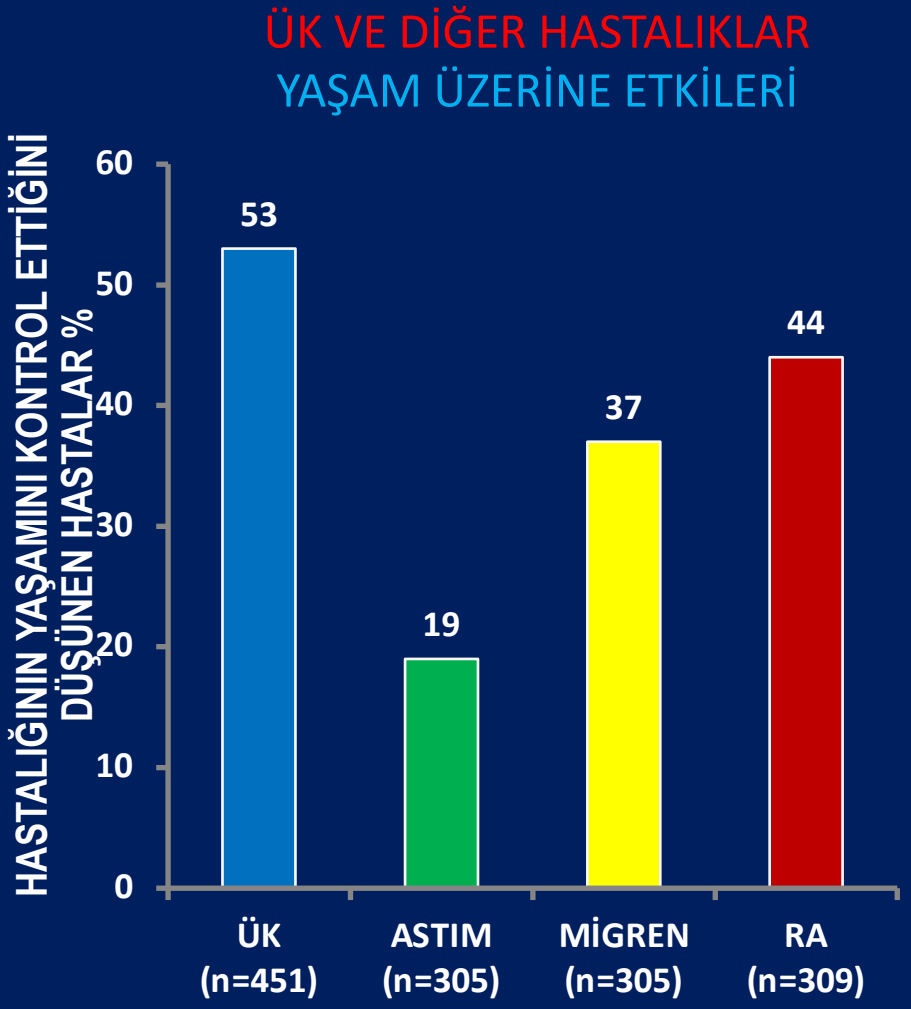
DÜNYADA ÜLSERATİF KOLİT İNSİDANSI

1930-2010



Molodecky NA. *Gastroenterology* 2012; **142**: 46–54

ÜLSERATİF KOLİT – YAŞAMI OLUMSUZ ETKİLER

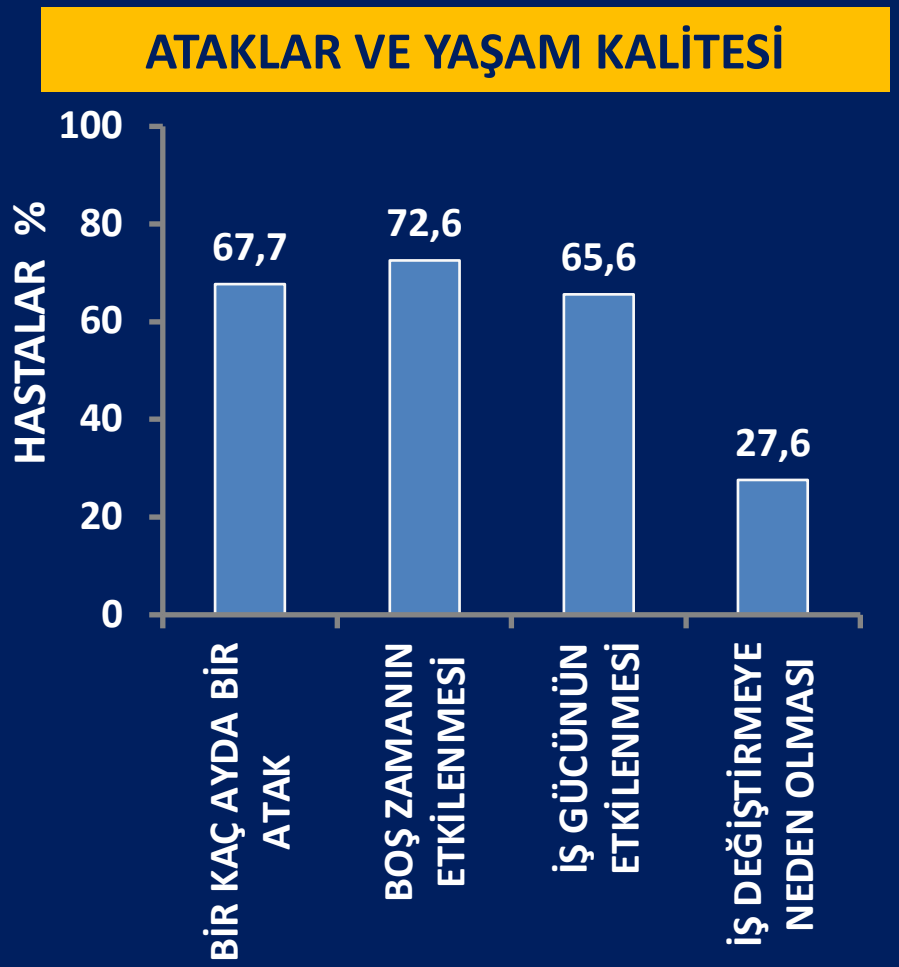


PSİKOLOJİK HASAR	HASTALAR %
HASTALIĞIN GELECEKTEKİ ETKİLERİ HAKKINDA TASALANMA	83.9
HAYATI DAHA STRESLİ YAŞAMA	81.6
HASTALIĞINDAN UTANÇ DUYMA	70.1
HASTALIĞINI PAYLAŞMAK İSTEMEME	66.3
HASTALIĞIYLA İLGİLİ DEPRESİF HİSSETME	62.3

Rubin DT. *Dig Dis Sci*. 2010; **55**:1044–52.

BİOLOJİK ÖNCESİ - ÜLSERATİF KOLİT SEMPTOMLAR VE YAŞAM KALİTESİ

SEMPTOM	HASTALAR (n=2,333) - %
REKTAL KANAMA	87.0
KRONİK İSHAL	84.5
HALSİZLİK	69.1
KİLO KAYBI	54.1
EKLEM AĞRISI	53.2

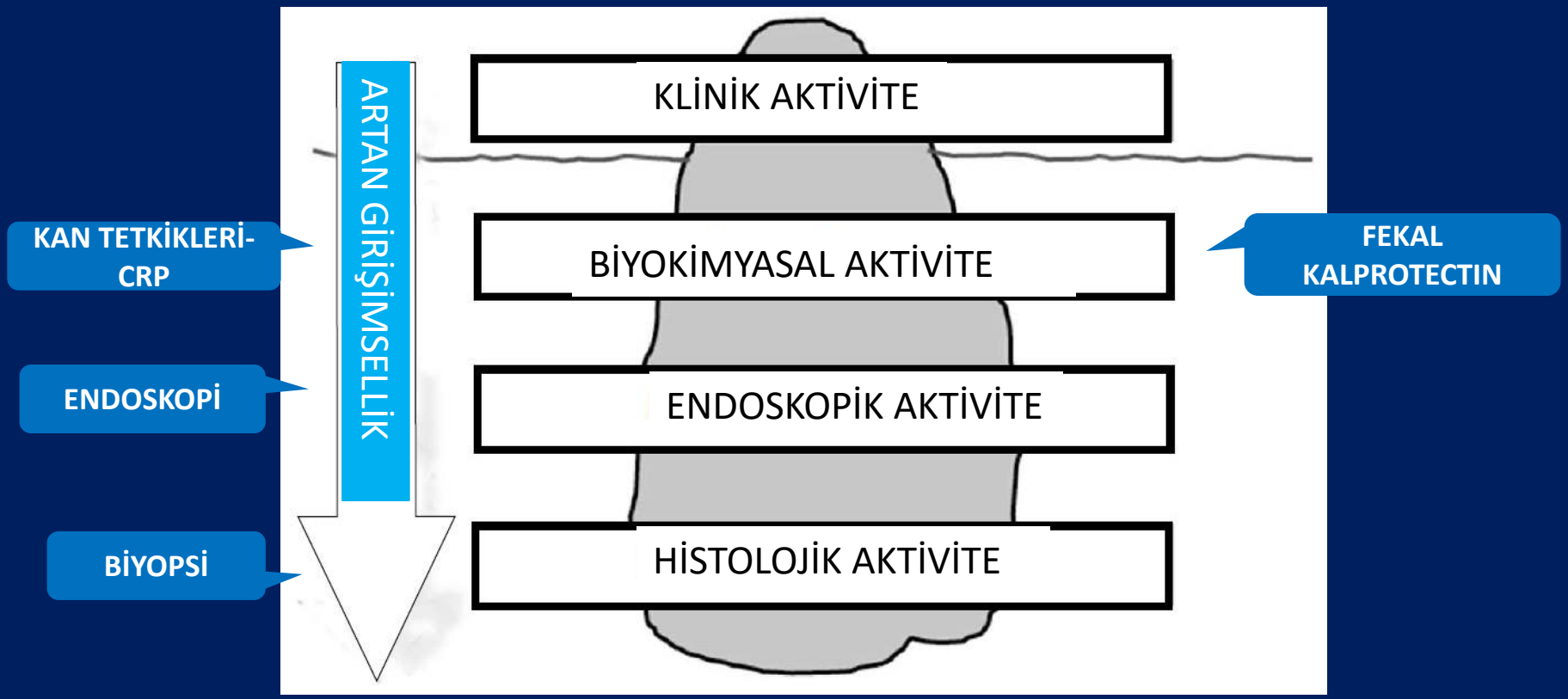


Ghosh S. *J Crohns Colitis*. 2007; **1**:10–20.

İBH'DA

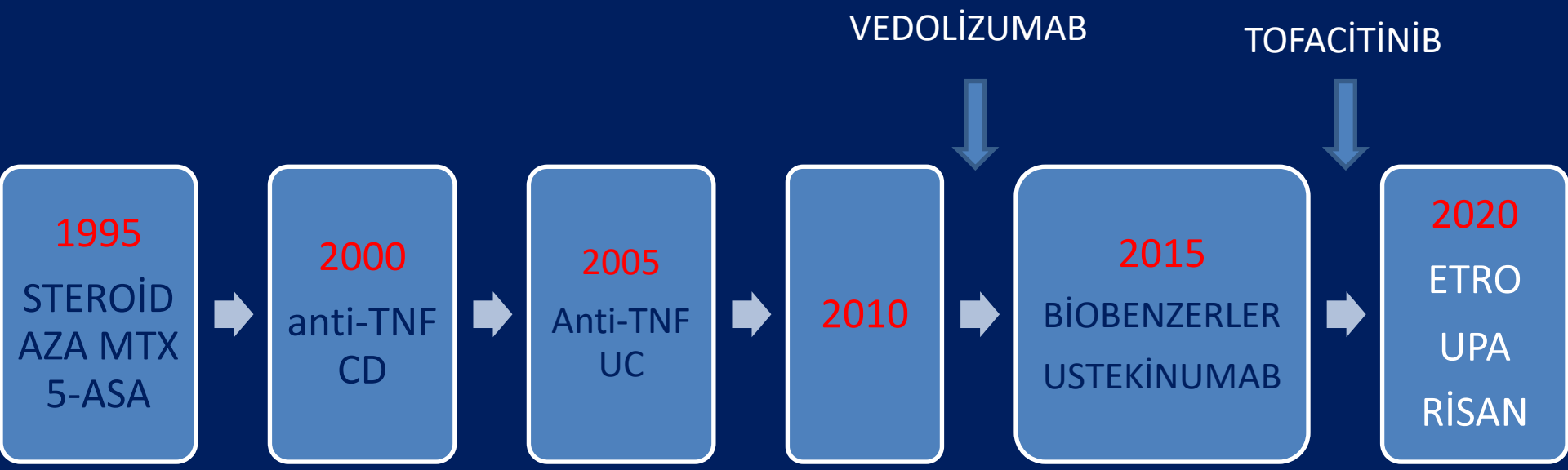
KLİNİK REMİSYON ≠ SÖNMÜŞ İNFLAMASYON

ICEBERG FENOMENİ

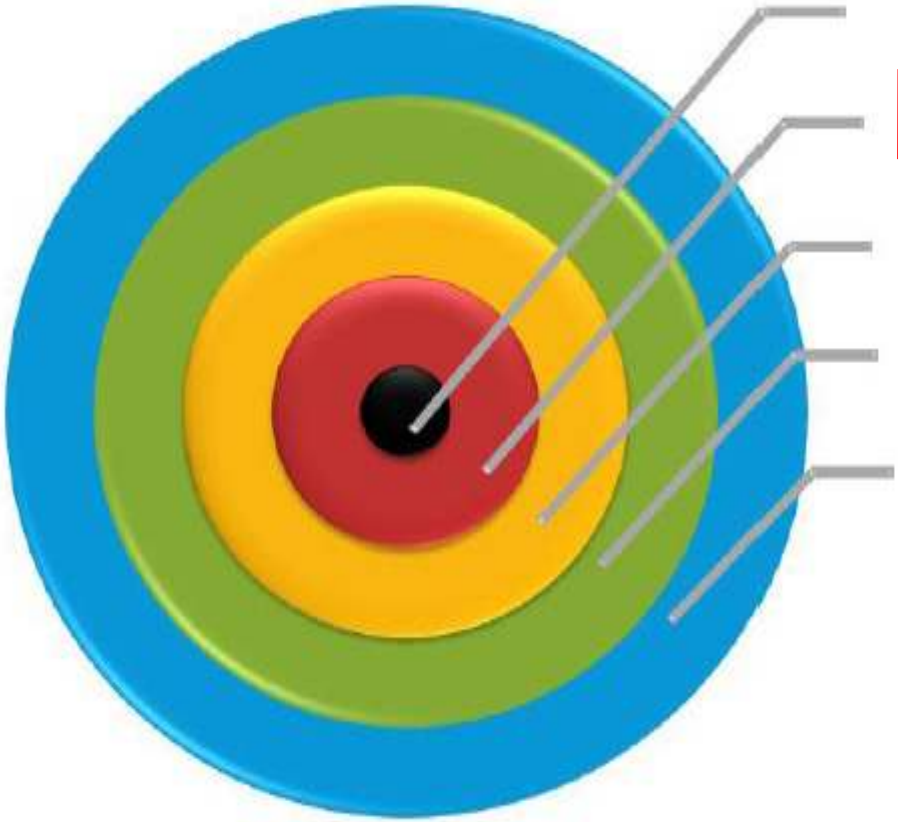


Rogler *et al*. *World J Gastroenterol* 2013; **19**: 7552-60.

İBH – İLAÇLARIN GELİŞİMİ



İBH'da TEDAVİ HEDEFLERİ



Derin remisyon [5]

Mukozal iyileşme [1–4]

Steroidsiz remisyon

Klinik remisyon

Semptom düzelmesi

1. Colombel JF *et al. N Engl J Med* 2010;362:1383–95.
2. Baert FJ *et al. Gastroenterology* 2010;138:463–68.
3. Sandborn WJ *et al. J Crohn's Colitis* 2010;4:S36:PO69 at ECCO.
4. Louis E *et al. Gastroenterology* 2012;142:63–70.
5. Colombel JF *et al. J Crohn's Colitis* 2010;4:S11:OP31 at ECCO.

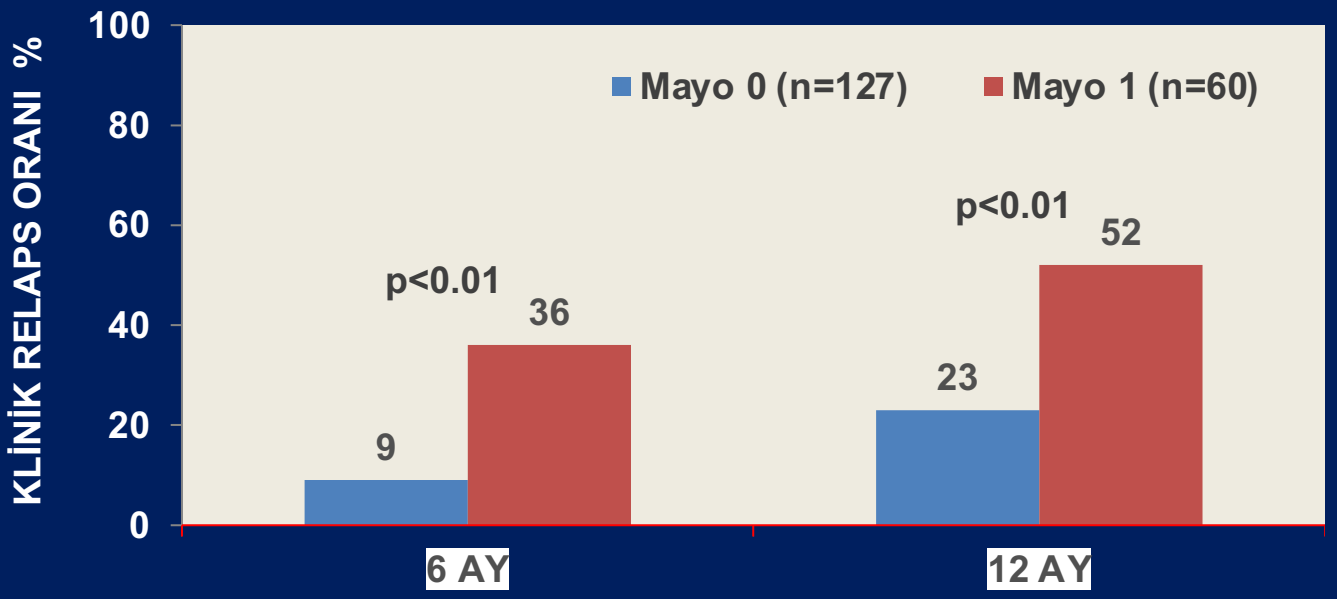
ÜLSERATİF KOLİT
KLİNİK REMİSYON (+) HASTALARDA ENDOSKOPİK AKTİVİTE

	TOPLAM (%)	Ü. KOLİT (%)	CROHN (%)
HASTA SAYISI	152	106	46
INFLAMASYON (-)	47 (31)	**33 (31)**	14 (31)
ENDOSKOPİK ve HİSTOLOJİK AKTİF	51 (34)	39 (37)	12 (27)
SADECE HİSTOLOJİK AKTİF	51 (34)	33 (31)	18 (40)
SADECE ENDOSKOPİK AKTİF	2 (1)	1 (1)	1 (2)

Baars et al. Inflamm Bowel Dis 2012;18:1634-40.

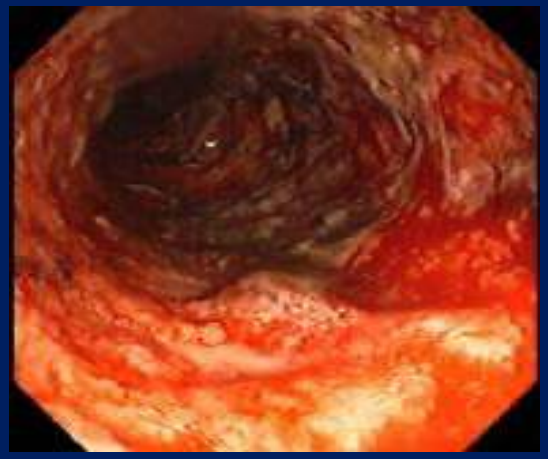
MAYO SKOR ‘’0 =1’’ ’MİDİR?

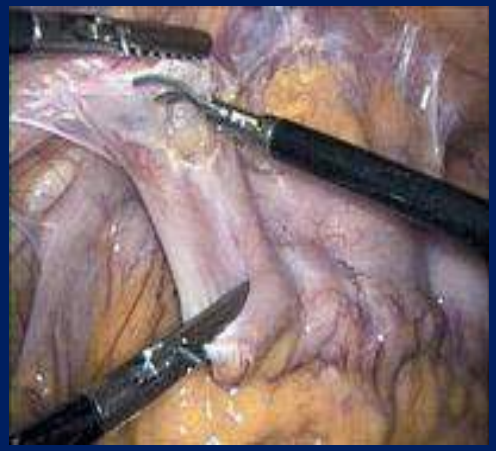
- 187 HASTALIK PROSPEKTİF SERİDE RELAPS ORANI
- RELAPS = İNDUKSİYON İHTİYACI, DOZ ARTTIRIMI, HOSPİTALİZASYON, KOLEKTOMİ



Barreiro-de Acosta *et al*. ECCO2014

ÜLSERATİF KOLİT - GERÇEKLER





PROKTOKOLEKTOMİ

MİDİR???

KOLEKTOMİ TAM BİR ÇÖZÜM MÜDÜR?

- MORTALİTE (2.5%)[1]
- DIŞKILAMA SIKLIĞI 3–10 /gün[1]
- BRİD İLEUS (20%)[1]
- POŞİT (10–60%)[1]
- POŞ-VAGİNAL FİSTÜL (4%)[1]
- İMPOTANS (1.5%)[2]
- KADIN FERTİLİTE AZALMASI (56–98%)[3–5]

1. Sagar PM *et al.* eds. *IBD* Spain: Elsevier Limited; 2003:491–11;
2. Pemberton JH *et al*. *Ann Surg* 1987;206(4):504–13;
3. Olsen KO et al. *Gastroenterology* 2002;122:15–19;
4. Johnson P *et al. Dis Colon Rectum* 2004;47;1119–26;
5. Gorgun E *et al*. *Surgery* 2004;136(4):795–803.

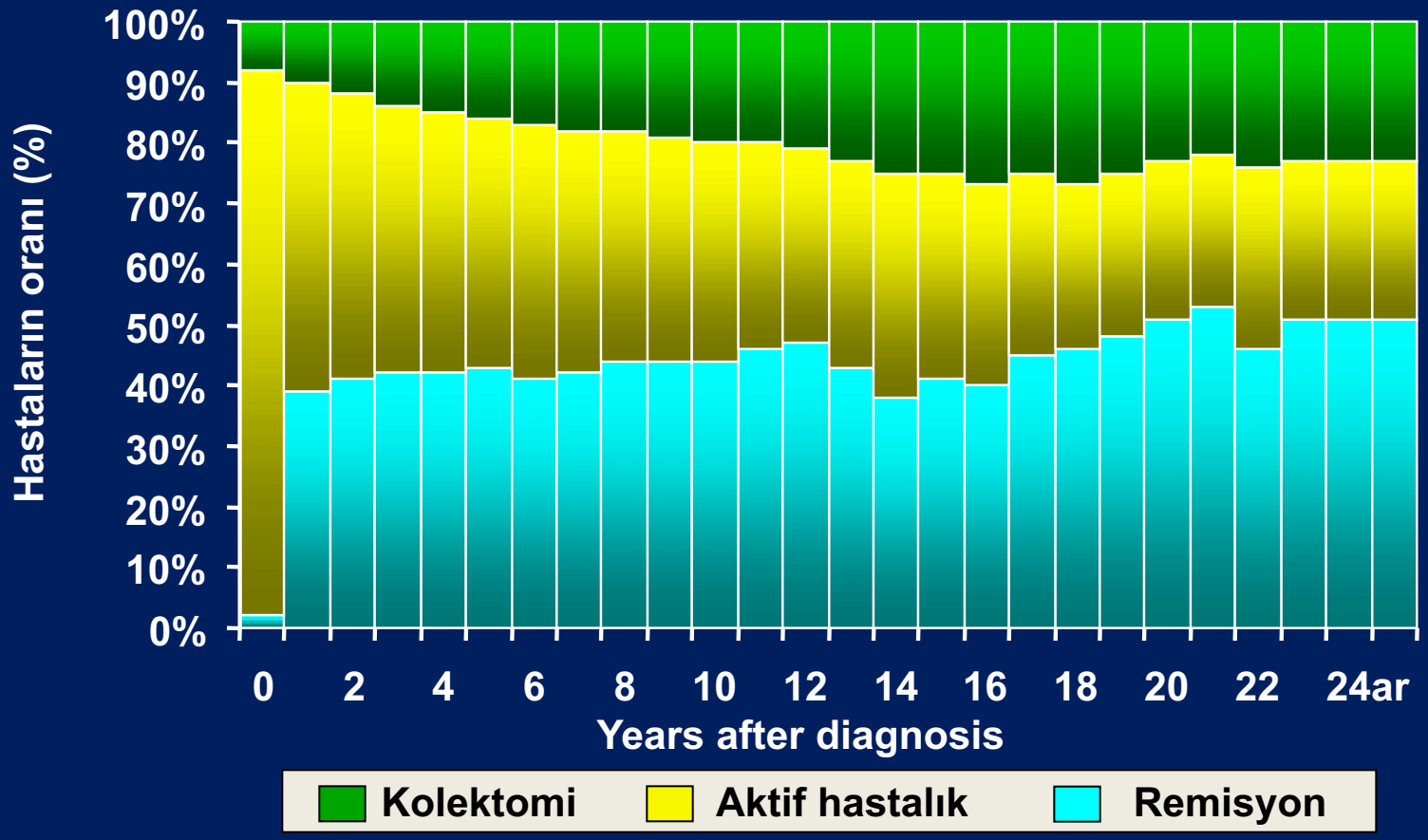
MUKOZAL İYİLEŞME=AZALMIŞ KOLEKTOMİ RİSKİ

NO BIOLOGICS

Frøslie KF *et al. Gastroenterology* 2007;133:412–22.

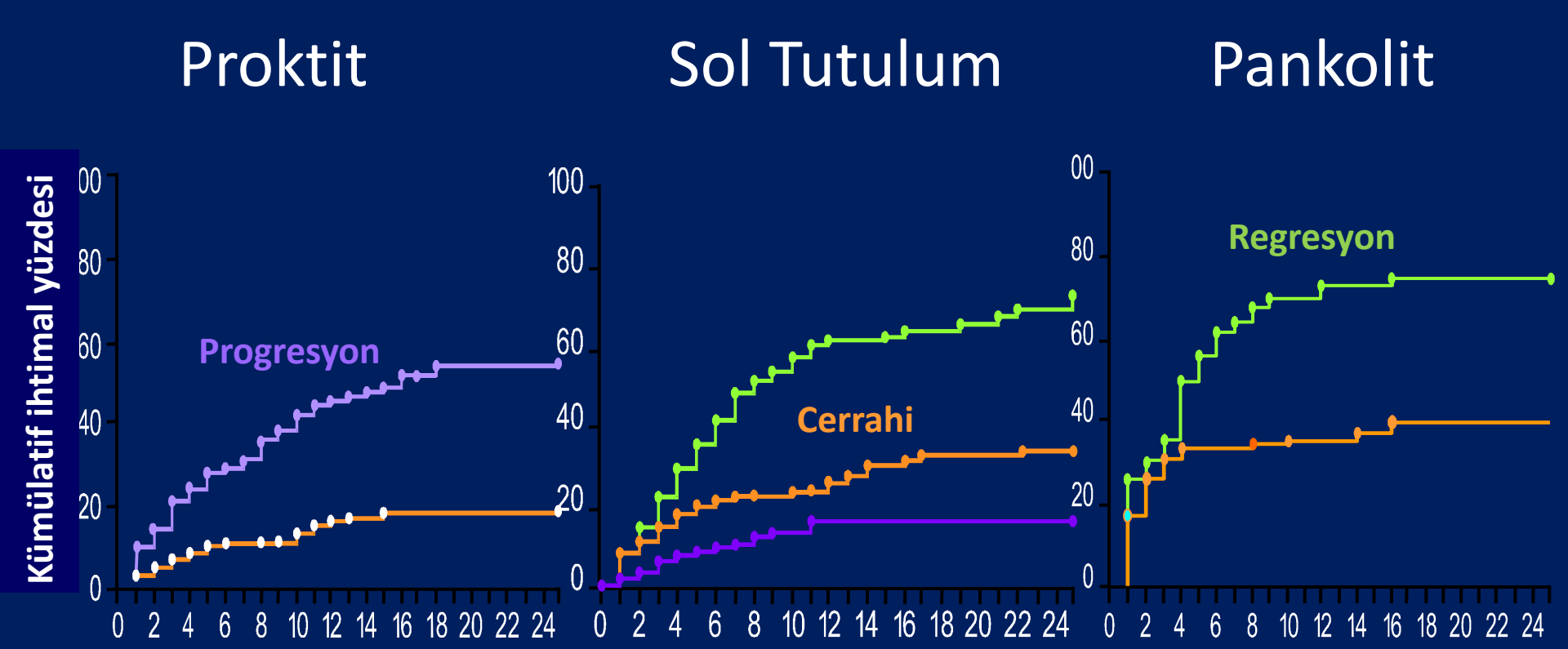
ÜLSERATİF KOLİT DOĞAL SEYİR

"Hastaların yaklaşık %20'si 10 yıl içerisinde kolektomiye maruz kalıyor"



Langholz E et al. Gastroenterology 1994;107:3-11.

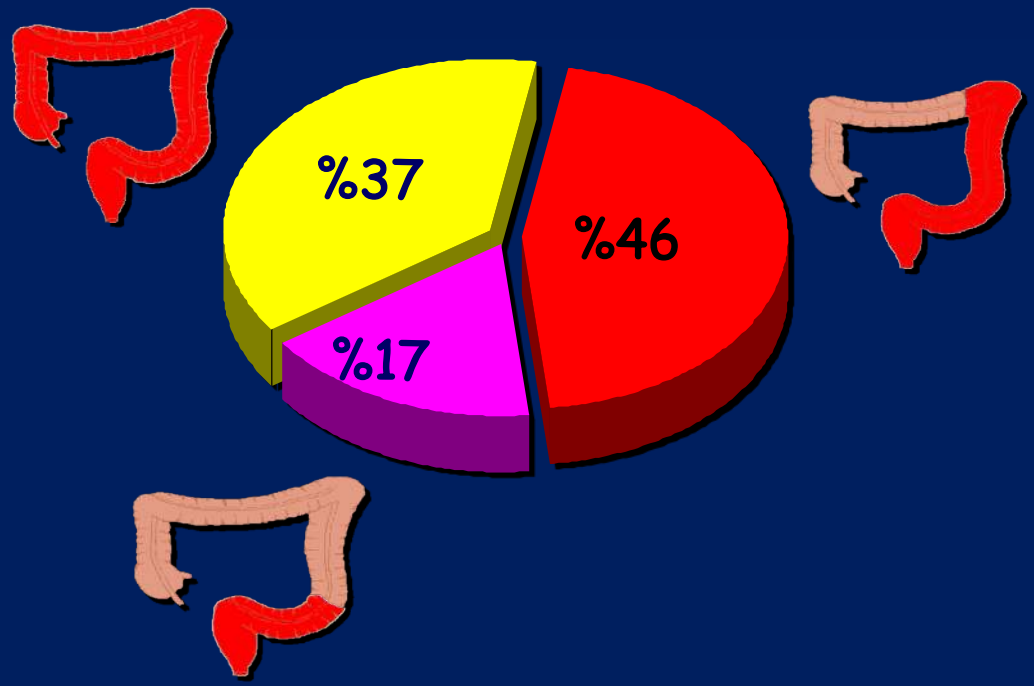
Ülseratif Kolitin Doğal Seyri



Langholz E, *et al*. *Scand J Gastroenterol* 1996; **31**: 260-6.

MEDİKAL TEDAVİYE YÖN VERENLER 1.

TUTULUM ALANI ve HASTALIK AKTİVİTESİ



Farmer RG, *et al*. *Dig Dis Sci* 1993; **38**: 1137-46.

MEDİKAL TEDAVİYE YÖN VERENLER 2.

Hastalık Aktivitesi

Table 1. Criteria for Evaluating the Severity of Ulcerative Colitis.*

Variable	Mild Disease	Severe Disease	Fulminant Disease
Stools (no./day)	<4	>6	>10
Blood in stool	Intermittent	Frequent	Continuous
Temperature (°C)	Normal	>37.5	>37.5
Pulse (beats/min)	Normal	>90	>90
Hemoglobin	Normal	<75% of normal value	Transfusion required
Erythrocyte sedimentation rate (mm/hr)	≤30	>30	>30
Colonic features on radiography	—	Air, edematous wall, thumbprinting	Dilatation
Clinical signs	—	Abdominal tenderness	Abdominal distention and tenderness

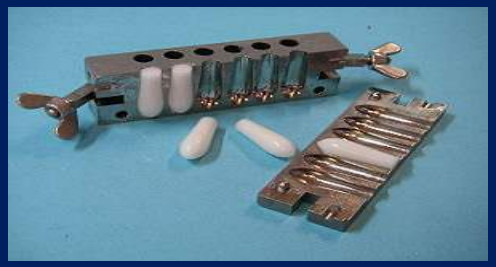
*Based on the criteria of Truelove and Witts.[12] Moderate disease includes features of both mild and severe disease.

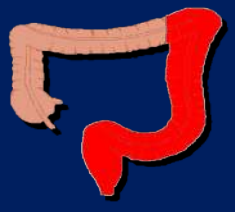
HAFİF-ORTA AKTİF ÜK İNDUKSİYON TEDAVİSİ

- 5-ASA

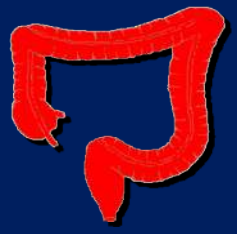
  hafif- orta aktivitede remisyon ve idamede ilk seçenek

  - TOPİKAL (DİSTAL HASTALIK)

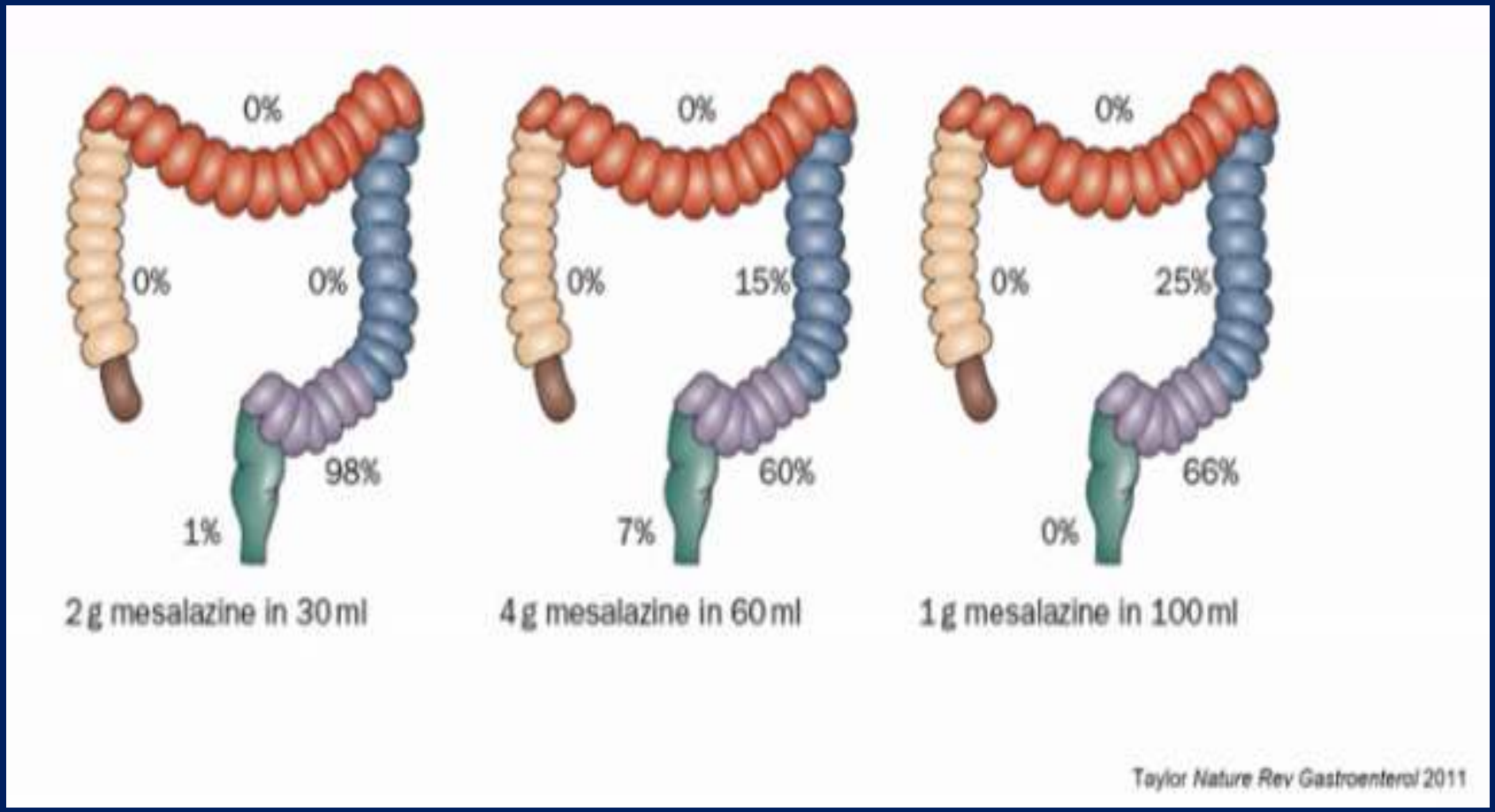




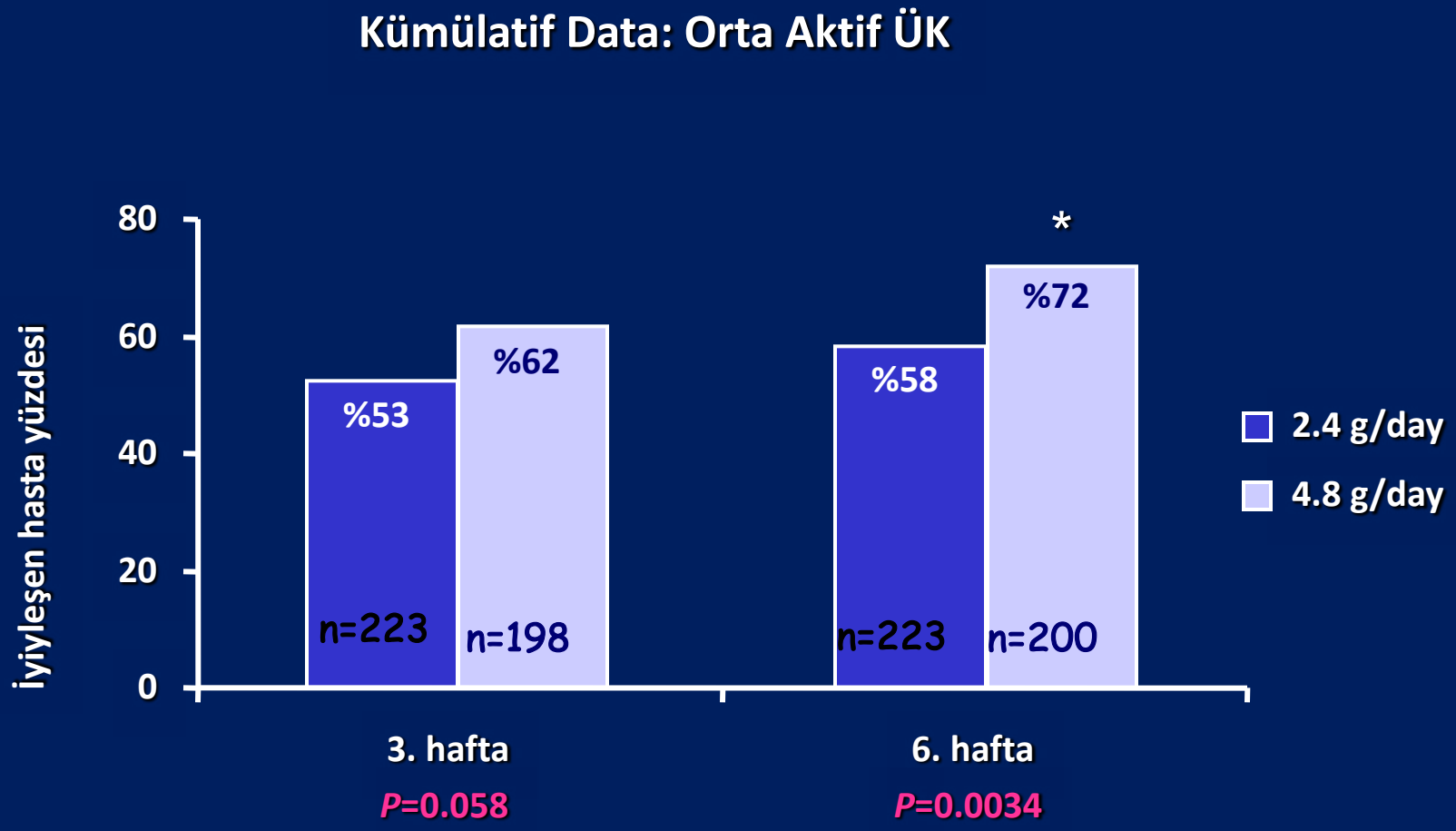
  - ORAL(YAYGIN HASTALIK)



REKTUMDA ETKİLİ OLMAK İSTERSEK?
SUPPOZİTUAR???



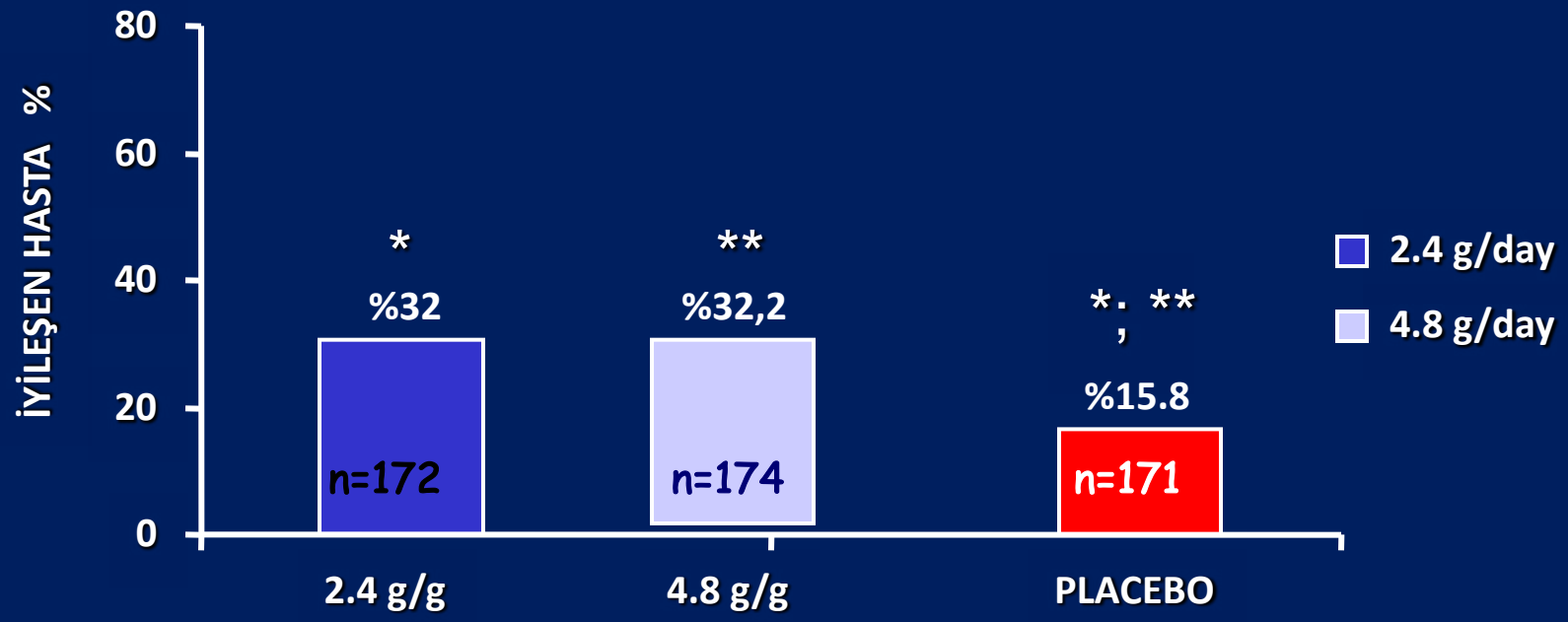
ASCEND I & II – KLİNİK REMİSYON 5-ASA DOZ BAĞIMLI ETKİ



Hanauer SB, *et al*. *Am J Gastroenterol* 2005; 100: 2478-85.

5-ASA – MUKOZAL İYİLEŞME 8. HAFTA

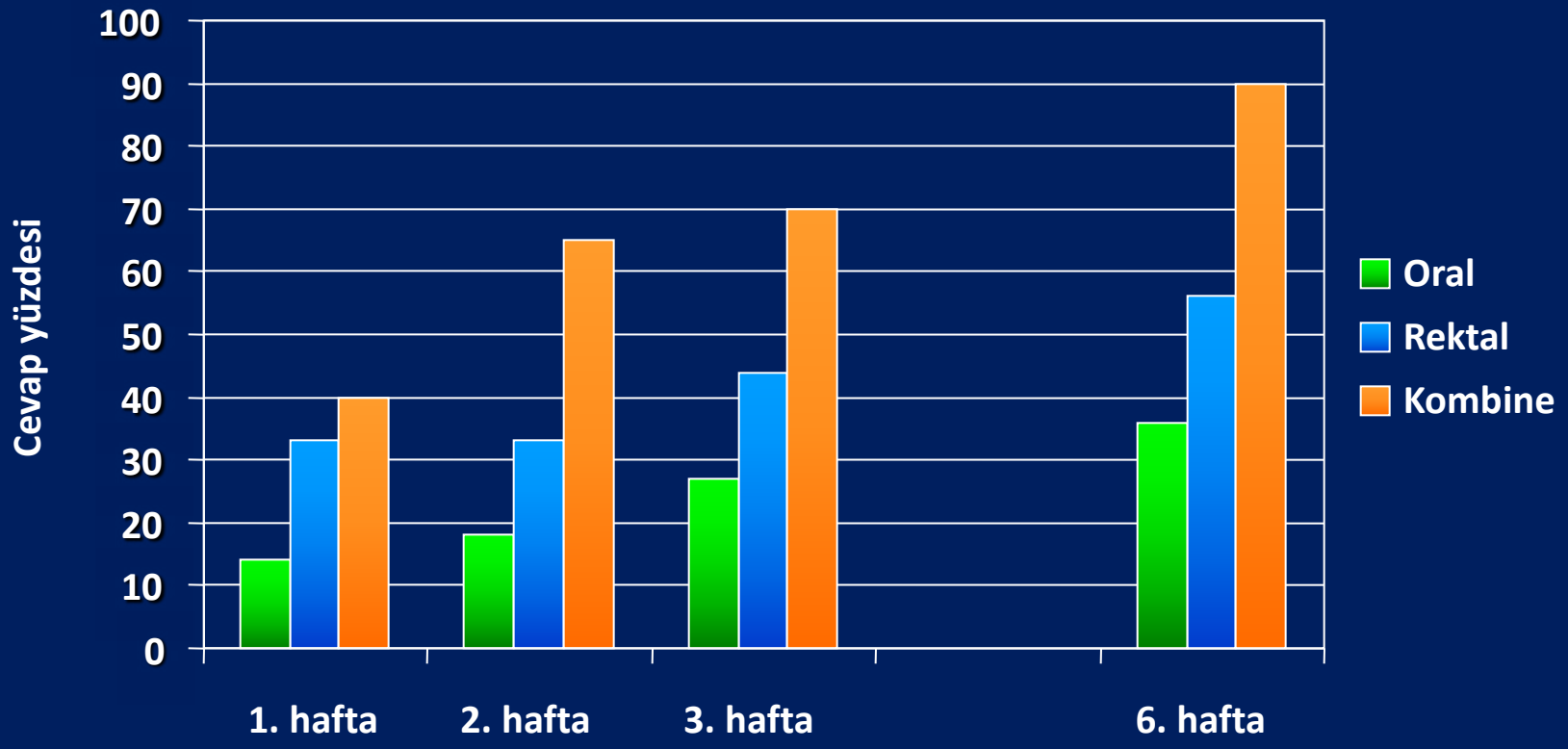
ORTA AKTİF ÜLSERATİF KOLİT
REMİSYON İNDUKSİYONU



*; ** p<0.05

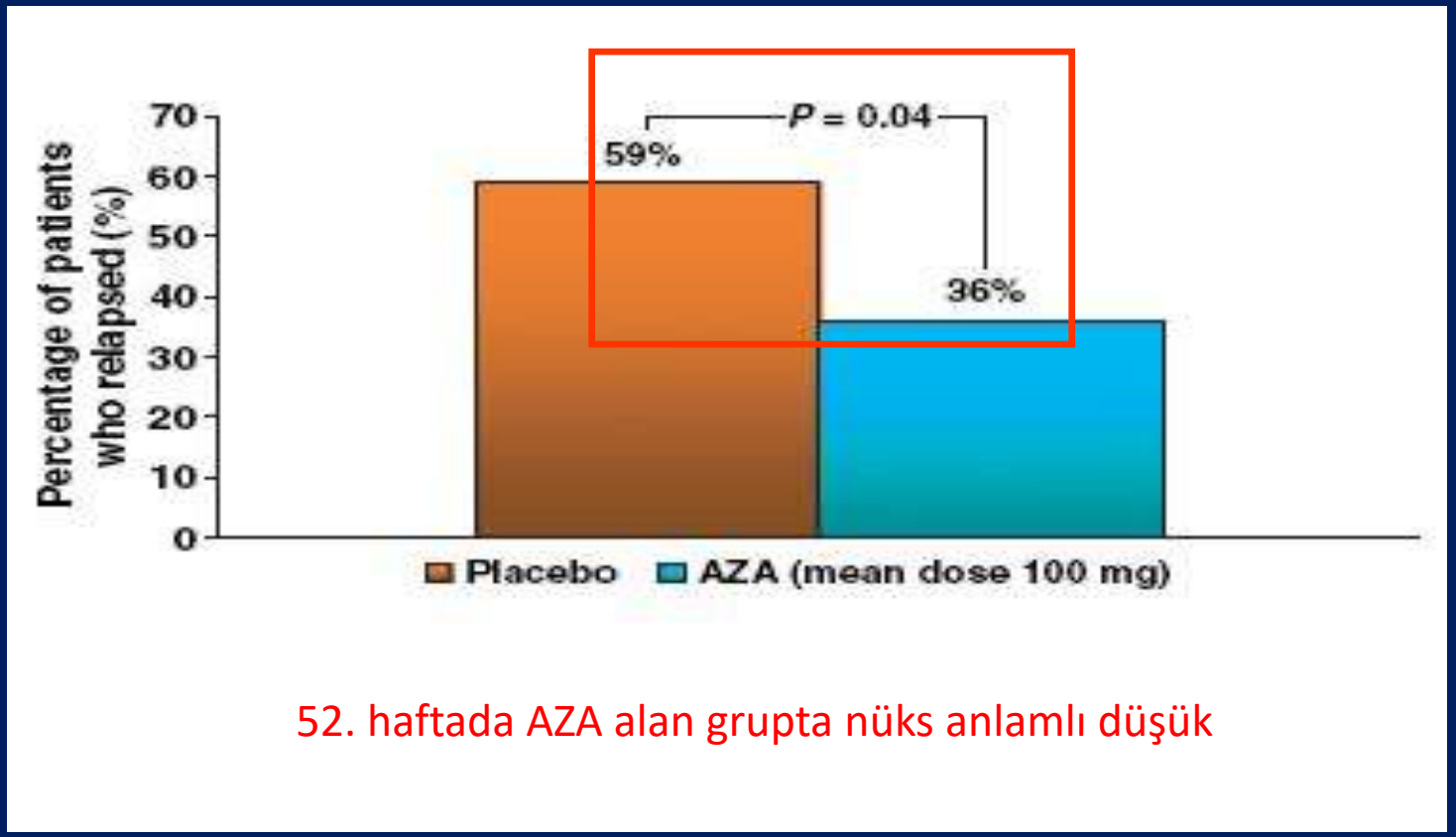
Sandborn WJ, *et al. Aliment Pharmacol Ther* 2007; 26: 205-15.

HAFİF-ORTA AKTİF ÜK REMİSYON İNDUKSİYONU 5-ASA ORAL – LOKAL – KOMBİNE TEDAVİLER



Safdi, et al. *Am J Gastroenterol* 1997

ÜLSERATİF KOLİTTE AZA



52. haftada AZA alan grupta nüks anlamlı düşük

Hawthorne AB, *et al. BMJ* 1992; **305**: 20-2.

STEROİD BAĞIMLI ÜK'TE AZA

- Hedef: Steroid kesilmesi + klinik ve endoskopik remisyon

Table 3 Outcome of the study drugs

	AZA	5-ASA	Total	p Value*	OR* (95% CI)
Intent to treat					
Success	19 (53 %)	7 (19 %)	26		
Failure	17 (47 %)	29 (81 %)	46		4.78 (1.57–14.5)
Total	36	36	72	0.006	
Per protocol					
Success	19 (58 %)	7 (21 %)	26		
Failure	14 (42 %)	27 (79 %)	41	0.003	5.26 (1.59–18.1)
Total	33	34	67		

OR (95% CI), odds ratio (95% confidence interval).
AZA, azathioprine; 5-ASA, 5-aminosalicylic acid.
*From logistic regression models including terms for age and sex.

AZA ile kombine tedavide steroidin tamamen kesilmesi ve tam remisyon hedefine yaklaşık 2 hastadan 1'inde ulaşılmış...

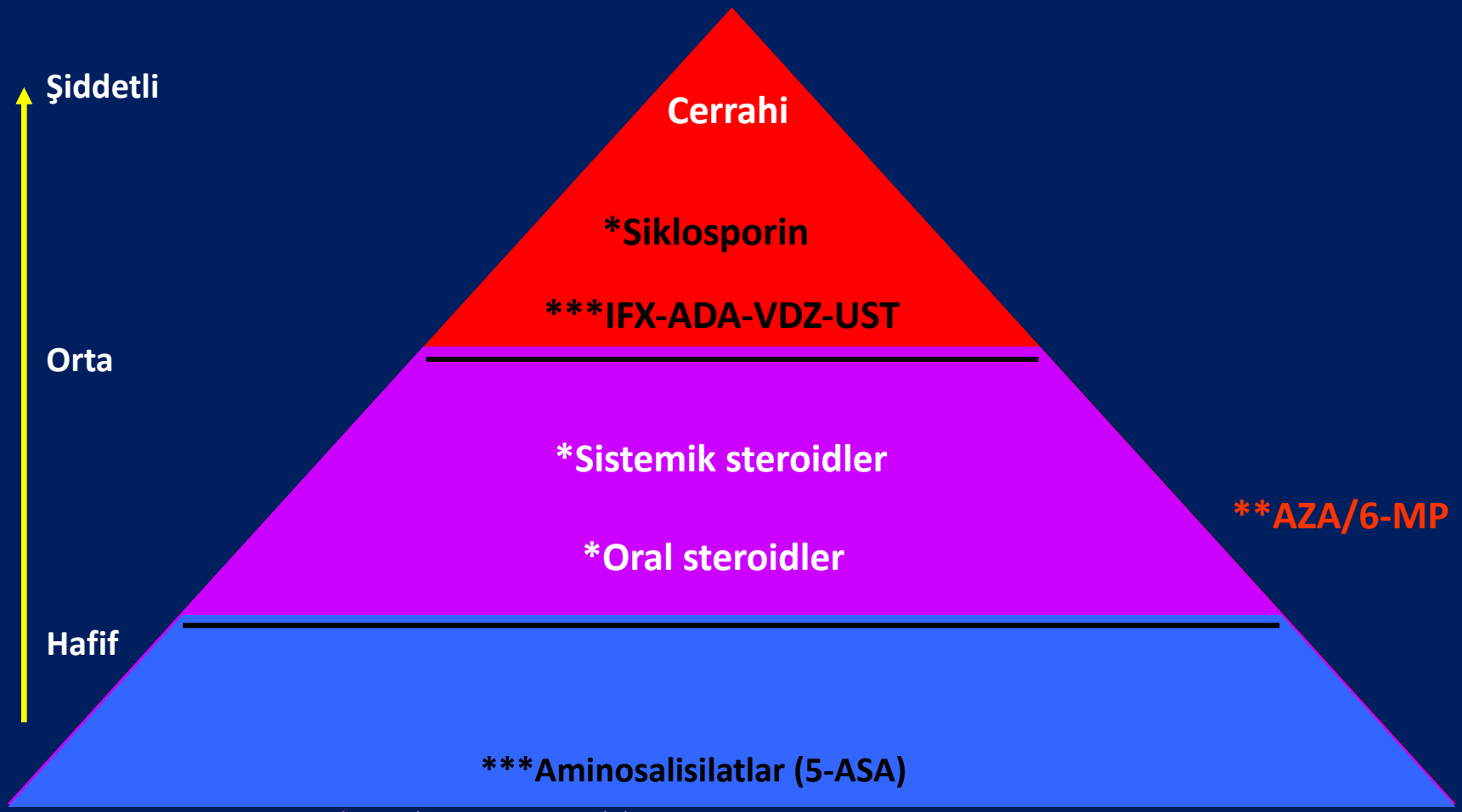
Ardizzone S, *et al. Gut* 2006; **55**: 47–53.

STEROİD CEVAPSIZLIĞI = ARTAN KOLEKTOMİ RİSKİ

%15

Faubion WA Jr *et al. Gastroenterology* 2001;121:255–60.

Ülseratif Kolitte Tedavi Piramidi



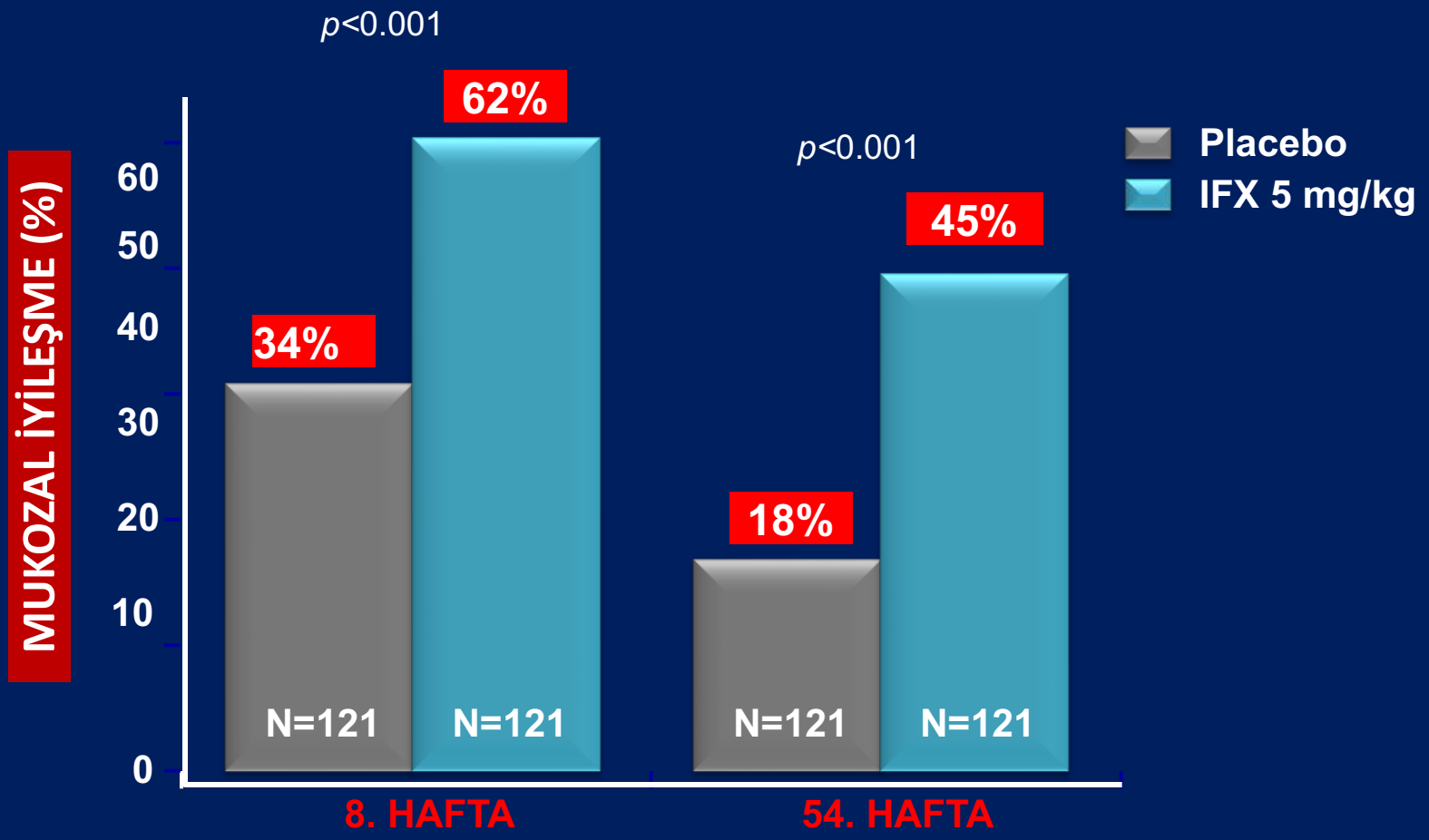
* Sadece remisyon induksiyonu

** Sadece remisyonun idamesi

*** Hem remisyon induksiyonu hem de remisyonun idamesi

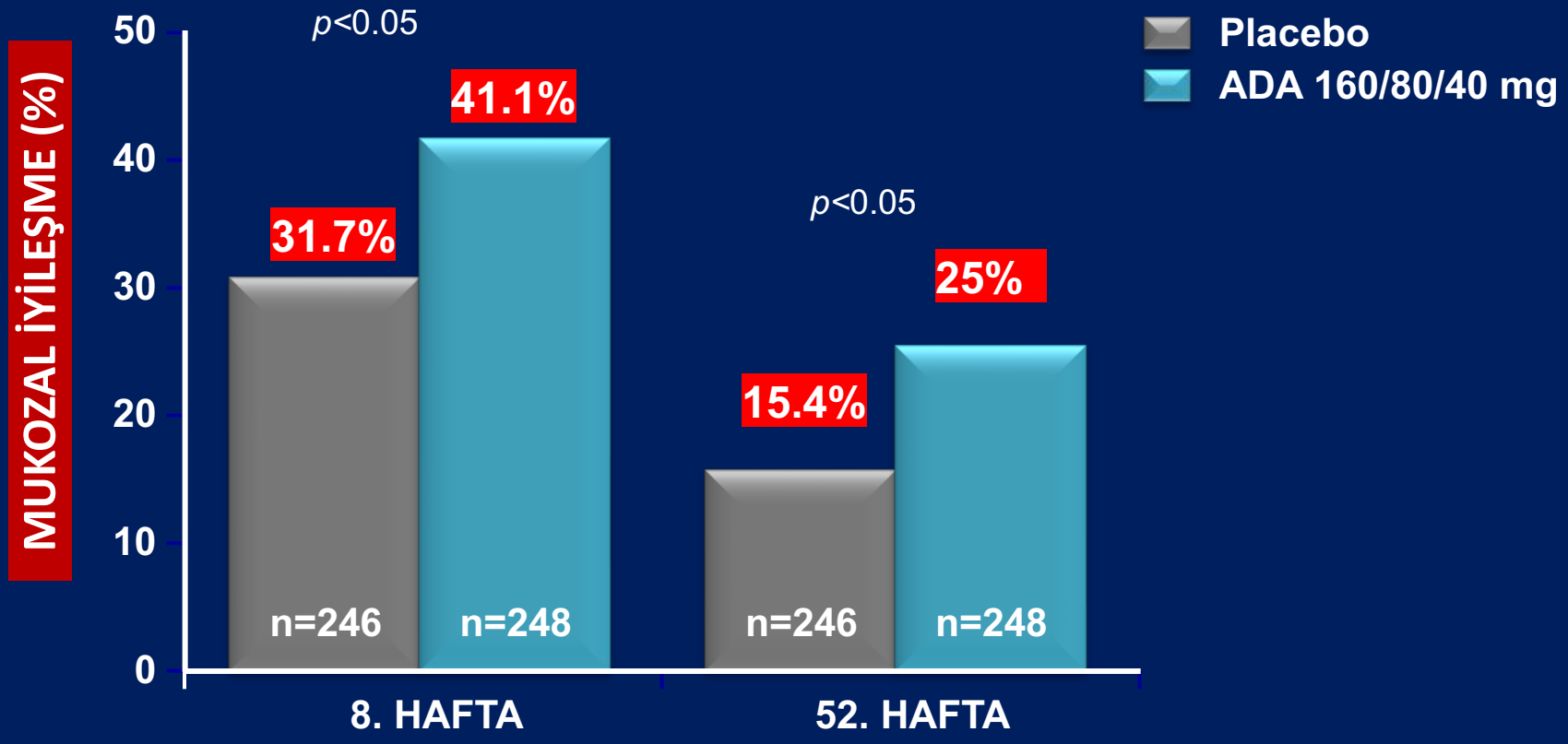
ÜLSERATİF KOLİTTE BİYOLOJİKLER

ACT-1: MUKOZAL İYİLEŞME



Rutgeerts P. *NEJM* 2005; **353**:2462-76.

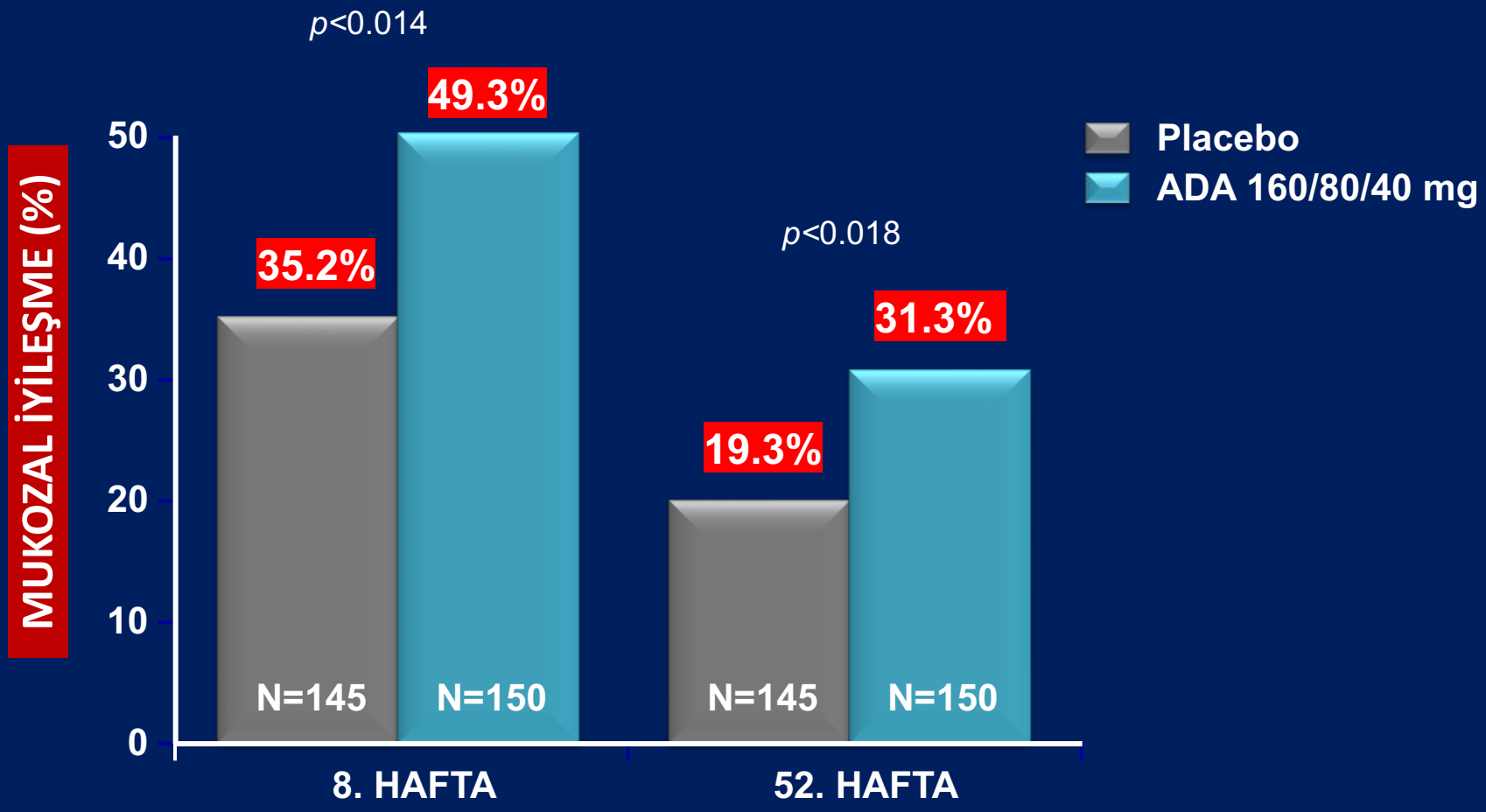
ULTRA 2: MUKOZAL İYİLEŞME – TÜM HASTALAR



ITT ; NRI METODUYLA
MUKOZAL İYİLEŞME = ENDOSKOPİ SKORU 0 YA DA 1

Sandborn W, *et al. Gastroenterology* 2012; 142: 257–65

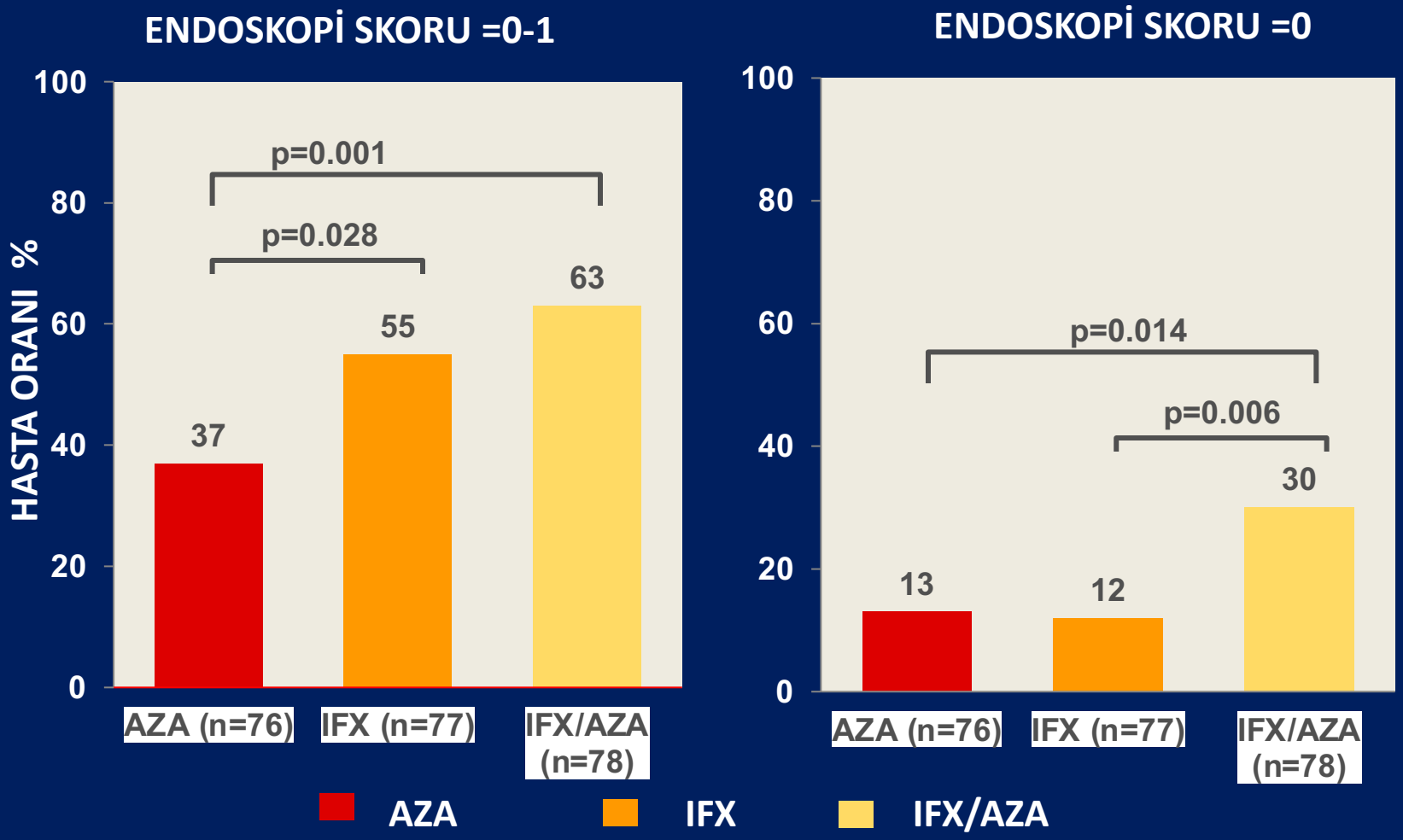
ULTRA 2: MUKOZAL İYİLEŞME – anti-TNF naif HASTALAR



ITT ; NRI METODUYLA
MUKOZAL İYİLEŞME = ENDOSKOPİ SKORU 0 YA DA 1

Sandborn W, *et al. Gastroenterology* 2012; 142: 257–65

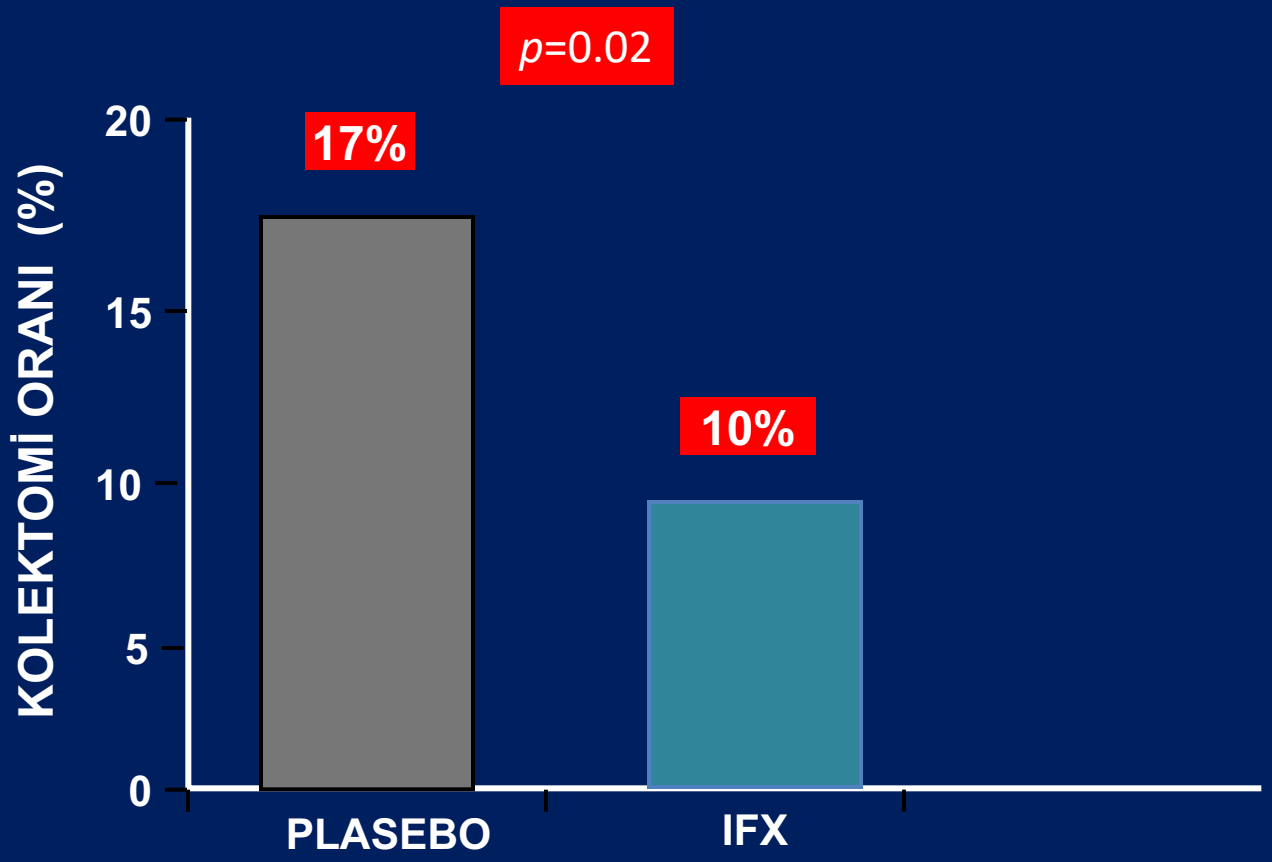
16. HAFTA MUKOZAL İYİLEŞME



Panaccione *et al*. *Gastroenterology* 2014:**146**;392-400.

ACT-1 – ACT-2 KOLEKTOMİ ORANLARI

728 HASTA - 54. HAFTA

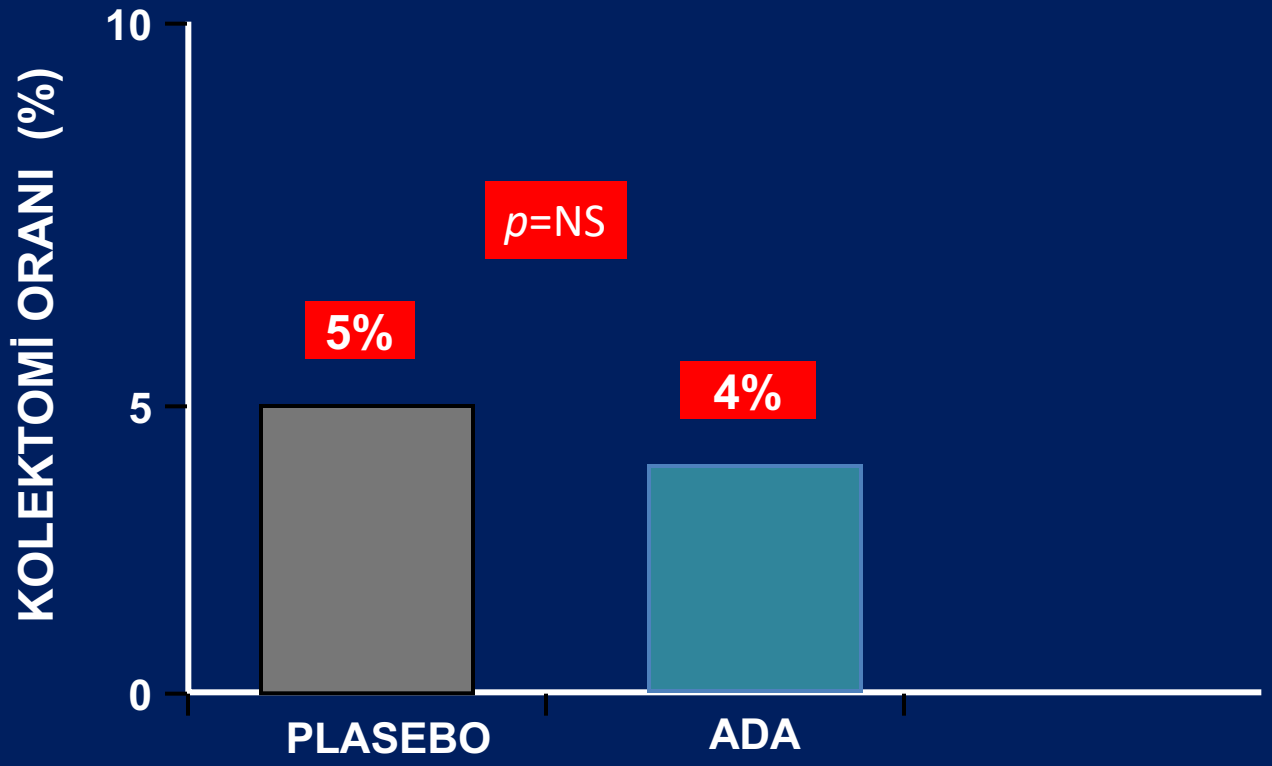


Sandborn W, *et al. Gastroenterology* 2012; 142: 257–65

ULTRA-1 – ULTRA-2: KOLEKTOMİ ORANLARI

963 HASTA - 52. HAFTA

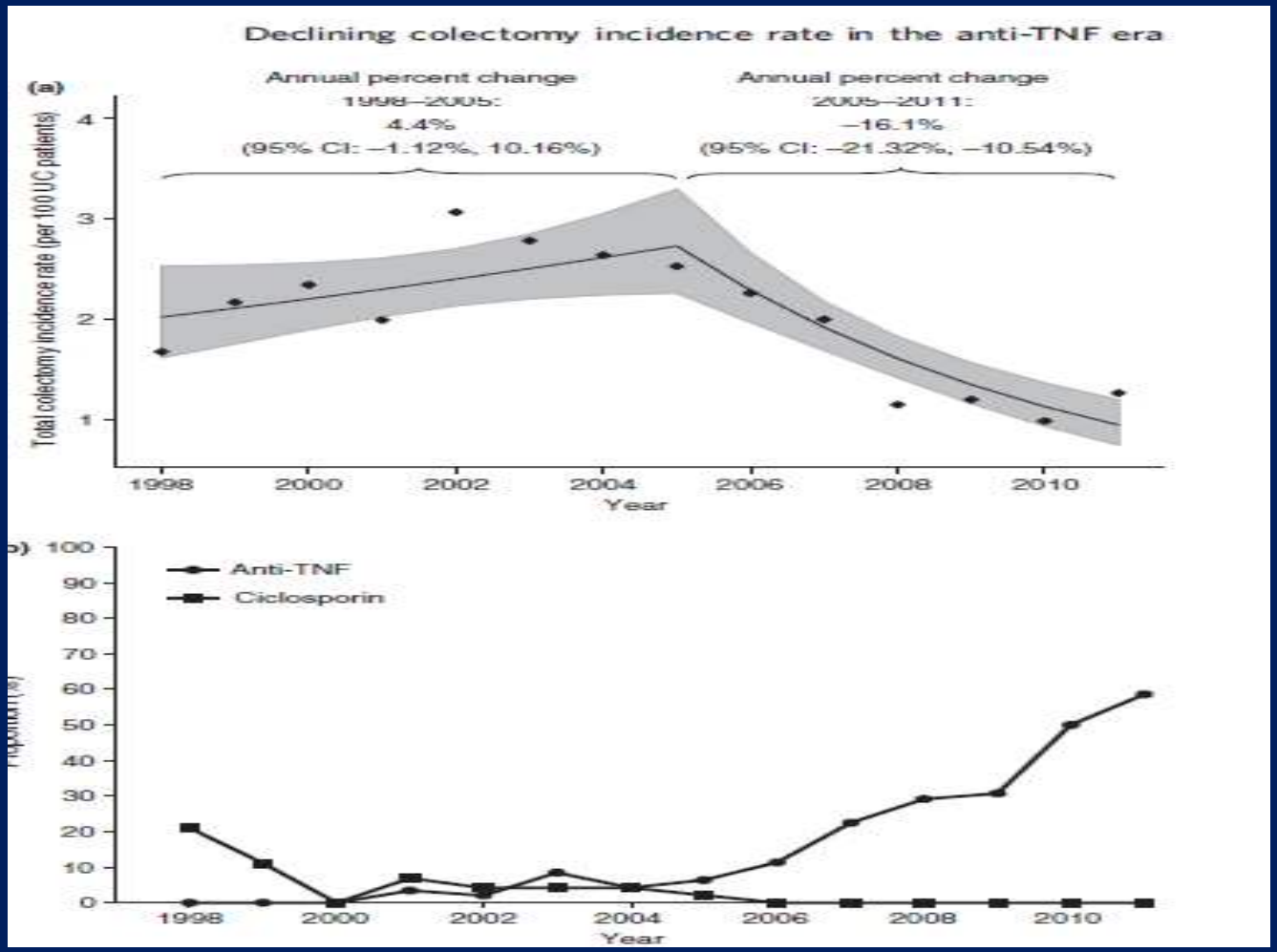
ULTRA-2: %40 HASTA IFX ALMIŞ



Feagan BG. *Gastroenterology* 2014; 146: 110–8.

TOPLUM BAZLI KOHORTLAR NE DİYOR?

KANADA



Reich KM. *Aliment Pharmacol Ther* 2014; **40**: 629–638

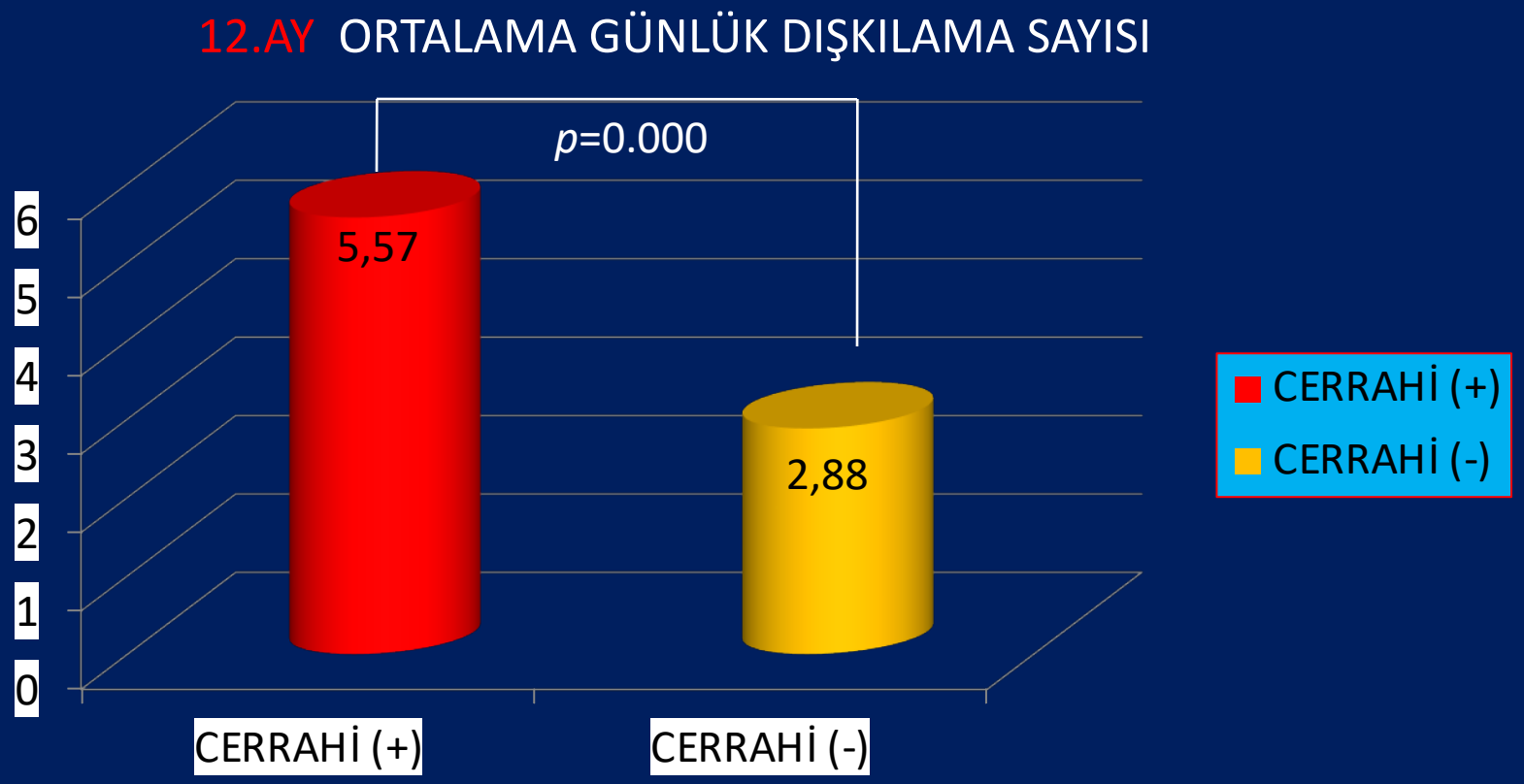
CERRAHPAŞA 2015

Ü. KOLİT BİYOLOJİK ALTINDA CERRAHİ ORANI

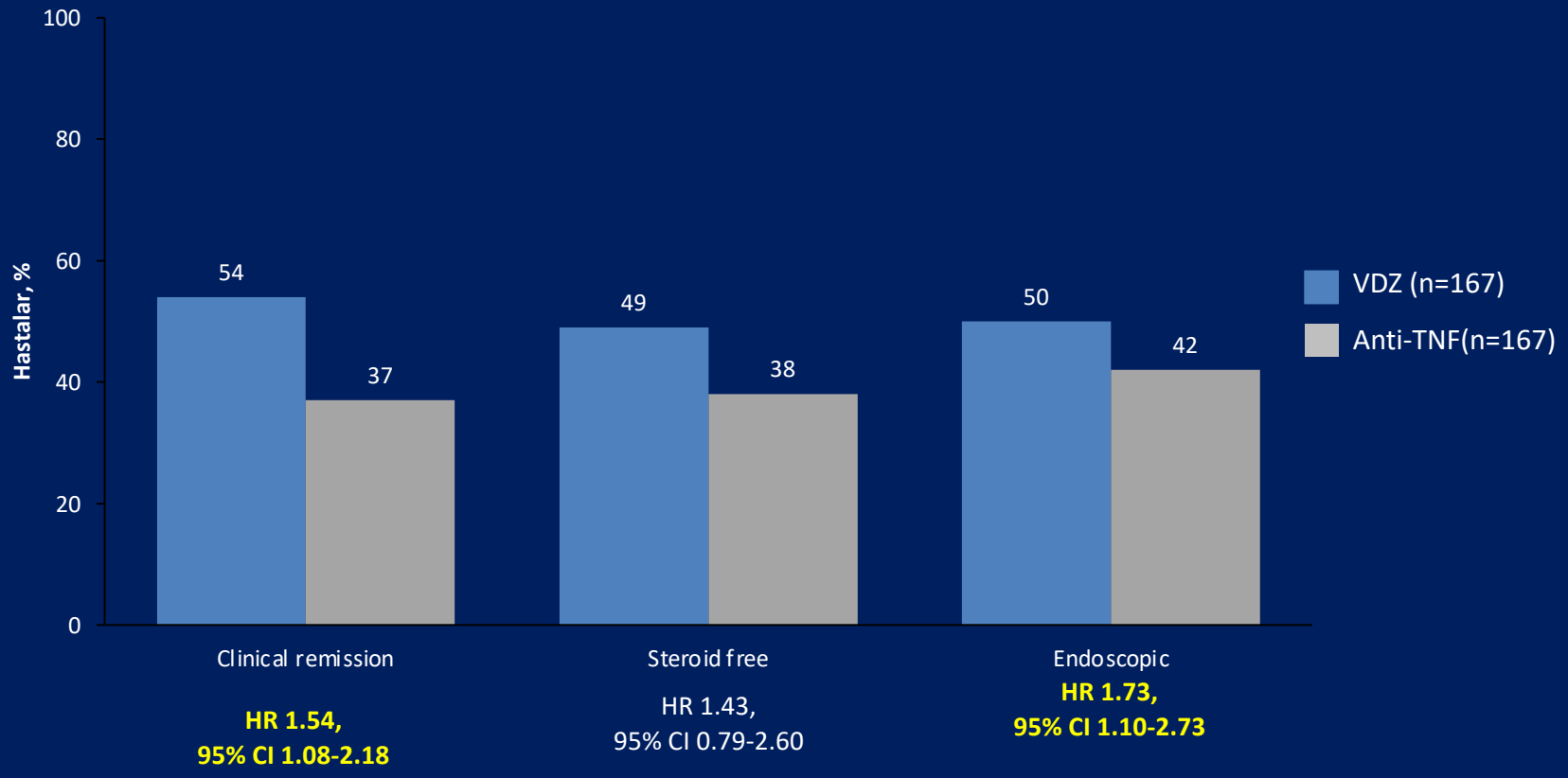
BİYOLOJİKTEN CERRAHİYE GEÇEN SÜRE 10,71±3,4 AY

CERRAHPAŞA 2015- CERRAHİ İNDİKATÖRÜ

Ü. KOLİT – BİYOLOJİK ALTINDA DIŞKILAMA SIKLIĞI



VDZ vs anti-TNF – 12. AY



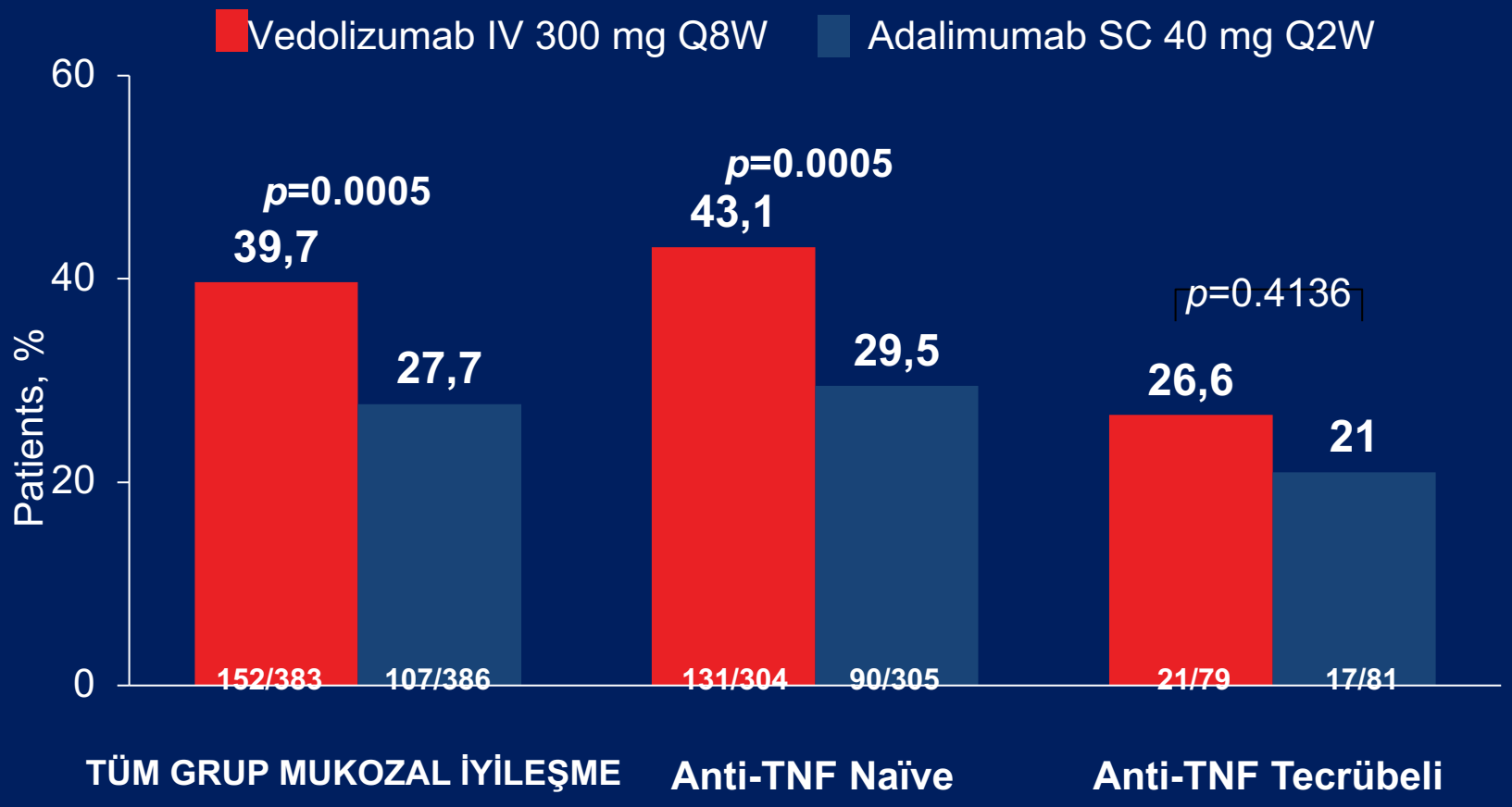
Faleck D, et al. J Crohns Colitis 2018;12 (suppl 1):S019–S

VARSITY – VDZ vs ADA

	Vedolizumab IV 300 mg Q8W n=385	Adalimumab SC 40 mg Q2W n=386
Mean age, y (SD)	40.8 (13.7)	40.5 (13.4)
Male, n (%)	234 (60.8)	216 (56.0)
Mean weight, kg (SD)*	72.7 (17.0)	73.4 (18.4)
Mean duration of UC, y (SD)†	7.3 (7.2)	6.4 (6.0)
Prior anti-TNF use, n (%)‡	80 (20.8)	81 (21.0)
Concomitant steroids, n (%)‡	139 (36.1)	140 (36.3)
Concomitant immunomodulators, n (%)	101 (26.2)	100 (25.9)
Complete Mayo score, n (%)		
Mild (<6)	9 (2.3)	5 (1.3)
Moderate (6 to 8)	154 (40.0)	169 (43.8)
Severe (9 to 12)	217 (56.4)	210 (54.4)
Mean faecal calprotectin, µg/g (SD)	2929 (5920)	2771 (4064)

Sands BE, et al. Gastroenterology. 2019;156(Suppl 1):S-81 [oral presentation]; Takeda Pharmaceuticals International AG, data on file VDZ001. March 2019.

VARSITY: VDZ vs ADA
END. REMİSYON SUBGRUP İNCELEMESİ



Schreiber S, et al. J Crohns Colitis. 2019;13(Suppl 1):S612–3 (abst OP34).

TÜRKİYE TOTAL VDZ VERİLERİ

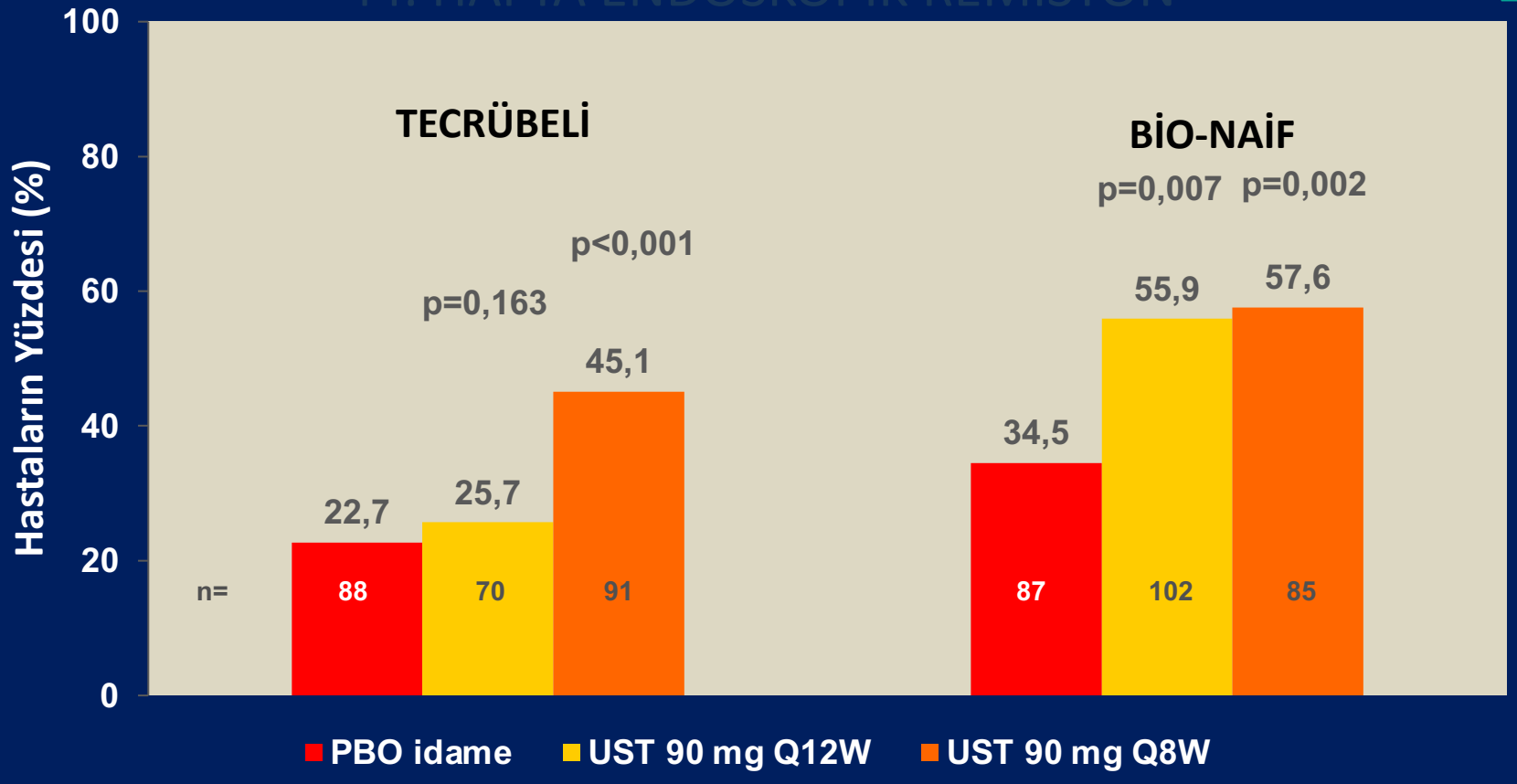
VEDOLİZUMAB ÇALIŞMA SONUÇLARI			
ÇALIŞMA PROTOKOLÜ	Anti-TNF TECRÜBELİ	KLİNİK REMİSYON	MUKOZAL İYİLEŞME
GEMINI 1 UC	%42	%42	%52
GEMINI 2 CD	%50	%39	NA
VARSITY UC	%20	%31	%40
VICTORY UC	%48	%54	%50
VICTORY CD	%90	%35	%63
FRENCH UC	%98	%39	NA
FRENCH CD	%99	%36	NA
TÜRKİYE UC	%98	%33	%15
TÜRKİYE CD	%95	%36	%15

UNIFI

ÜLSERATİF KOLİTTE USTEKİNUMAB

44. HAFTA ENDOSKOPİK REMİSYON

ECCO 2019



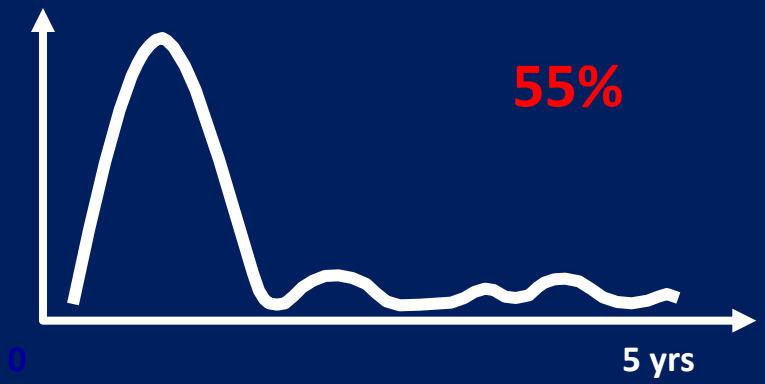
PBO idame: Ustekinumab IV indüksiyon dozuna klinik yanıt sergileyen ve bu idame çalışmasına girişte plasebo SC grubuna randomize edilen hastalar.

[a]Küresel tanım: Mutlak dışkı sayısı ≤ 3, rektal kanama alt skoru = 0 ve endoskopi alt skoru 0 ya da 1

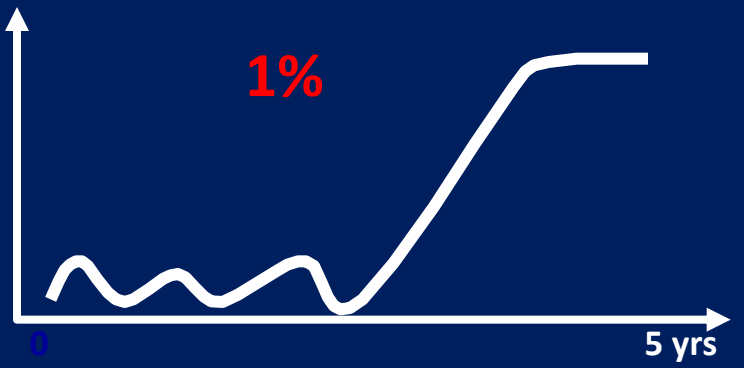
BİYOLOJİKLERLE
TEDAVİ BİR ÖMÜR BOYU MU?

HASTANIN KİMLİK KARTI HANGİSİ?

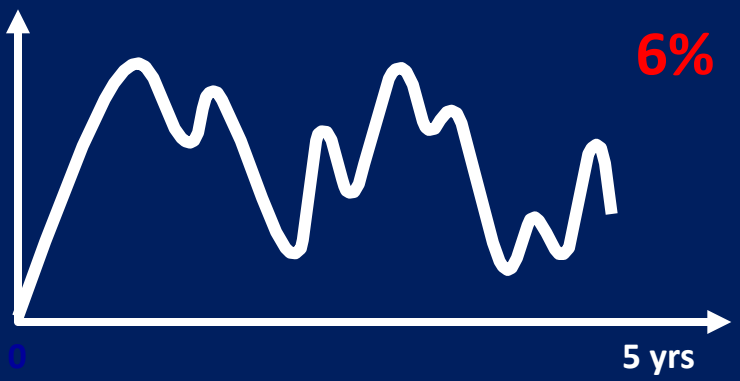
İNİSYAL AKTİVİTE SONRASI REMİSYON



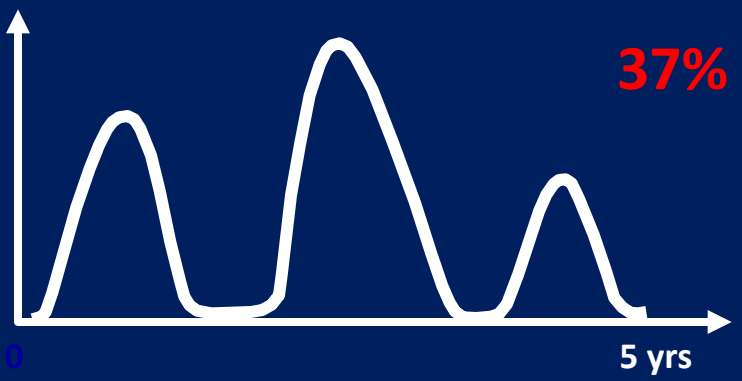
AKTİVİTEDE ARTIŞ



KRONİK DEVAMLI



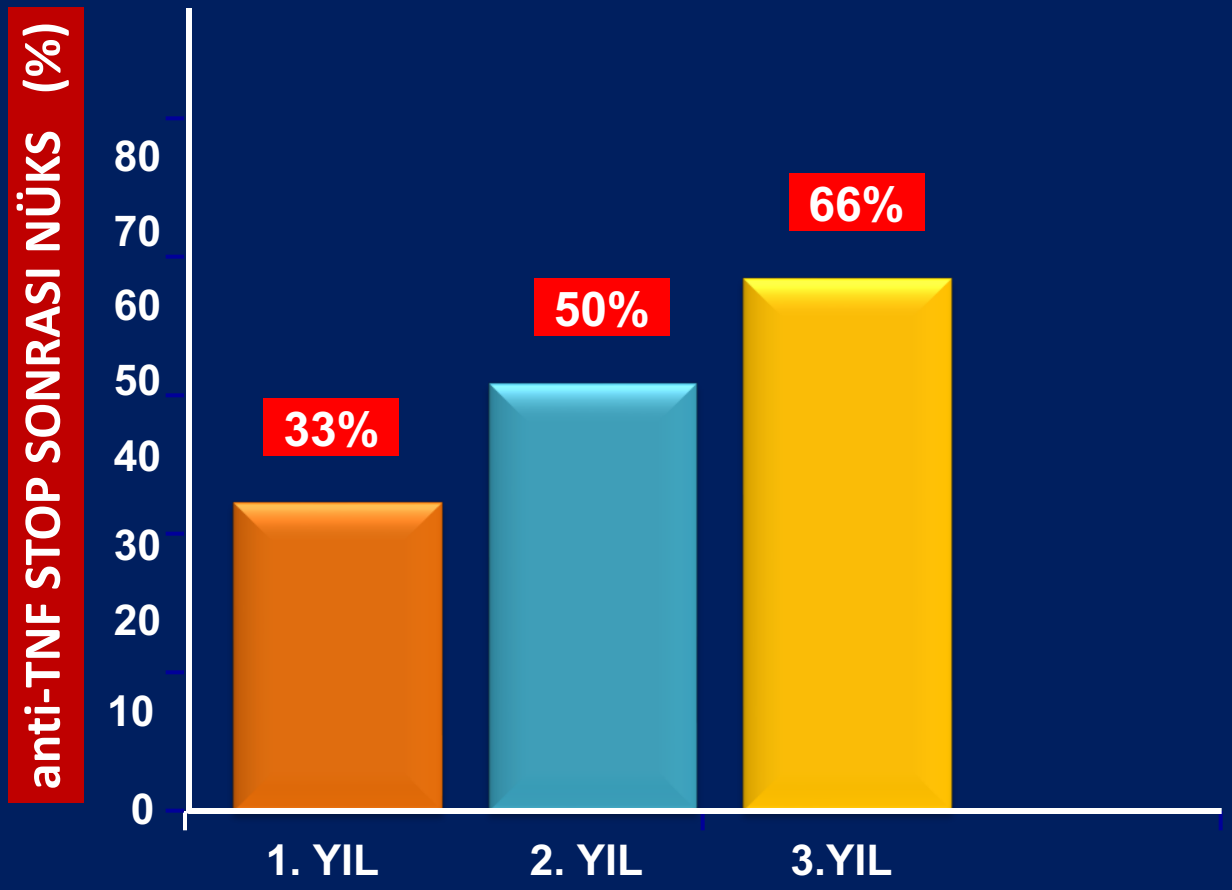
KRONİK ARALIKLI



Solberg IC *et al. Scand J Gastroenterology* 2009;44:431–40

TEDAVİ BİR ÖMÜR BOYU MU?

anti-TNF sonrası nüks??



Farkas K. *Gut* 2012; **61** (suppl 3): OP054-A12.

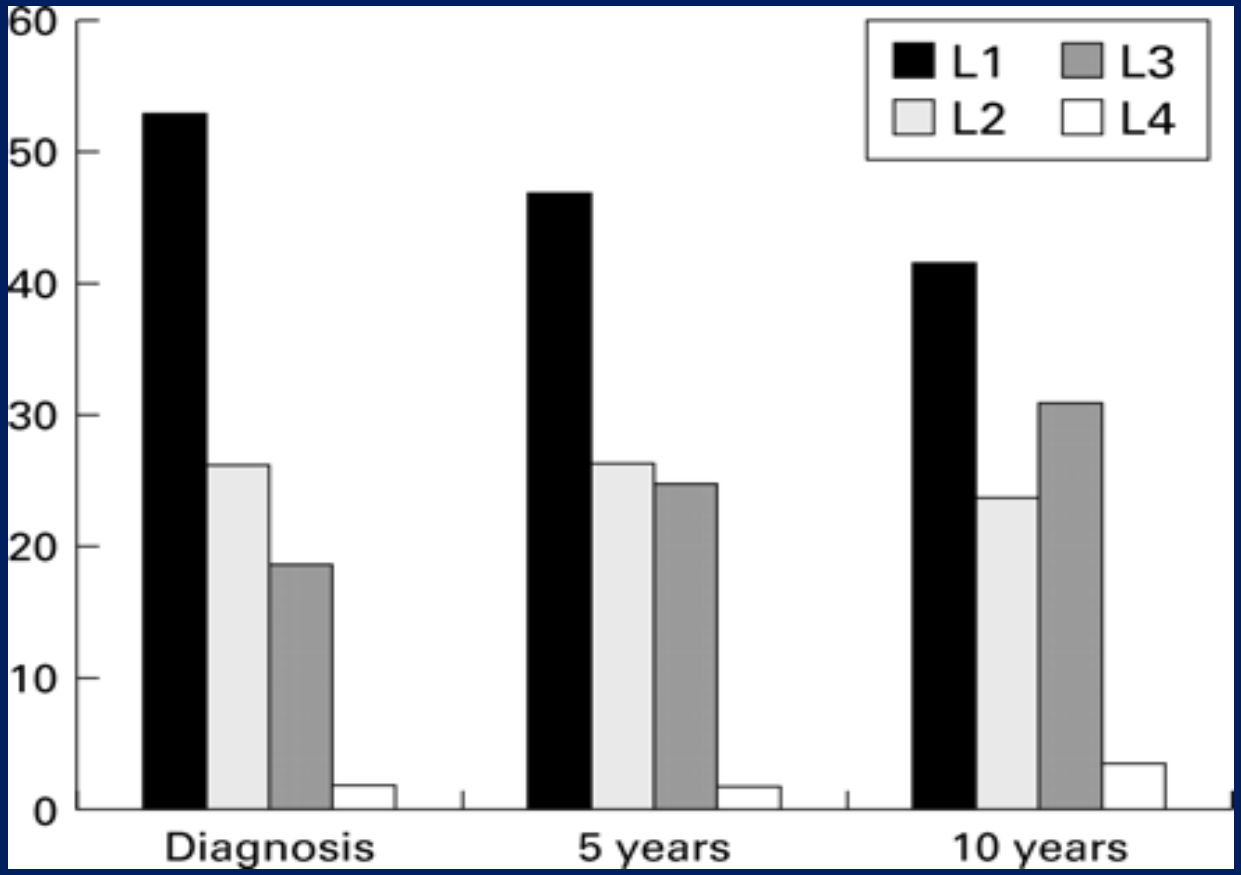
CROHN HASTALIĞI

CROHN HASTALIĞI – KÖTÜ PROGNOSTİK KRİTERLER

- Yaş < 40 yıl
- İlk tanıda steroid ihtiyacı
- Belirgin kilo kaybı
- Ekstensif ince bağırsak tutulumu
- Perianal hastalık

Beaugerie L. *Gastroenterology* 2006; **130**: 650-6.

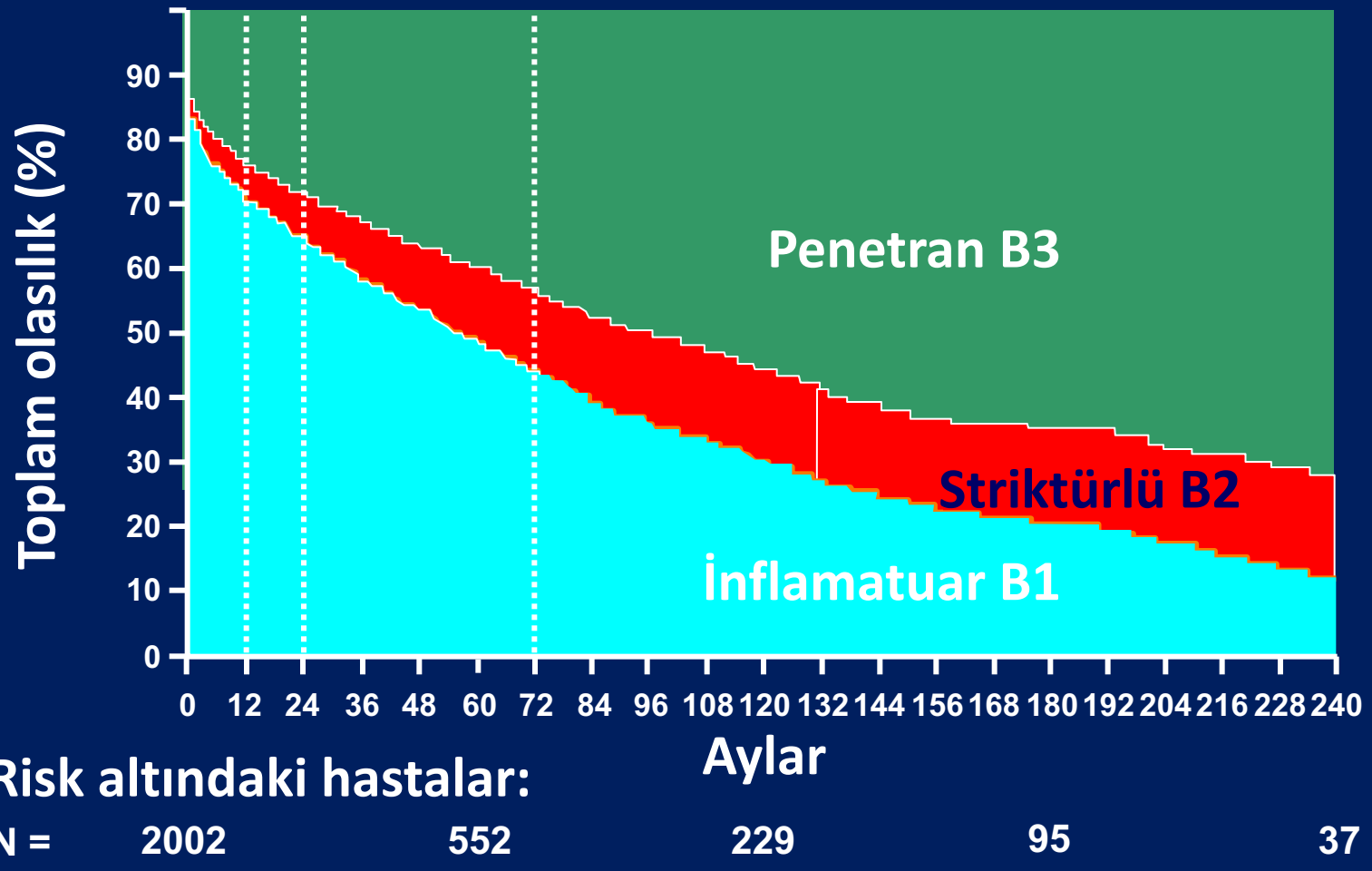
CROHN'da LOKALİZASYON DEĞİŞİMİ



Tanı sonrası 5. yılda değişim $p=0.01$; 10. yılda değişim $p<0.001$ (Hastaların %16'sı)

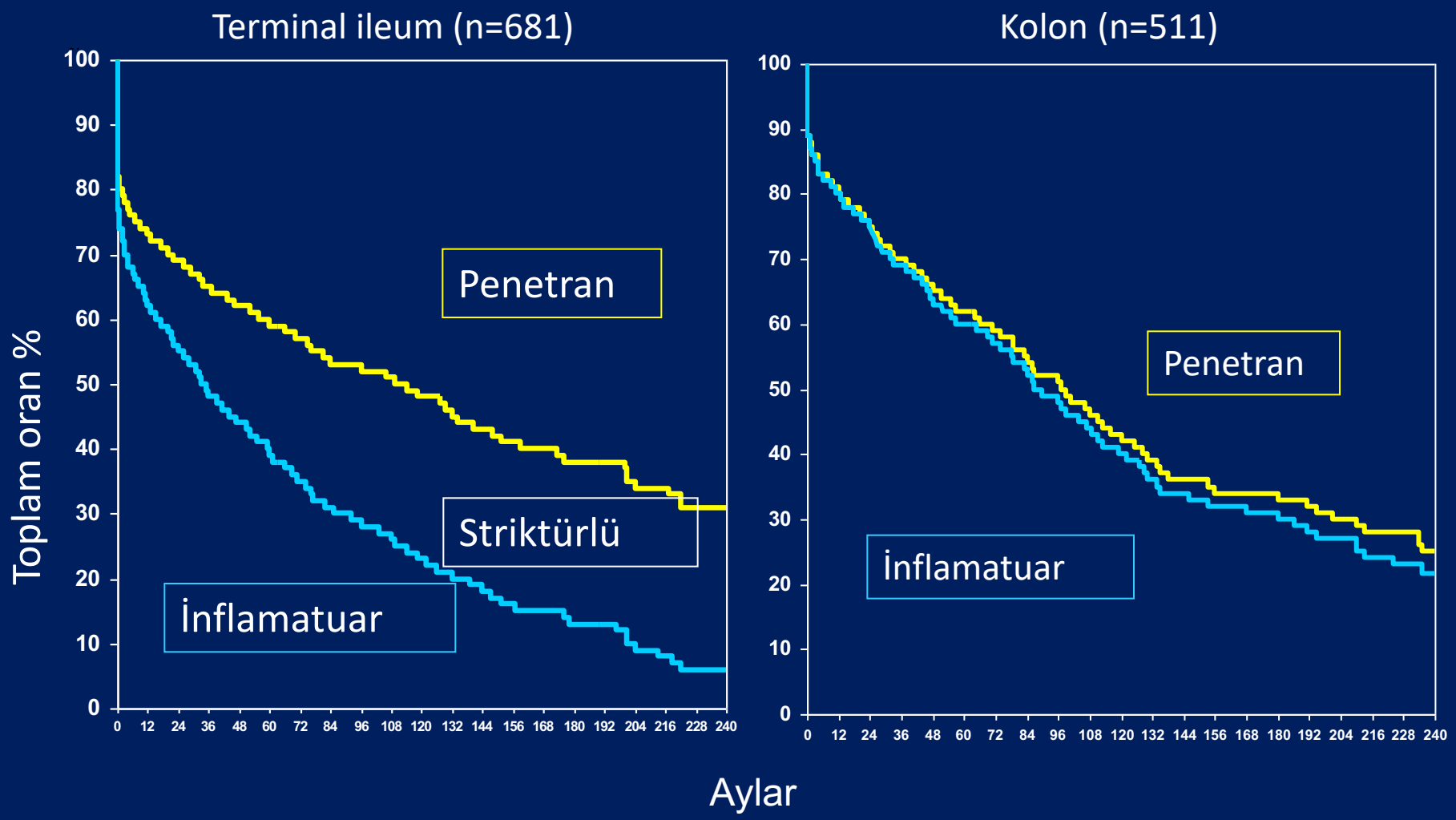
Louis E, *et al*. *Gut* 2001; **49**: 777-82

CROHN'un DEĞİŞEN KLİNİĞİ



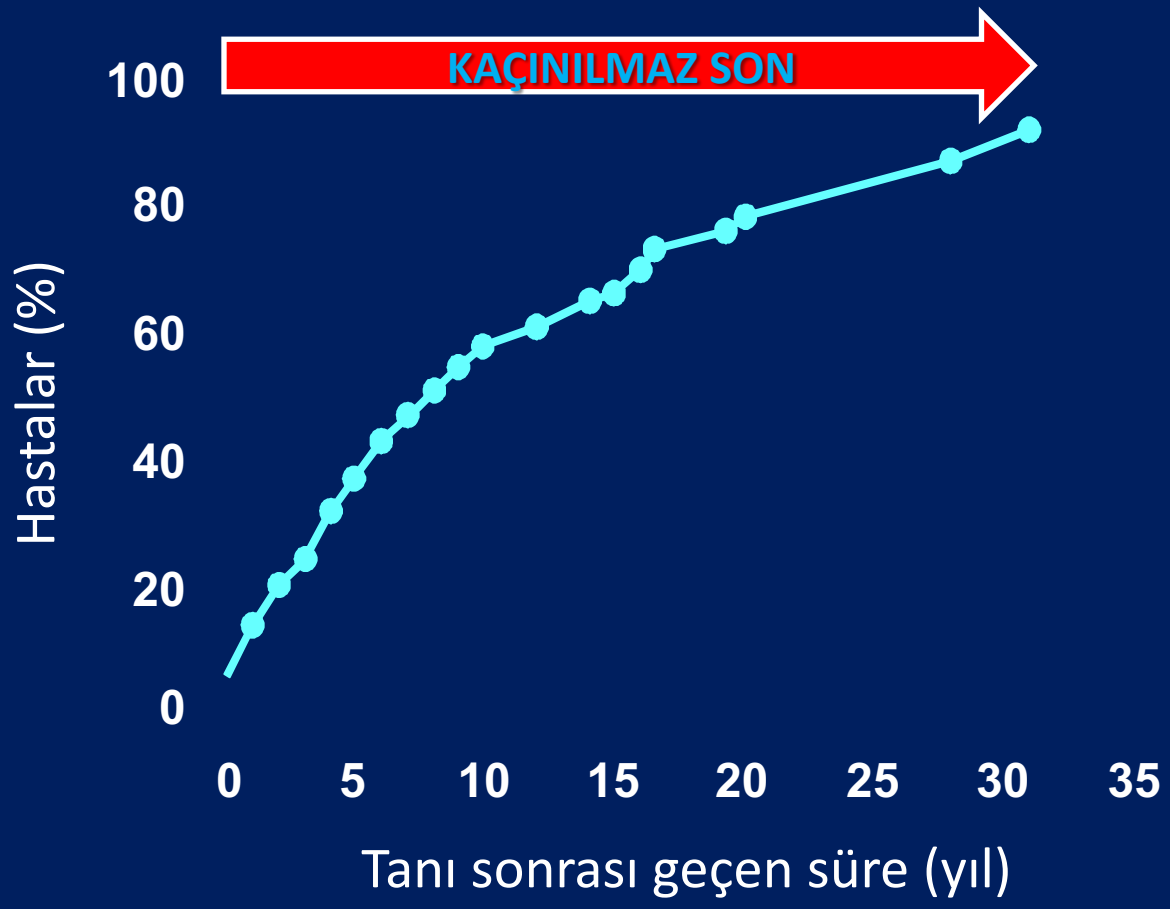
Cosnes J, *et al*. *Inflamm Bowel Dis* 2002; **8**: 244-50.

TUTULUMA GÖRE KLİNİK DEĞİŞİM



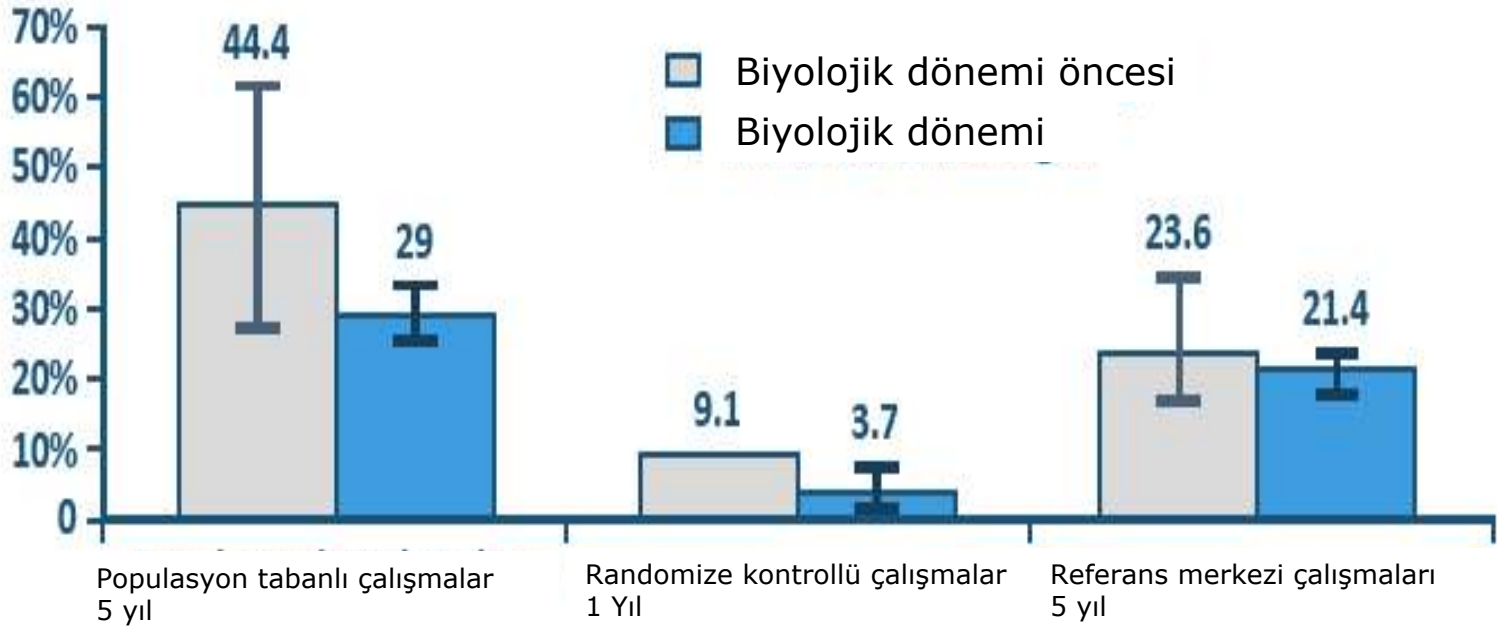
Cosnes J, *et al*. *Inflamm Bowel Dis* 2002; **8**: 244-50.

CROHN'da KÜMÜLATİF CERRAHİ ORANI



Mekhjian HS *et al*. *Gastroenterology* 1979; 77: 907-13.

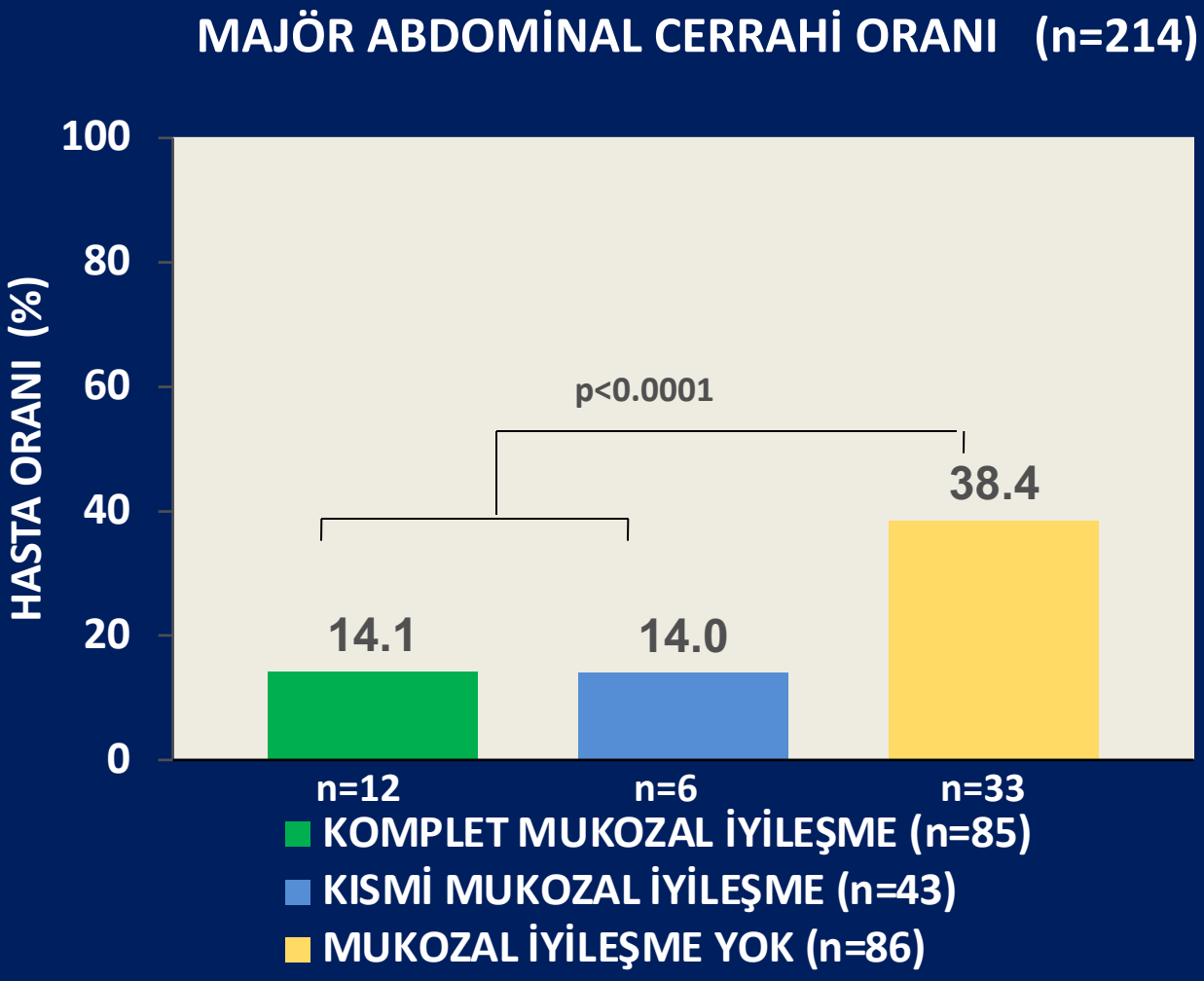
BİYOLOJİKLER ÇAĞINDA CERRAHİ İHTİYACI



Bouguen G. *Gut* 2011; **60**: 1178-81.

Leuven cohort

MUKOZAL İYİLEŞME ve CERRAHİ

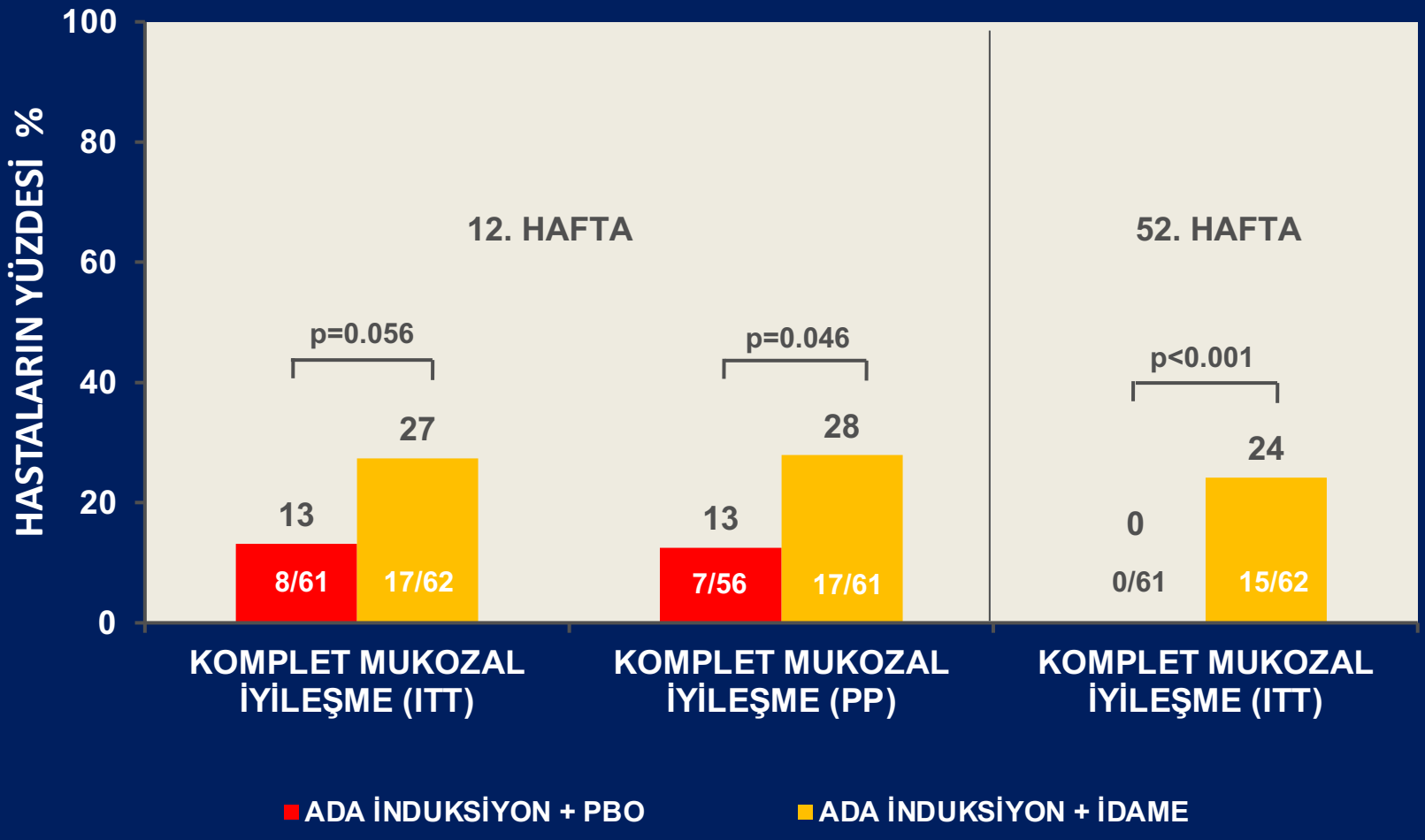


Schnitzler F. *Inflamm Bowel Dis* 2009; **15**: 1295-1301.

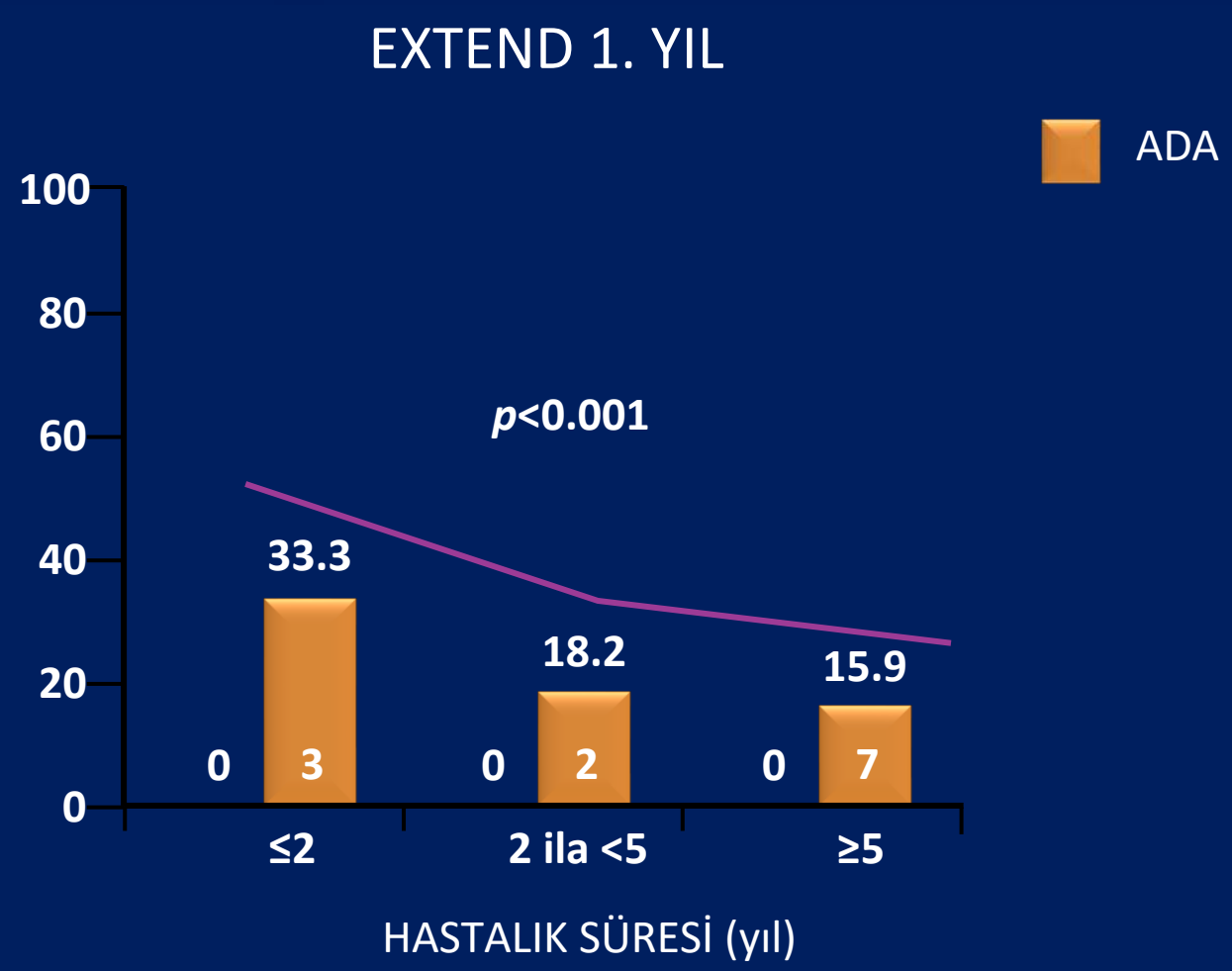
EXTEND

ADA MUKOZAL İYİLEŞME - 1.YIL

%50 anti-TNF TECRÜBELİ

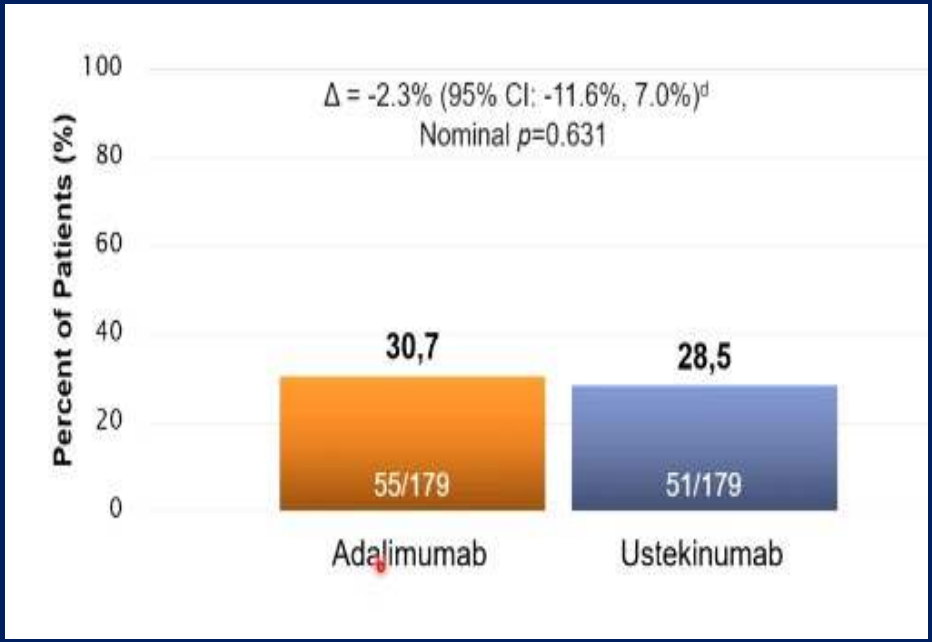


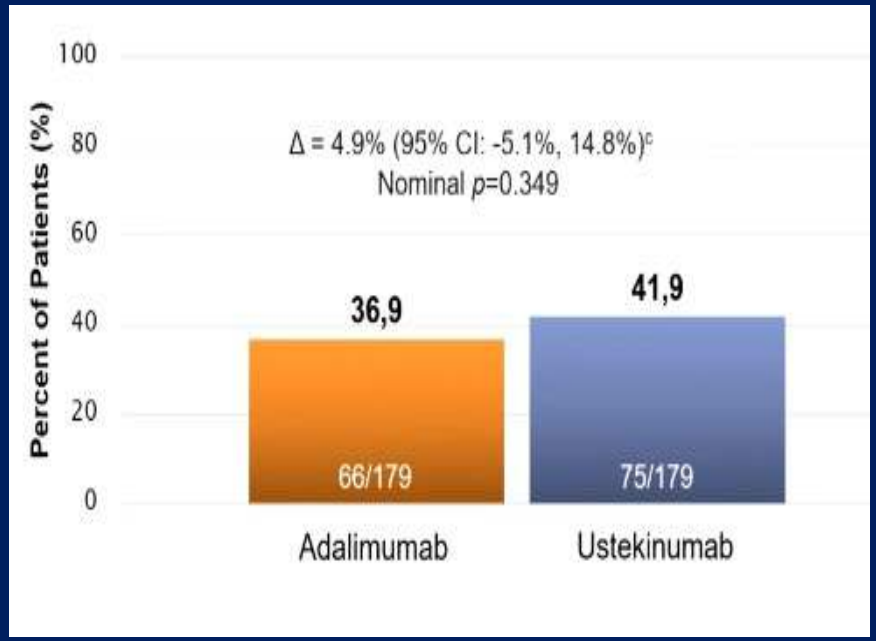
HASTALIK SÜRESİ – MUKOZAL REMİSYON ORANLARI



Colombel *JF et al. Gut* 2010; **59**:A 188 .

52. HAFTA ENDOSKOPİK REMİSYON – CEVAP SEAVUE– ADA vs UST

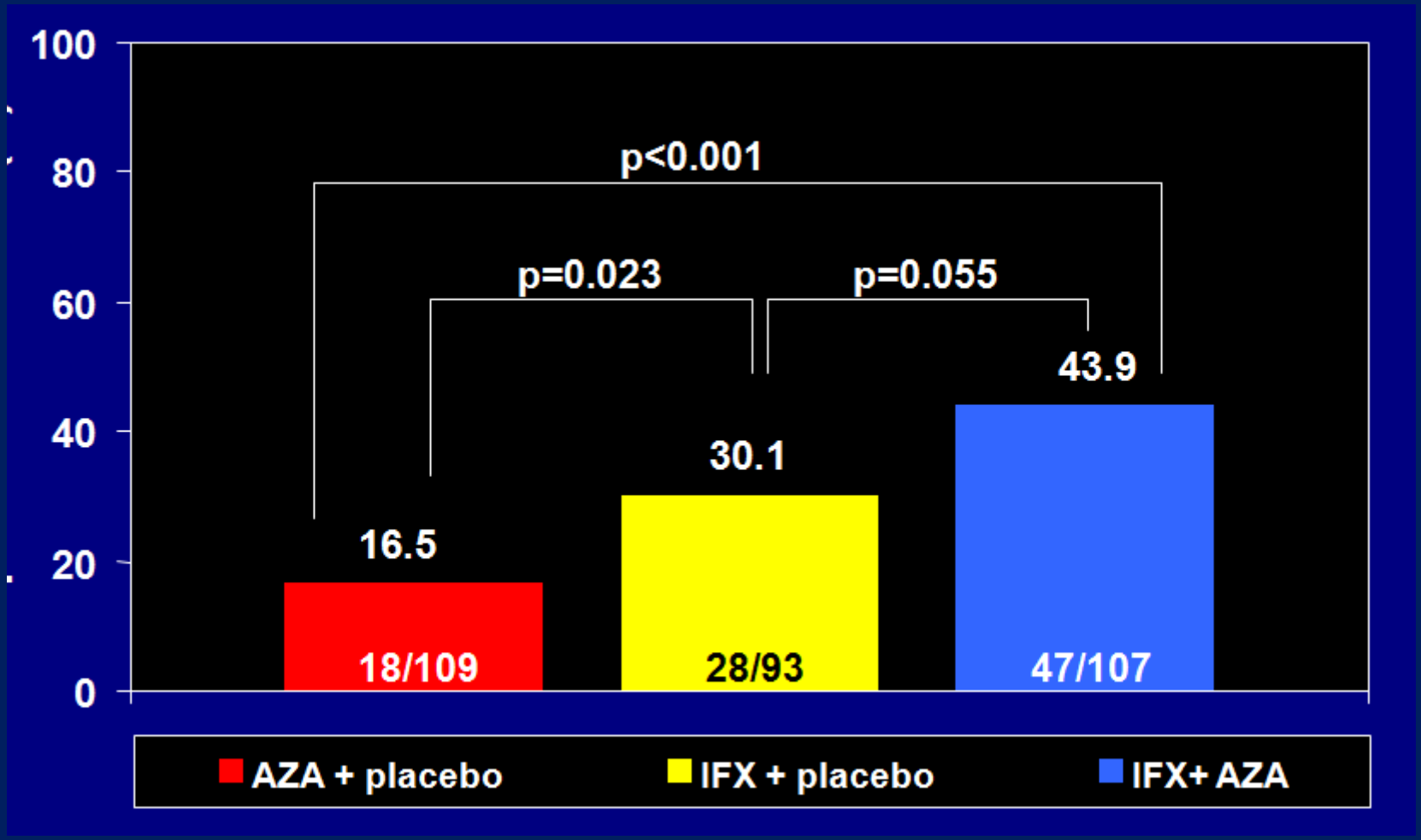




Sands BE. DDW 2021 OP 775d

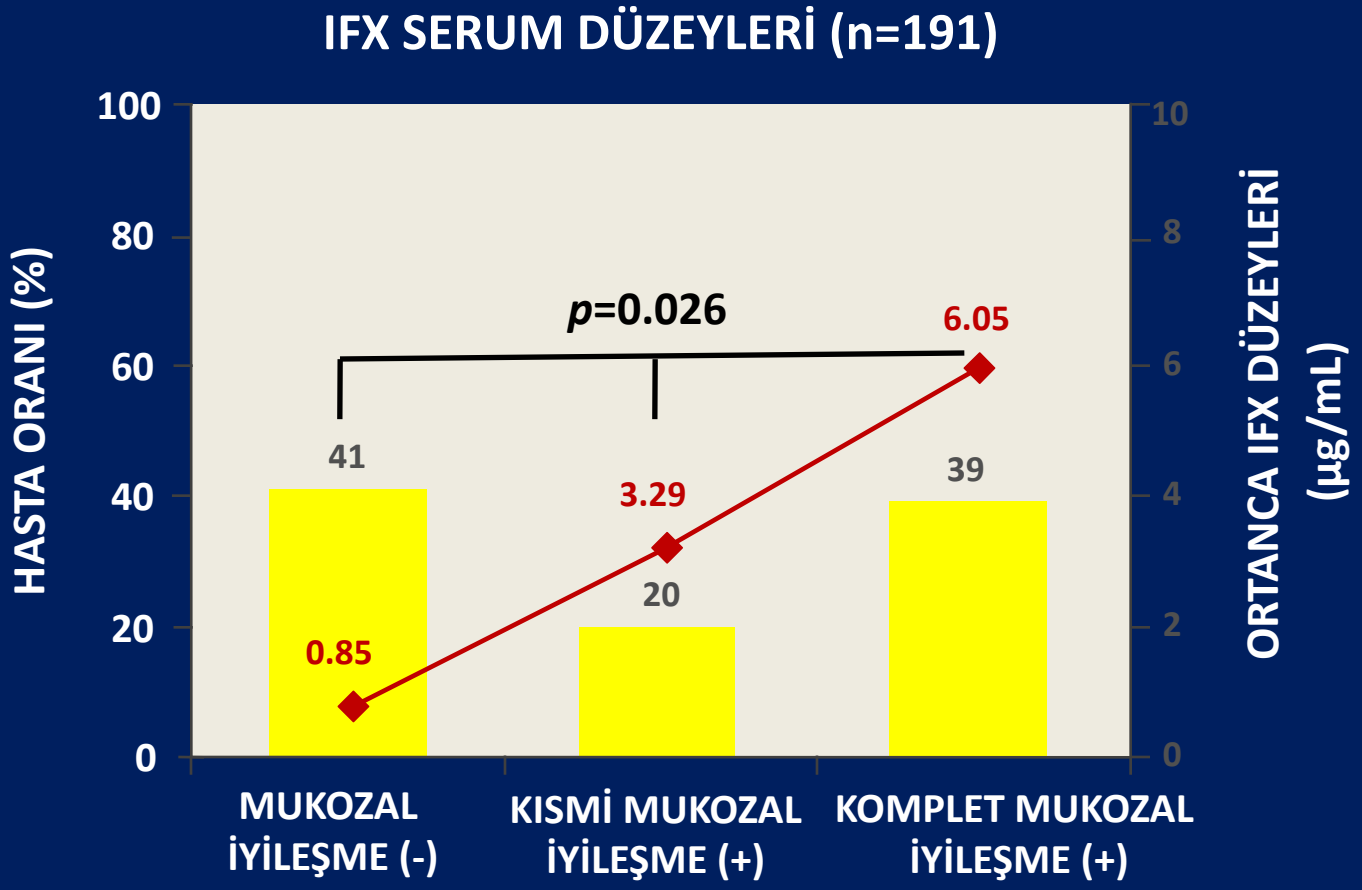
SONIC ÇALIŞMASI

26. HAFTA MUKOZAL İYİLEŞME



Sandborn WJ. ACG 2008

IFX SERUM DÜZEYİ – MUKOZAL İYİLEŞME



Van Moerkercke W. UEGW 09; OP 327.

VDZ – KOLON vs İNCE BAĞIRSAK

Hastalık yeri	Klinik remisyon	Steroidsiz remisyon	Endoskopik iyileşme
İzole ince bağırsak hastalığı	HR 0.70 95% CI 0.32-1.51	HR 0.60 95% CI 0.17-2.05	HR 1.45 95% CI 0.52-4.10
Kolonik veya ileokolonik hastalık	HR 1.51 95% CI 1.04-2.20	HR 4.90 95% CI 2.44-9.83	HR 1.70 95% CI 1.10-2.61

Bohm M, et al. J Crohns Colitis 2018;12 (suppl 1):S018.

TÜRKİYE TOTAL VDZ VERİLERİ

VEDOLİZUMAB ÇALIŞMA SONUÇLARI			
ÇALIŞMA PROTOKOLÜ	Anti-TNF TECRÜBELİ	KLİNİK REMİSYON	MUKOZAL İYİLEŞME
GEMINI 1 UC	%42	%42	%52
GEMINI 2 CD	%50	%39	NA
VARSITY UC	%20	%31	%40
VICTORY UC	%48	%54	%50
VICTORY CD	%90	%35	%63
FRENCH UC	%98	%39	NA
FRENCH CD	%99	%36	NA
TÜRKİYE UC	%98	%33	%15
TÜRKİYE CD	%95	%36	%15

PRİMER YANITSIZLIK ORANLARI

	2.-6. HAFTA CEVABI	6. AY KLİNİK REMİSYON		12. AY KLİNİK REMİSYON		PRİMER CEVAPSIZLIK
		PRİMER CEVAPLI	TÜM HASTALAR	PRİMER CEVAPLI	TÜM HASTALAR	
IFX	59%	39%	25%	25%	25%	40%
ADA	58%	40%	24%	36%	21%	**40%**
CZP	64%	48%	31%	42%	27%	**36%**

KLİNİK ÇALIŞMALARDA PRİMER YANITSIZLIK %13-33

Ding NS, *et al*. *Aliment Pharmacol Ther* 2016; **43**: 30–51.

SEKONDER YANITSIZLIK ORANI

IFX.....%13/yıl

ADA.....%20/yıl

ÜÇ YILDA % 50

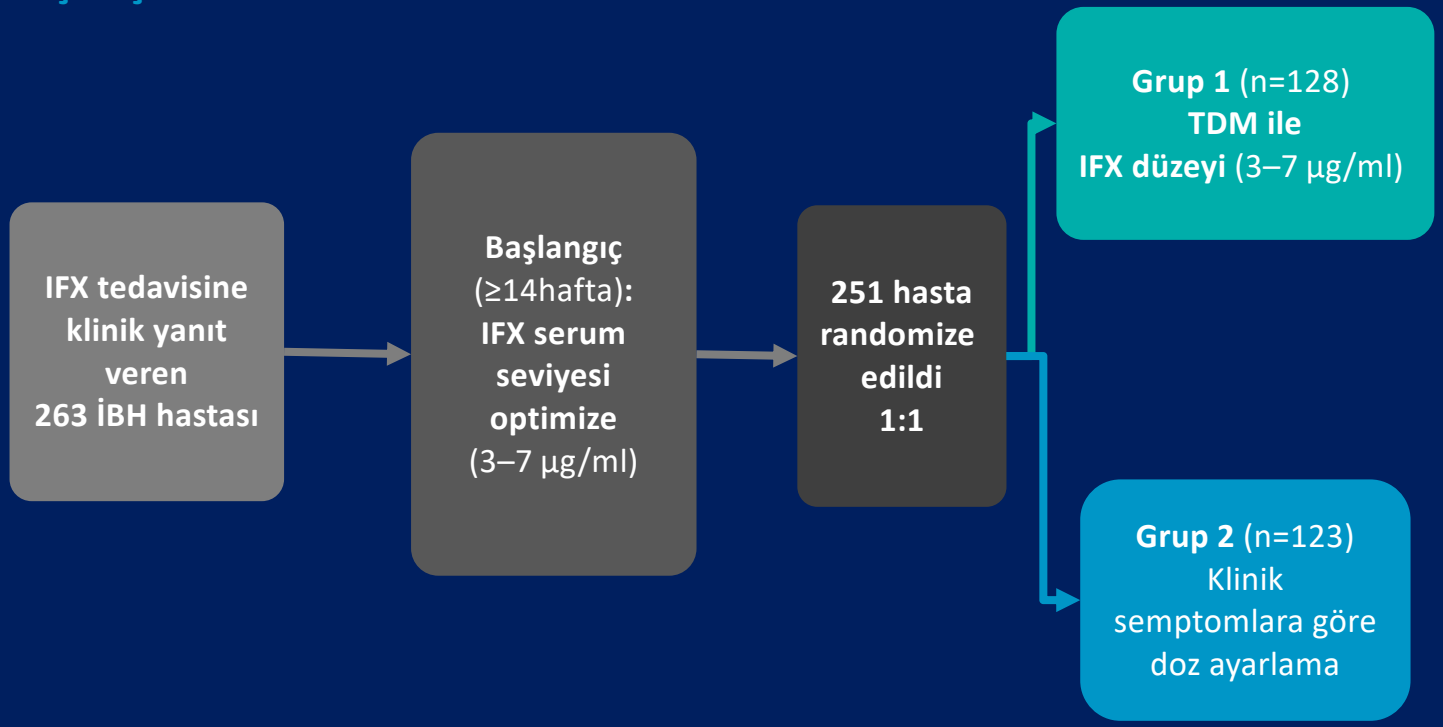
Gisbert JP. *Am J Gastroenterol* 2009; **104**:760–7.
Billioud V. *Am J Gastroenterol* 2011; **106**: 674–84.

Anti-TNF ALTINDA AKTİF HASTA

	ANTİKOR NEGATİF	ANTİKOR POZİTİF
anti-TNF SEVİYESİ **DÜŞÜK**	DOZ İNTENSİFİKASYONU	1.IS (-)…İS EKLE 2.IS(+)…SWITCH (SINIF İÇİ)
Anti-TNF SEVİYESİ **NORMAL**	AKTİVİTE(?) 1.AKTİF; SWITCH (SINIF DIŞI) 2.İNAKTİF (SEBEBİ YÖNET)	SWITCH (SINIF DIŞI)

TAXIT

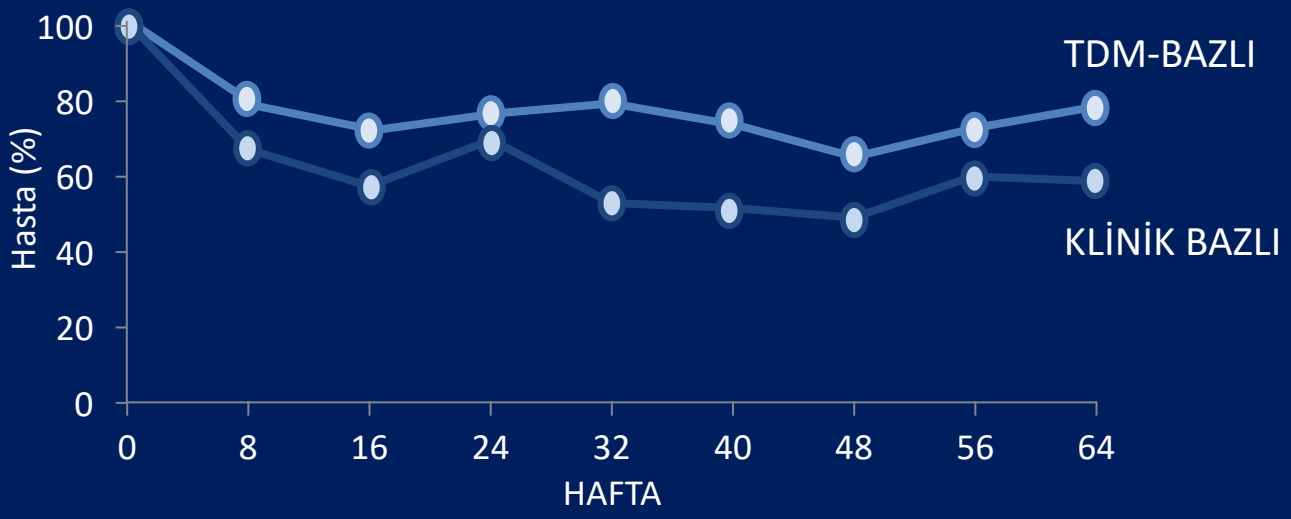
- **PRİMER SONLANIM:** KLİNİK ve BİOKİMYASAL REMİSYON
- **ÇALIŞMA TASARIMI**



Vande Casteele N, et al. Gastroenterology 2015;148:13207–29.

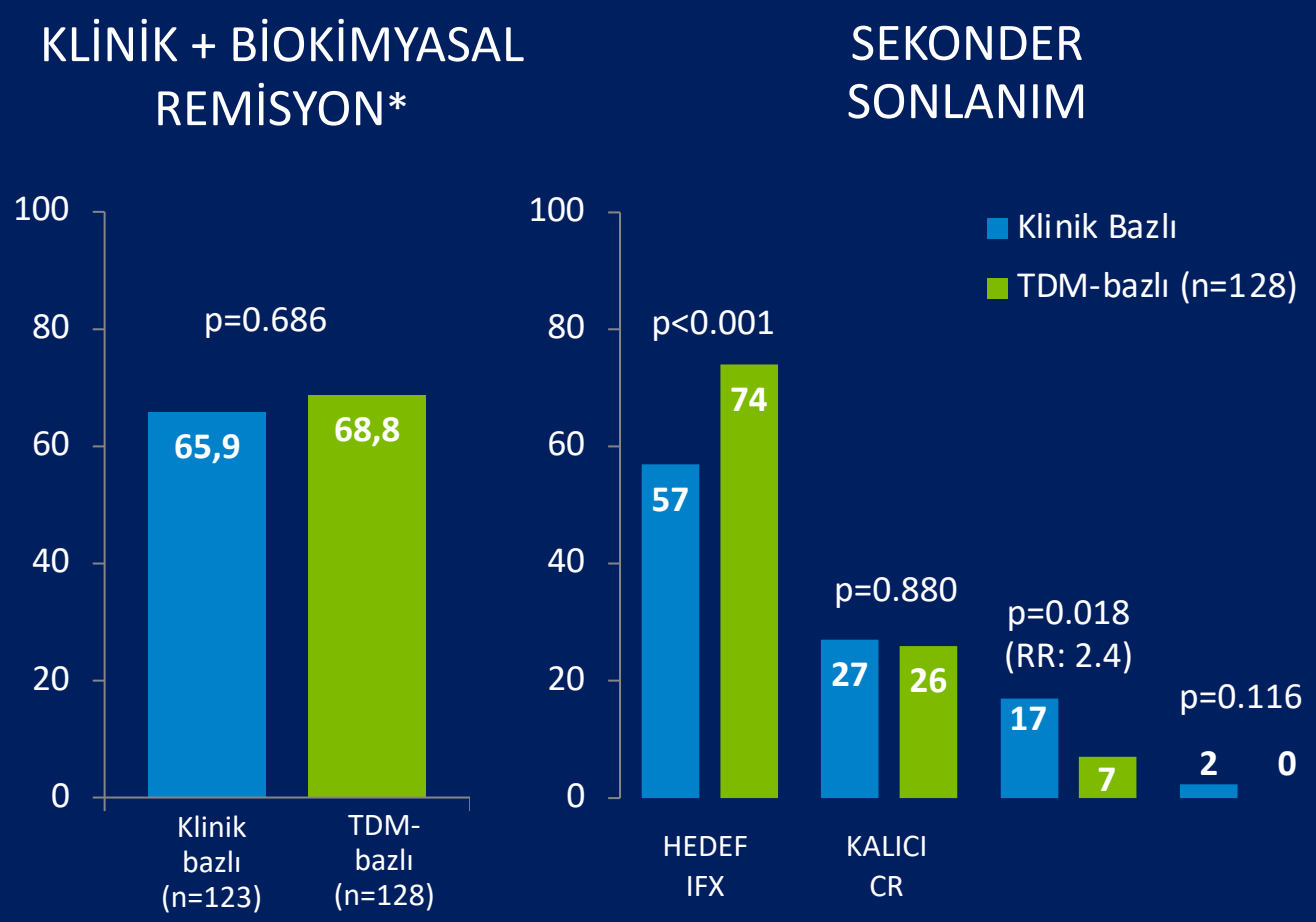
TAXIT: TDM = HEDEF IFX TUTULMASI

- HEDEF IFX……TDM-BAZLI %74…KLİNİK BAZLI %57 (p<0.001)



Vande Casteele N, *et al. Gastroenterology* 2015;148:1320–9.

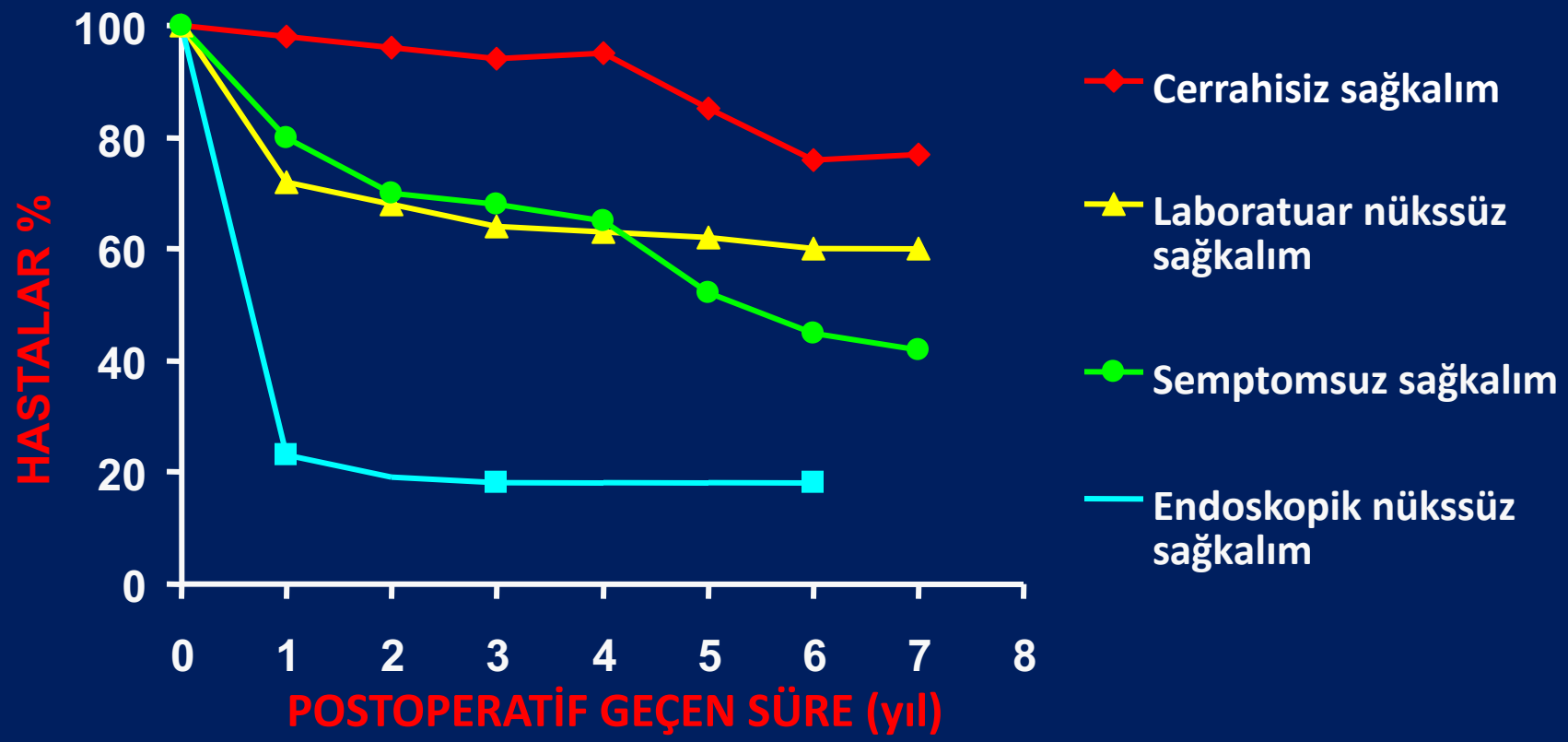
TAXIT: TDM-BAZLI vs KLİNİK BAZLI



*HBI≤4 for CD and PMS ≤2 for UC with no individual sub score >1, CRP ≤5 mg/l

Vande Casteele N, *et al. Gastroenterology* 2015;148:1320–1329

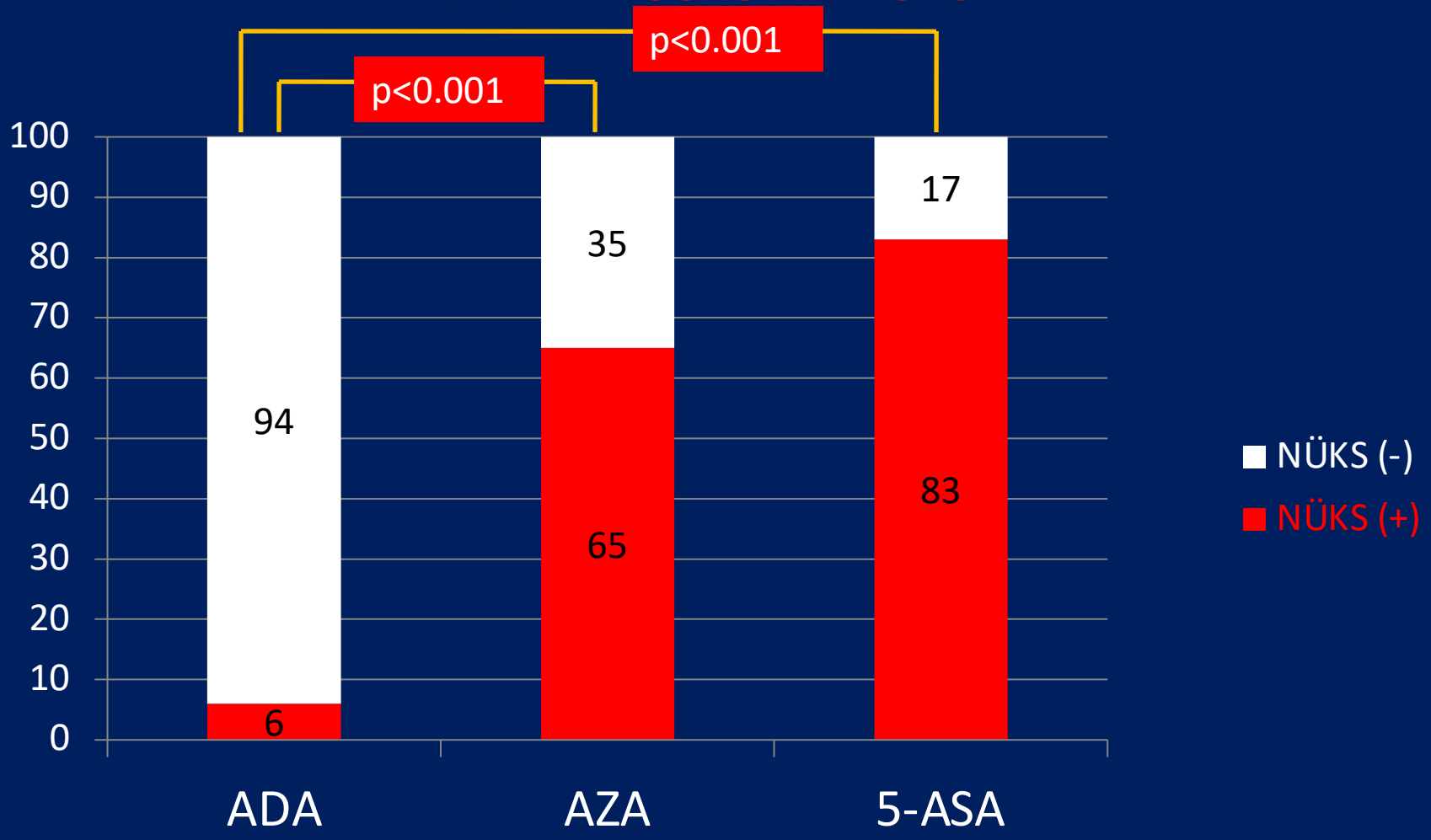
CROHN'da CERRAHİ SONRASI NÜKS



Rutgeerts P, *et al*. *Gastroenterology* 1990; **99**: 956-63.

POSTOP NÜKS – ADA vs. AZA & 5-ASA

12. AY ENDOSKOPİK NÜKS



Savarino E. *Gastroenterology* 2013; **144**: S-21.

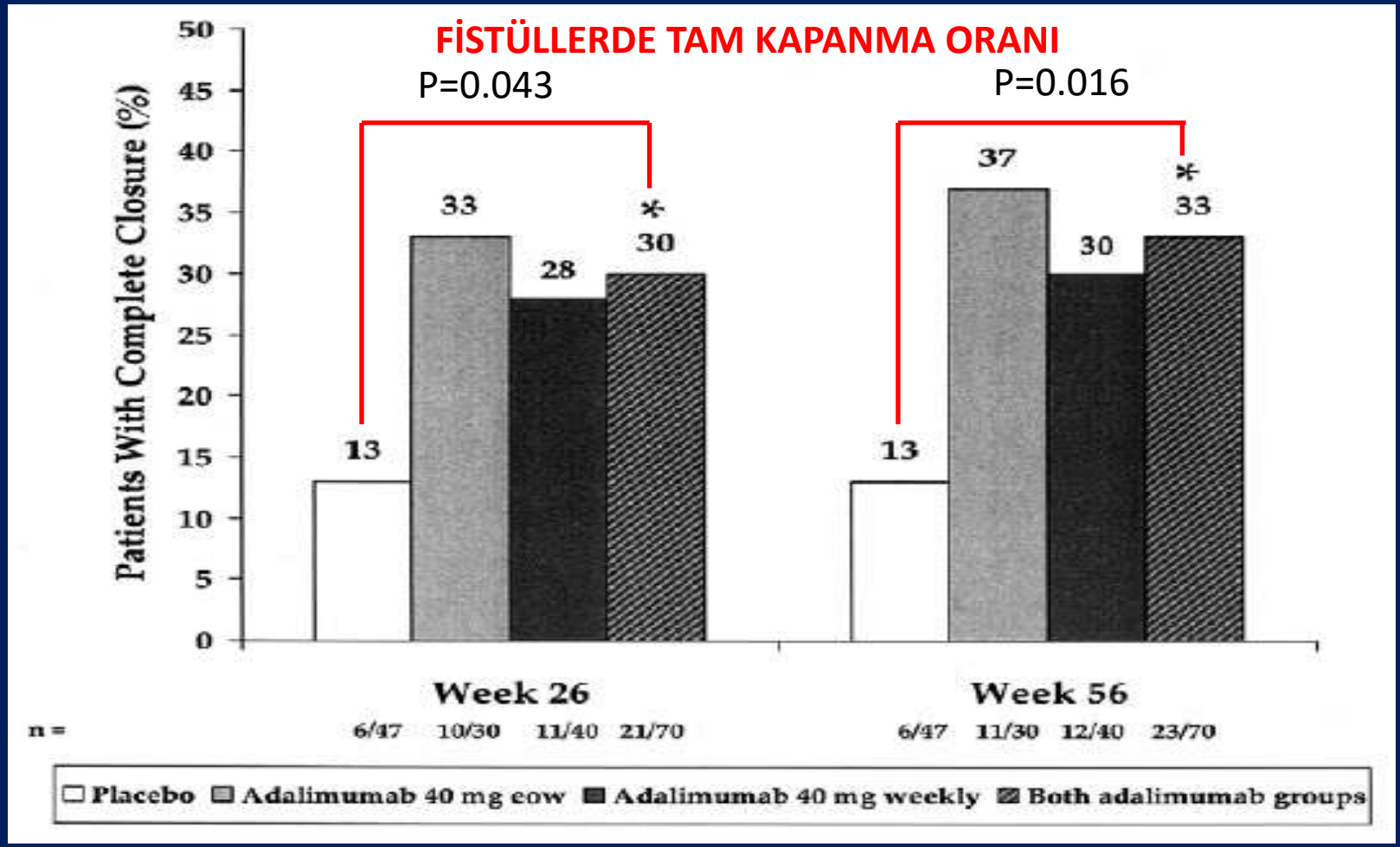
PERİANAL HASTALIKTA TEDAVİ HEDEFİ

Etki Kaybı Olmadan

Sürdürülebilir Cevap

PERİANAL FİSTÜLLERDE ADA – CHARM

weekly - eow



Colombel JF. *Gastroenterology* 2007; **132**:52–65

PERİANAL FİSTÜL - SONUÇLAR

- Crohn hastalığının en problemli manifestasyonu.
- Sık kullanılmalarına rağmen antibiyotikler ve purin analogları konusunda yeterli çalışma yok.
- Biyolojikler 1 yıllık tedavi sonunda yaklaşık %30-50 hastada tam fistül kapanması sağlasa da kesildiklerinde nüks oranı yüksek.
- Nihai tedavi hedefi olan radyolojik tam düzelme combo tedaviye rağmen ancak %20 düzeyinde.

PERİANAL FİSTÜL – NE YAPMALI?

DİVERSİYON STOMASI

PROKTEKTOMİ

İBH SAĞALTIMINDA NELERE DİKKAT ETMELİYİZ?

- **Kötü prognozlu hastaları tanımla**
- **Immunsupresanlarla erkenden müdahale et**
- **Immunsupresanların doz ayarlamasını erkenden gerçekleştir**
- **Uygun zamanlarda hastaları tekrar gözden geçir**
  - Prednizon için 2–4 hafta sonra
  - Azathioprine için 10–12 hafta sonra
- **Steroidsiz remisyonu hedefle**
- **Semptomların ötesini tedavi et**
  - Biomarkerlar ve mukozal iyileşmeyi gözlemle

- **Sürekli ve uzun periyotlarda kortikosteriod kullanma!**
- **Kortikosteroid toksisitesini göz ardı etme !**
- **Azathioprine kullanımını tam remisyon elde etmediğinde standart dozlarda ve uzun süre kullanma !**


TEŞEKKÜRLER