

# Inflammatory Bowel Disease: Diagnostic and Treatment Options

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The questions below are based on the article “Inflammatory Bowel Disease: Diagnostic and Treatment Options,” which begins on page 11 of this issue. Choose the single best answer for each question.

- 1. Which of the following best explains the current understanding of the genetic and pathophysiologic basis of Crohn’s disease (CD)?**
  - (A) Inactivation of the cytokine interleukin-12 results in a proinflammatory state and the development of CD
  - (B) A link between specific genetic markers and the development of CD has not yet been identified
  - (C) Mutations in the NOD 2/CARD 15 gene result in failure of NF-κB activation, dysfunction in the innate immunity, and stimulation of a proinflammatory state
  - (D) Inflammation is thought to be secondary to a genetic predisposition to infection by the bacteria *Saccharomyces cerevisiae*
  - (E) Mutations in the centromere region of chromosome 20 result in inflammation and autoimmune destruction of intestinal mucosa
- 2. A 45-year-old man with a history of ulcerative colitis (UC) is admitted to the hospital after experiencing 3 days of fevers, chills, abdominal pain, and worsening bloody diarrhea. He has a temperature of 101.2°F, pulse of 100 bpm, and blood pressure of 90/50 mm Hg. On examination, his abdomen is soft but diffusely tender. Correct initial management of this patient includes all of the following EXCEPT**
  - (A) Obtain blood cultures and stool cultures and perform tests for *Clostridium difficile* and cytomegalovirus
  - (B) Perform abdominal imaging studies to rule out toxic megacolon or perforation
  - (C) Begin intravenous (IV) hydration and make patient nothing by mouth
  - (D) Begin cyclosporine therapy to induce remission
  - (E) Begin IV steroids after ruling out underlying infection or toxic megacolon
- 3. Despite aggressive inpatient therapy, the patient in question 2 continues to have severe abdominal pain and hematochezia and is unable to tolerate oral nutrition for 1 week. What should be the next step in management of this patient?**
  - (A) Add budesonide and repeat abdominal imaging to evaluate progression of disease
  - (B) Add oral metronidazole
  - (C) Increase dose of IV steroids to 3 mg/kg divided 3 times daily
  - (D) Begin azathioprine therapy
  - (E) Obtain surgical consultation for possible colectomy
- 4. A 24-year-old woman presents to your clinic with new-onset abdominal pain and hematochezia that began 2 months ago. On examination, her abdomen is benign and she denies current bloody bowel movements. Colonoscopy shows distal colitis up to 40 cm and biopsies are consistent with UC. What is the most appropriate therapy for this patient?**
  - (A) Prednisone 40 mg/d
  - (B) Mesalamine suppositories
  - (C) Mesalamine enemas in combination with an oral 5-aminosalicylate (5-ASA) drug
  - (D) Azathioprine in combination with prednisone
  - (E) No therapy is recommended until patient experiences further symptoms
- 5. Which of the following is an indication for the use of capsule endoscopy?**
  - (A) A high clinical suspicion of inflammatory bowel disease (IBD) despite normal colonoscopy and small bowel follow-through
  - (B) Detection of distal lesions in patients with negative computed tomography enteroclysis
  - (C) Evaluation of suspected strictures in patients with CD
  - (D) Evaluation of fistula in CD
  - (E) Evaluation of extra-intestinal manifestations of IBD

For answers, see page 44.

**Answers to the review questions asked on page 33. The article on inflammatory bowel disease begins on page 11.**

1. (C) Mutations in the NOD 2/CARD 15 gene result in failure of NF- $\kappa$ B activation, dysfunction in the innate immunity, and stimulation of a proinflammatory state
2. (D) Begin cyclosporine therapy to induce remission
3. (E) Obtain surgical consultation for possible colectomy
4. (C) Mesalamine enemas in combination with an oral 5-ASA drug
5. (A) A high clinical suspicion of IBD despite normal colonoscopy and small bowel follow-through

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