<<ΔΙΕΠΙΣΤΗΜΟΝΙΚΗ ΣΥΝΕΔΡΙΑ ΛΟΙΜΩΞΙΟΛΟΓΙΑ-ΑΝΟΣΟΛΟΓΙΑΣ>>

ΛΟΙΜΩΞΗ ΣΕ ΑΣΘΕΝΗ ΜΕ ΙΔΙΟΠΑΘΗ ΦΛΕΓΜΟΝΩΔΗ ΝΟΣΟ ΤΟΥ ΕΝΤΕΡΟΥ

ΑΦΡΟΔΙΤΗ ΜΠΙΤΟΥΛΗ

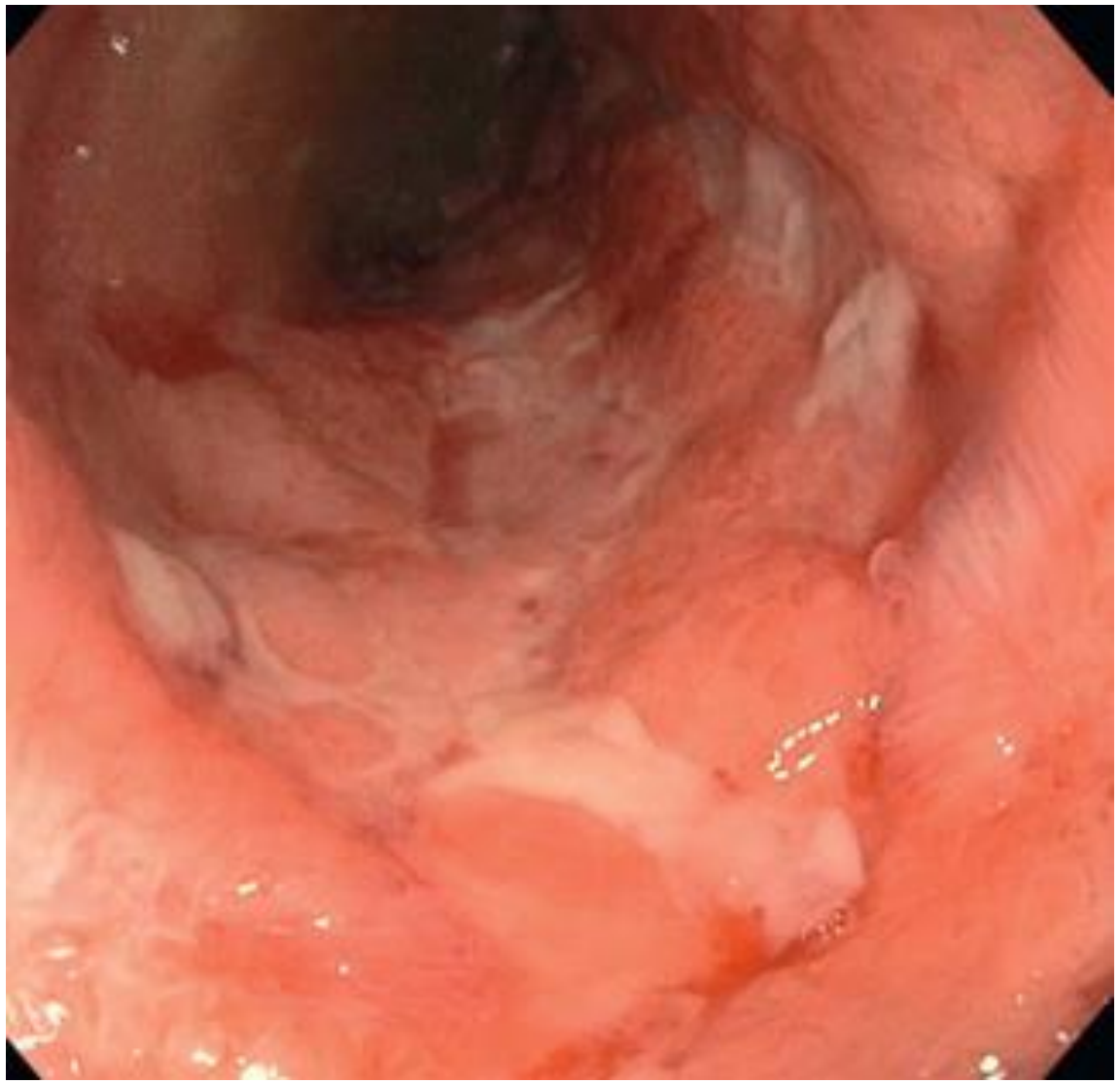
ΓΑΣΤΡΕΝΤΕΡΟΛΟΓΟΣ- ΕΠΙΣΤΗΜΟΝΙΚΟΣ ΣΥΝΕΡΓΑΤΗΣ Δ’ ΠΑΝΕΠΙΣΤΗΜΙΑΚΗΣ ΠΑΘΟΛΟΓΙΚΗΣ ΚΛΙΝΙΚΗΣ Α.Π.Θ.

ΣΥΓΚΡΟΥΣΗ ΣΥΜΦΕΡΟΝΤΩΝ

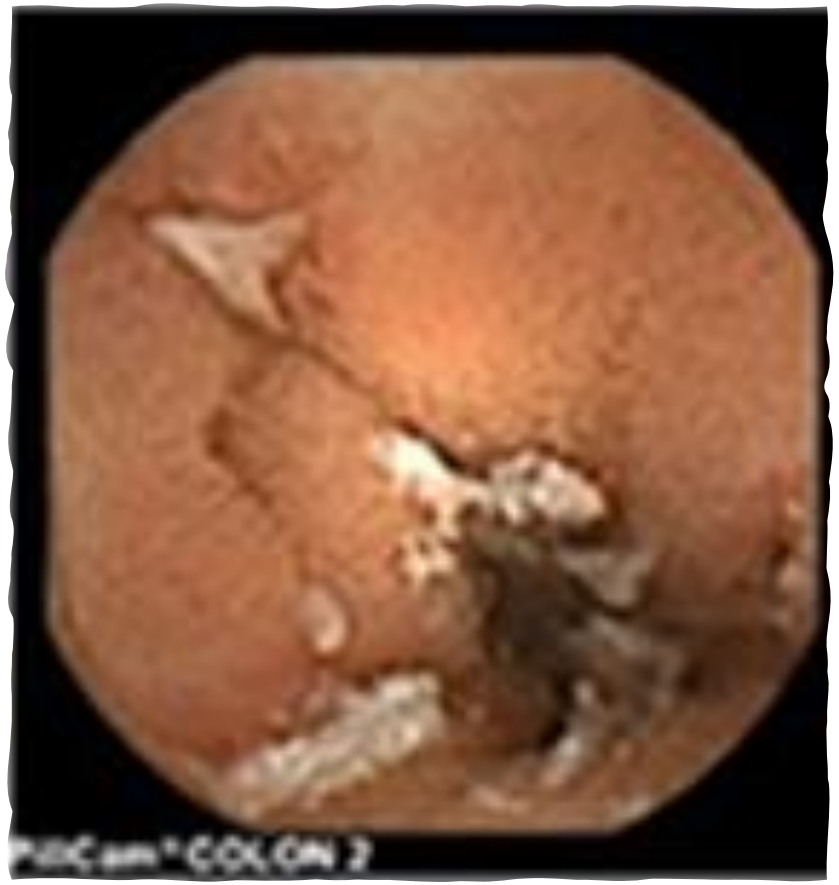
- Καμία για τη συγκεκριμένη ομιλία

ΔΙΑΓΝΩΣΗ ΑΣΘΕΝΗ ΜΕ N.CROHN

- **3/2022:** Άντρας 25 χρονών παρουσιάζει διαρροικό σύνδρομο από 3μήνου (5-6 κενώσεις),κοιλιακό άλγος, ήπια πυρετική δεκατική κίνηση, Hb: 12,3mg/dl, CRP:6(<0,5),ΤΚΕ:52,Καλπροτεκτίνη:780
- **Α/Ι**: ελεύθερο, καπνιστής 5p/y
  - **<u>Κολονοσκόπηση</u>**: Μεγάλα έλκη στο ανιόν, τυφλό οιδηματώδης εξελκωμένη ειλεοτυφλική βαλβίδα, μεγάλα έλκη στον τελικό ειλεό→Εικόνα συμβατή με N.Crohn



ΔΙΑΓΝΩΣΗ-ΘΕΡΑΠΕΙΑ ΑΣΘΕΝΗ ΜΕ NC



- **<u>Ενδοκοπική κάψουλα</u>**: Παρουσία αφθωδών ελκών στη νήστιδα και μεγάλα έλκη στα τελευταία 30cm του τελικού ειλεού.
- **<u>Θεραπεία:</u>** Έναρξη adalimumab 40mg/2wk, αφού πρώτα έλαβε πρώτα βραχύ σχήμα κορτικοστεροειδών p.o

ΠΟΡΕΙΑ ΝΟΣΟΥ

- Από τη 12η βδομάδα θεραπείας πλήρης κλινική ύφεση και αποκατάσταση εργαστηριακού φλεγμονώδους συνδρόμου
- Επαναληπτική κολονοσκόπηση μετά από 6 μήνες θεραπείας→ Πλήρης επούλωση των ελκών τόσο στο παχύ όσο και στο λεπτό έντερο
- **9/2022-4/2024:** Πλήρης υποκειμενική κλινική και εργαστηριακή ύφεση υπό adalimumab 40mg/2wk.

ΕΜΦΑΝΙΣΗ ΠΕΡΙΠΡΩΚΤΙΚΟΥ ΑΠΟΣΤΗΜΑΤΟΣ

- **4/2024:** Εμφάνιση περιπρωκτικού αποστήματος
  - ✓ Σιπροφλοξασίνη 500mg 1 x 2 και Μετρονιδαζόλη 500mg 1x3 για 10 μέρες
  - ✓ ***Μαγνητική πυέλου***: Από τη 12η ώρα του πρωκτικού δακτυλίου άρχεται συραγγώδης πόρος, φέρεται ουραίως για να καταλήξει στο δέρμα της αριστερής πλάγιας επιφάνειας της μεσογλουτιαίας σχισμής, μήκος ~1,7cm
  - ✓ Χειρουργική διάνοιξη λόγω μη υποχώρησης με την αντιβιοτική αγωγή

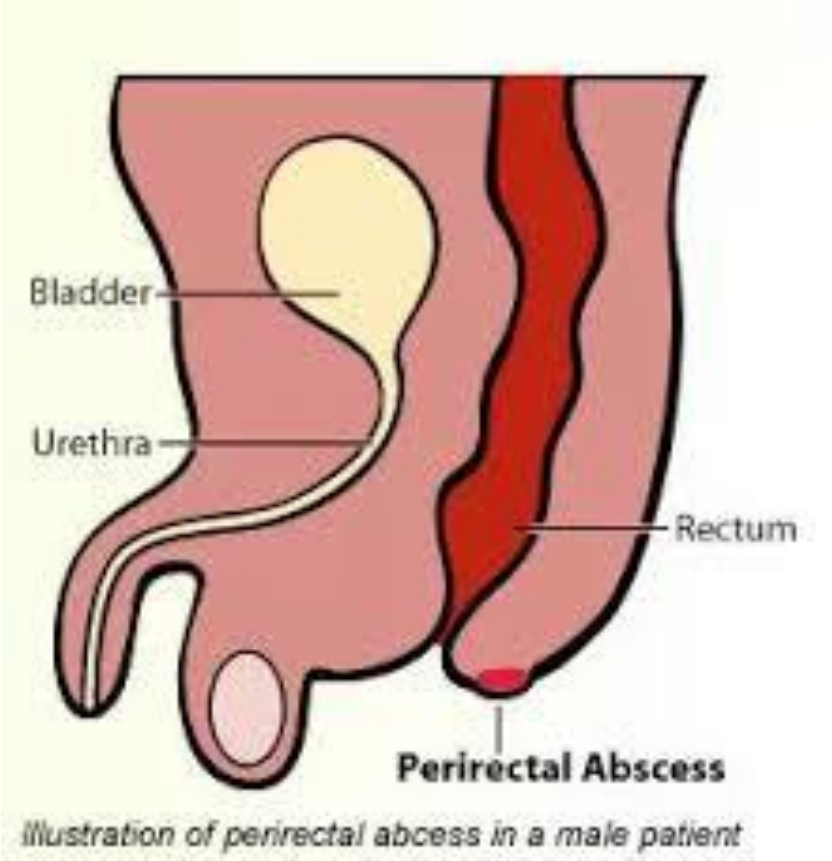


Illustration of perirectal abcess in a male patient

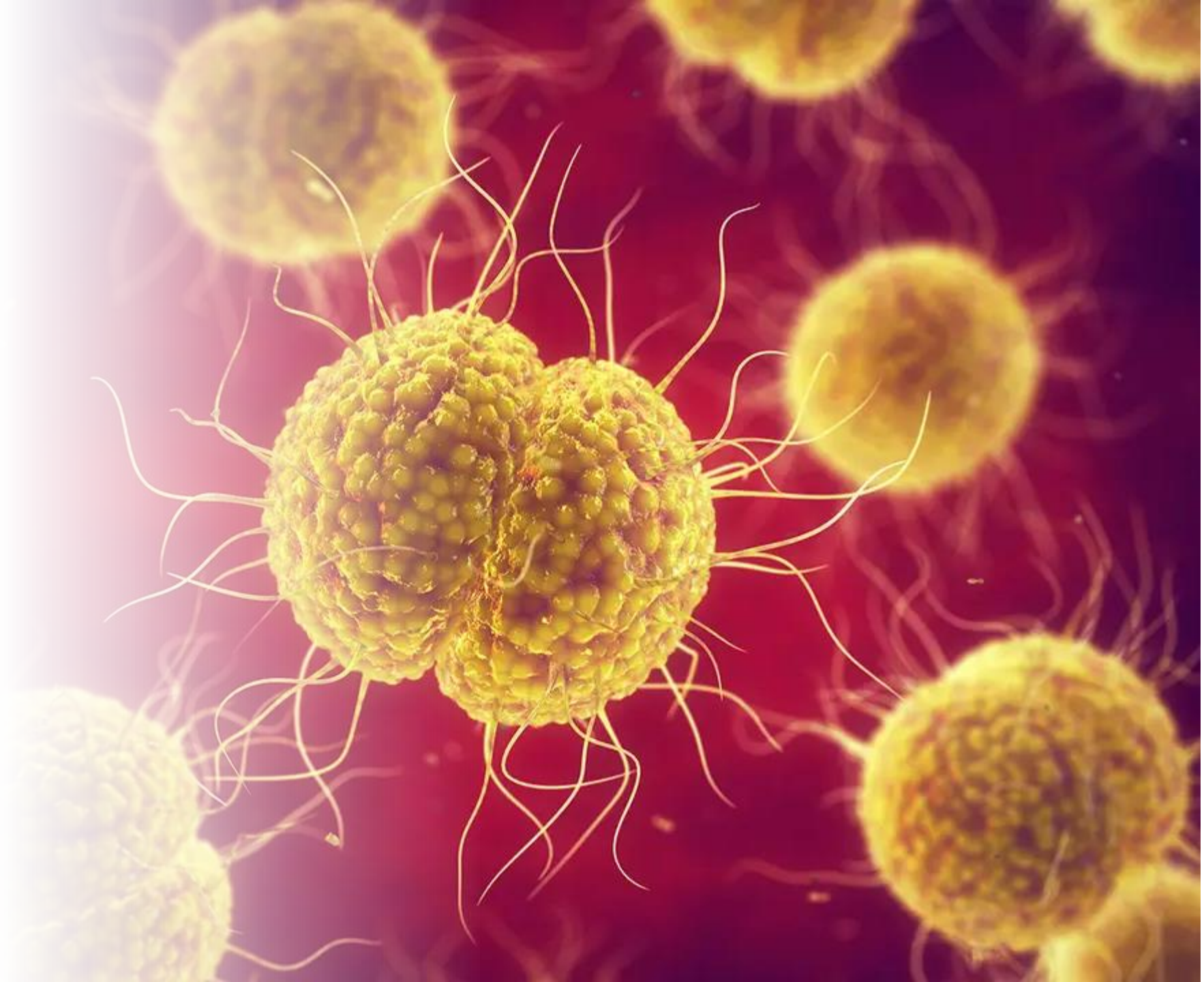
ΔΙΕΡΕΥΝΗΣΗ…

- Εξαφάνιση αποστήματος αλλά παρόλα αυτά εκροή κιτρινοπράσινου πηχτού υγρού από το πρωκτό.
- **Καλλιέργεια κοπράνων:** αρνητική
- **Παρασιτολογική κοπράνων**: αρνητική
- **Τοξίνη και αντιγονο Α & Β για Cl.Difficile:**αρνητική
- **<u>Κολονοσκόπηση</u>**: Φυσιολογικός βλεννογόνος κατά μήκος όλου του παχέος εντέρου και του ειλεού. Δεν επισκοπήθηκε στόμιο συριγγίου.

Απόφαση του ασθενούς για γνωστοποίηση της σεξουαλικής του ζωής χωρίς προφυλάξεις

Παραπομπή σε εξειδικευμένο Ιατρείο Σεξουαλικώς Μεταδιδόμενων Νοσημάτων

ΔΙΑΓΝΩΣΗ



ΓΟΝΟΡΡΟΙΑ

- ***Θεραπεία: ενέσιμη κεφτριαξόνη και αζιθρομυκίνη p.o***

ΣΚΕΨΕΙΣ-ΠΡΟΒΛΗΜΑΤΙΣΜΟΙ

- ✓Λήψη καλού ιστορικού (ακόμη και σεξουαλική ταυτότητα)
- ✓Ενας ανοσοκατασταλμένος ασθενής δεν κινδυνεύει μόνο από ευκαιριακές λοιμώξεις ,αλλά από οποιαδήποτε λοίμωξη
- ✓Μία λοίμωξη μπορεί να μιμείται έξαρση της νόσου και να δυσχεραίνει τη διάγνωση

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doi:10.1093/ecco-jcc/jjab052
Advance Access publication March 17, 2021
ECCO Guideline/Consensus Paper

ECCO Guideline/Consensus Paper

ECCO Guidelines on the Prevention, Diagnosis, and Management of Infections in Inflammatory Bowel Disease

T. Kucharzik,[a] P. Ellul,[b] T. Greuter,[c] J. F. Rahier,[d] B. Verstockt,[e,o] C. Abreu,[f] A. Albuquerque,[g] M. Allocca,[h] M. Esteve,[i] F. A. Farraye,[j] H. Gordon,[k] K. Karmiris,[l] U. Kopylov,[m] J. Kirchgesner,[n] E. MacMahon,[o] F. Magro,[p,o] C. Maaser,[q] L. de Ridder,[r] C. Taxonera,[s,o] M. Toruner,[t] L. Tremblay,[u] M. Scharl,[v] N. Viget,[w] Y. Zabana,[i] S. Vavricka[v]; on behalf of the European Crohn's and Colitis Organisation [ECCO]

ΑΝΟΣΟΚΑΤΑΣΤΑΛΜΕΝΟΙ ΑΣΘΕΝΕΙΣ

Statement 2.1

IBD patients at risk for opportunistic infections are those treated with immunosuppressive agents, particularly in combination [EL1]. Further predictive factors are malnutrition, obese body mass index [BMI], comorbidities, active disease, and older age [EL3]

Statement 2.2

Immunosuppressive agents should be classified according to mechanism of action, dose, duration, and route of administration [EL5]

Journal of Crohn's and Colitis, 2021, 879–913
doi:10.1093/ecco-jcc/jjab052

ΑΝΟΣΟΚΑΣΤΑΛΤΙΚΑ ΦΑΡΜΑΚΑ

Table 1. IBD therapeutic agents and different degrees of immunosuppression.

Drugs	Degree of immunosuppression	Comment
Aminosalicylates		No systemic effects
Topical steroids		Systemic immunosuppression with oral topical steroids [oral budesonide] at doses >6 mg/day
Systemic steroids		Moderate-severe immunosuppression with doses of ≥20 mg for >2 weeks
Vedolizumab		Gut-selective treatment. No systemic effects, but increased risk for intestinal infections
Methotrexate		Moderate-severe immunosuppression with >20 mg per week [>0.4 mg/kg/week]. Lower doses can be considered as low immunosuppression
Azathioprine/6-MP		Moderate-severe immunosuppression with >3 mg/kg/day [AZA] or >1.5 mg/kg/day [6-MP]. Lower doses can be considered as low immunosuppression
Ciclosporin Tacrolimus Anti-TNF Tofacitinib Ustekinumab		There are different nuances within the group of moderate-severe immunosuppression that cannot be reflected by this simplified category. For instance, combination therapy [combination of any of these or combination with other immunosuppressive drugs such as AZA, methotrexate, or steroids] results in an increased risk for opportunistic infections. Immunosuppression of anti-TNF is probably higher compared with ustekinumab and tofacitinib

IBD, inflammatory bowel disease; 6-MP, 6-mercaptopurine; TNF,tumour necrosis factor; AZA, azathioprine.
Simplified degree of immunosuppression [the table helps to decide if live vaccines can be administered safely]:
No:

Selective:

Low:

Moderate-severe:

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doi:10.1093/ecco-jcc/jjab052

ΕΛΕΓΧΟΣ ΠΡΙΝ ΤΗΝ ΕΝΑΡΞΗ ΑΝΟΣΟΚΑΤΑΣΤΟΛΗΣ

Statement 3.1*

Serological screening for hepatitis A, B, C, HIV, Epstein-Barr virus, cytomegalovirus, varicella zoster virus, and measles virus [in the absence of documented past infection or vaccination for the latter two] is recommended for all IBD patients at baseline [EL4] and especially before or during immunosuppressive treatment [EL1]. A Pap smear for human papillomavirus screening is also recommended [EL1]

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ΗΠΑΤΙΤΙΔΑ B,C,E

Statement 3.4*

Patients with IBD and chronic hepatitis B infection should be treated with specific antiviral nucleos[t]ide analogues [EL1]

Statement 3.5*

Prophylactic treatment with antiviral agents is not recommended in patients with IBD and previous HBV infection [HB core Ab-positive, HBsAg-negative] [EL3]

Statement 3.6*

Patients with IBD and hepatitis C should be treated in accordance with national and international guidelines [EL5]. Patients with IBD and hepatitis C should be closely monitored for disease exacerbation when being treated with direct-acting antiviral agents [DAAs] [EL5]

3.2.4. Hepatitis E virus

The clinical features of acute hepatitis E are similar to those of other acute viral hepatitis. In immunocompetent persons, acute illness is infrequent and often mild due to brief viraemia.[66] Ribavirin therapy for 3 weeks in patients with severe hepatitis E leads to rapid improvement of liver enzymes and function.[66,67]

Journal of Crohn's and Colitis, 2021, 879–913

VZV-ΙΟΣ ΤΟΥ ΕΡΠΗΤΑ ΖΩΣΤΗΡΑ

- Αυξημένος κίνδυνος στους ασθενείς που λαμβάνουν JAKi.

Statement 3.8*

Recombinant herpes zoster vaccine [RZV] is the preferred vaccine for patients with IBD disease, given its efficacy and safety [EL3]. If RZV is not available, a live zoster vaccine [ZVL] is recommended in immunocompetent patients with IBD aged ≥50 years [EL4]

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CMV-ΚΥΤΤΑΡΟΜΕΓΑΛΟΙΟΣ

Statement 3.9*

Concurrent CMV colitis worsens the prognosis of active IBD. Patients with refractory IBD should be tested for CMV colitis [EL3], especially if they are not responding to immunosuppressive therapy [EL2]

Statement 3.10*

Immunohistochemistry [IHC], possibly tissue polymerase chain reaction [PCR], or both, are essential for confirming active CMV infection [colitis] in IBD and should be the standard tests [EL2]. Findings and potential interventions should be discussed in the clinical context

Statement 3.11*

Immunosuppressive therapy should not be discontinued in IBD patients with intestinal CMV reactivation in general [EL3]. Steroids should be tapered [EL4]. Antiviral therapy should be considered in steroid-refractory IBD patients with CMV colitis [EL3]. Discontinuation of immunosuppressive therapy is recommended in symptomatic disseminated CMV infection [EL 4]

Intravenous ganciclovir 5 mg/kg twice daily for 5–10 days, followed by valganciclovir 900 mg daily until completion of a 2–3 week course, is the treatment of choice. An earlier transition to

Foscarnet 2η επιλογή σε ανθεκτικά περιστατικά

Journal of Crohn's and Colitis, 2021, 879–913

ΙΟΣ ΤΗΣ ΓΡΙΠΗΣ

Statement 3.13*

Patients on immunosuppressive therapy are considered to have an enhanced risk for development of severe influenza infection [EL5]. Annual influenza vaccination of patients on immunosuppressive therapy is recommended according to national guidelines [EL5]. Live vaccines should not be administered to immunosuppressed patients

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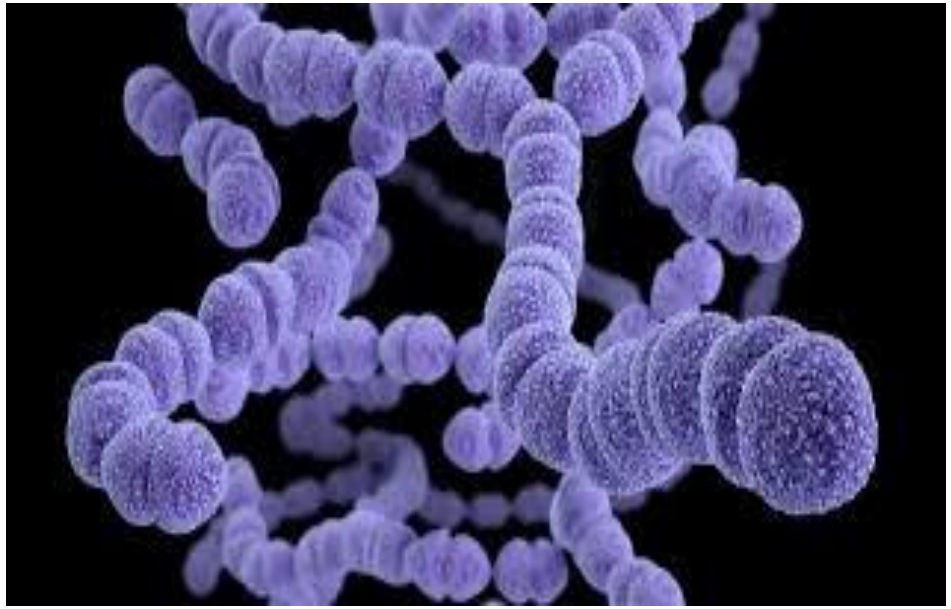
ΠΝΕΥΜΟΝΙΟΚΟΚΚΟΣ

- 2-3 φορές αυξημένος κίνδυνος νόσησης σε ανοσοκατασταλμένους ασθενείς με ΙΦΝΕ.
- Εμβόλια: Pneumo 13, Pneumo 23, Appexnar



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ΛΕΓΙΟΝΕΛΛΑ

Statement 5.2*

Patients with IBD on immunosuppressive therapy with pneumonia should be tested for *Legionella pneumophila* [EL4]. In case of *Legionella pneumophila* infection, immunosuppressive agents should be temporarily withheld until resolution of active infection [EL5]

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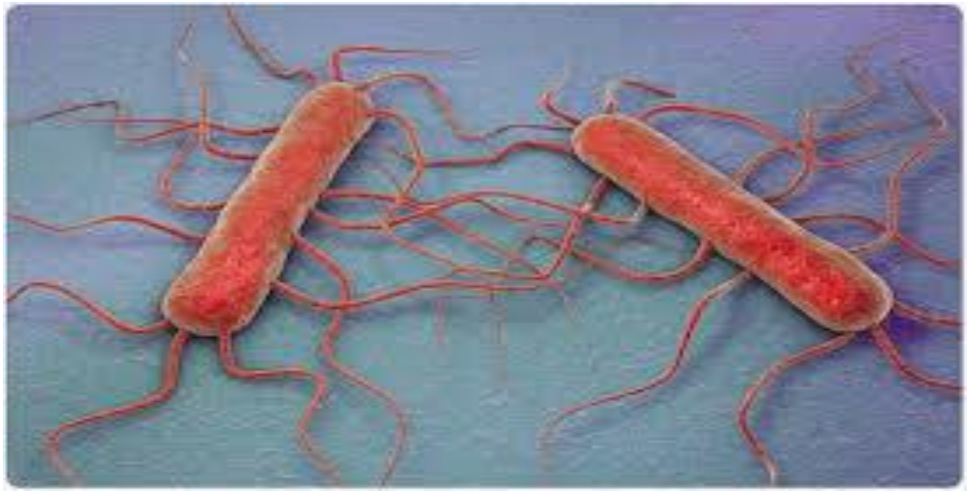
ΣΑΛΜΟΝΕΛΛΑ-ΛΙΣΤΕΡΙΑ

Statement 5.3*

Patients receiving immunosuppressive agents are at risk of more severe infections with *Salmonella enteritidis* and *S. typhimurium* [EL4] and systemic and central neurological infections with *Listeria monocytogenes.*[EL4] The incidence of *L. monocytogenes* infections appears higher in patients treated with anti-TNF agents compared with other immunosuppressive agents [EL4]. Immunosuppressive therapy should be temporarily withheld until resolution of the active infection [EL5]



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CL.DIFFICILE

ΑΥΞΗΜΕΝΟΣ ΕΠΙΠΟΛΑΣΜΟΣ ΜΕΤΑ ΤΗΝ ΠΑΝΔΗΜΙΑ COVID

Statement 5.4*

Screening for *C. difficile* infection [CDI] is recommended at every disease flare in patients with IBD and especially in patients receiving immunosuppressive therapy [EL3]

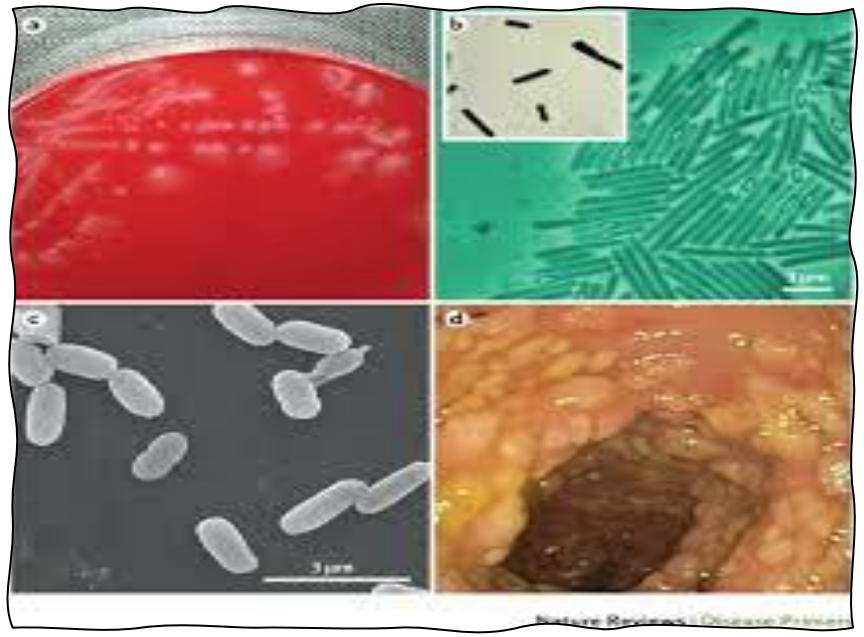

Table 3. Treatment options for *C. difficile* colitis.

	Treatment options*	Observations
Initial episode [10 days of therapy]	VAN 125 mg orally 4 times daily OR FDX 200 mg orally twice daily OR metronidazole, orally 500 mg 3 times daily	FDX less readily available than VAN If above drugs not available
Initial, fulminant [hypotension or shock, ileus, megacolon]	VAN, 500 mg 4 times daily [by mouth, nasogastric tube, or rectal] PLUS intravenous metronidazole [500 mg every 8 h]	If ileus: consider adding rectal instillation of VAN [retention enema: 500 mg in 100 ml, 4 times daily]
First recurrence	VAN 125 mg orally 4 times daily for 10 days	If metronidazole was used for the initial episode
	OR	If VAN was used for the initial episode
	prolonged tapered and pulsed VAN regimen [eg, 125 mg 4 times daily for 10–14 days, 2 times daily for a week, once daily for a week, and then every 2 or 3 days for 2–8 weeks]	If VAN was used for the initial episode
	OR FDX 200 mg twice daily for 10 days	
Second and subsequent recurrence	VAN in a tapered and pulsed regimen OR VAN 125 mg orally 4 times for 10 days followed by rifaximin 400 mg 3 times daily for 20 days OR FDX 200 mg twice daily for 10 days OR Faecal microbiota transplantation	

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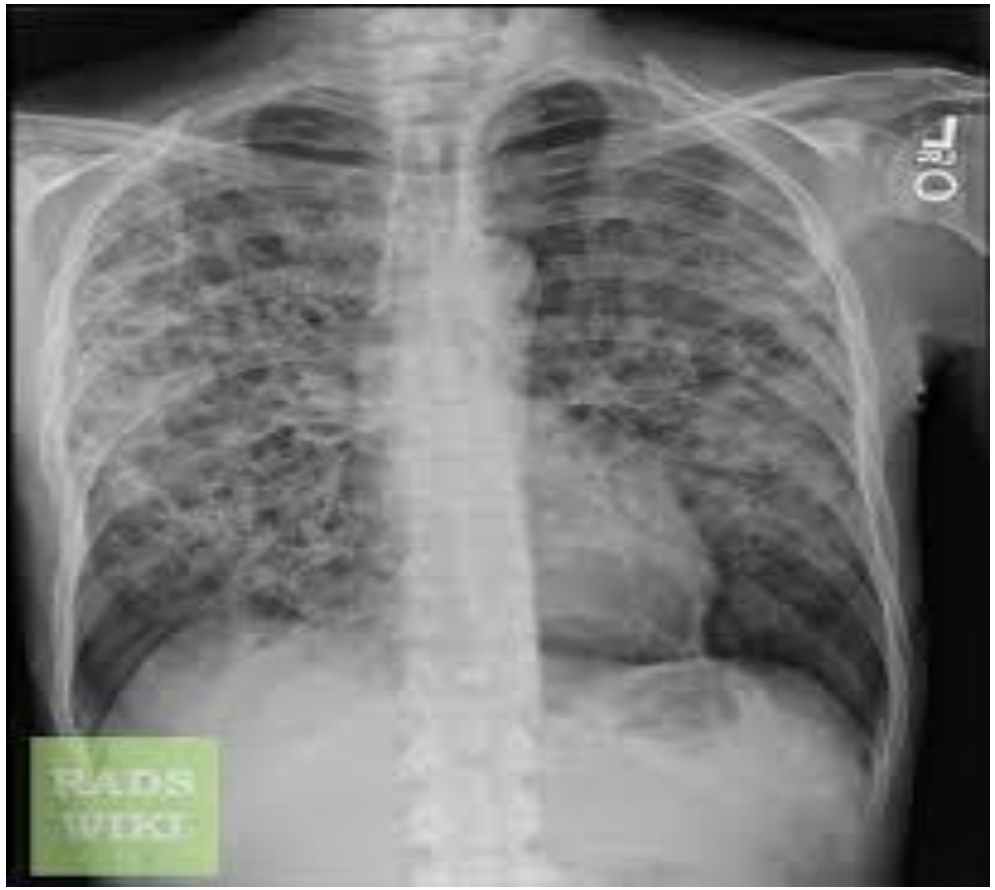
ΣΕ ΕΞΑΡΣΗ ΙΦΝΕ…

- ✓ Αποκλεισμός πρώτα εντερικής λοίμωξης
  1. Εργαστηριακός έλεγχος-δείκτες φλεγμονής
  2. Καλλιέργεια κοπράνων
  3. Παρασιτολογική κοπράνων
  4. Έλεγχος για Cl. Difficile
  5. Ενδοσκόπηση για αποκλεισμό CMV

PNEUMOCYSTIS JIROVECII

Statement 6.3

For patients with IBD on triple immunosuppressive therapy [including steroids, methotrexate, thiopurines, biologics], standard prophylaxis with TMP-SMX should be strongly considered [EL4]. For those on double immunosuppressive therapy, prophylactic TMP-SMX may also be considered, especially if one of these is a calcineurin inhibitor [EL4]. TMP-SMX should also be considered for any combination of high-dose corticosteroids, low lymphocyte count, or JAK inhibitors [EL5]



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ΠΡΟΛΗΨΗ

Table 5. Adult immunisation schedule for patients with IBD.

	Dosing, schedule, and remarks	Type of vaccine[a]	At diagnosis	At diagnosis and during follow-up	Strongly recommended before immunosuppressive treatment
IBD-specific vaccination programme					
Inactivated influenza [trivalent/quadrivalent or high dose]	Annual vaccination recommended for all patients on immunosuppressive therapy, according to national guidelines	Non-live		Yes	Yes
Zoster recombinant [RZV] [preferred]	For all patients ≥50 years. Consider in patients <50 years at increased risk of herpes zoster infection	Non-live			Yes
Zoster live [ZVL]	Use only if RZV is unavailable and patient is immunocompetent	Live-attenuated vaccine			Yes
Pneumococcal conjugate 13-valent [PCV13] and polysaccharide 23-valent [PPSV23]	Single dose of PCV13 followed by PPSV23 after 8 weeks, and a PPSV23 booster after 5 years. Additional PPSV23 booster according to national guidelines. If PPSV23 provided first, then administer a single dose of PCV13 after 1 year and a PPSV23 booster after 5 years. Additional PPSV23 booster according to national guidelines	Non-live	Yes	Yes	Yes
Hepatitis A [Hep A][b]	Consider hepatitis A vaccination. Schedule and dosage according to national guidelines	Non-live		Yes	
Human papillomavirus [HPV]	Two or three doses depending on age, for unvaccinated patients, both sexes	Non-live	Yes	Yes	
Hepatitis B [Hep B][c]	Three-dose series. Additional booster might be necessary according to level of seroprotection. Titres should be regularly checked	Non-live	Yes	Yes	Yes
Routine vaccination programme					
Tetanus, diphtheria, pertussis [Tdap or Td]	If previously immunised, single dose of Tdap, then Td or Tdap every 10 years according to national guidelines	Non-live	Yes	Yes	
Meningococcal vaccines[d]	For patients at high risk of invasive meningococcal disease. Schedule and dosage according to national guidelines	Non-live	Yes	Yes	
Measles, mumps, rubella [MMR]	Adults without evidence of immunity should receive 2 doses separated by at least 28 days	Live-attenuated vaccine	Yes		Yes
Varicella	Two doses 4–8 weeks apart only in patients with no history of chickenpox or shingles, no previous immunisation, and negative serology for varicella zoster	Live-attenuated vaccine	Yes		Yes
Poliomyelitis [inactivated parenteral poliovirus]	Schedule and dosage according to national guidelines	Non-live	Yes	Yes	
SARS-CoV-2	Schedule and dosage according to national guidelines	Non-live	Yes		Yes

- **Πολύ καλό ιστορικό**
- **Προσεκτική κλινική εξέταση**
- **Αποκλεισμός έξαρσης νόσου ή συμπτωματολογίας που σχετίζεται με τη νόσο**
- **Έγκαιρη διάγνωση**
- **Διακοπή ανοσοκατασταλτικής θεραπείας**
- **Ορθή θεραπευτική αντιμετώπιση και με τη βοήθεια ιατρών άλλων ειδικοτήτων**
- **ΠΡΟΛΗΨΗ**


Thank
you