

# IBD News

Winter 2009

U-M Division of Gastroenterology




University of Michigan  
Health System

## Newsflash:

### All Restrooms in Michigan are Your Restrooms!

The Michigan Legislature passed the Restroom Access Act at the end of 2008, and Governor Jennifer Granholm signed it into law for 2009. This new law requires all retail establishments that have employee-only restrooms to allow customers to use the restroom if they have a signed prescription stating that this person has IBD and that they need immediate access to a restroom.

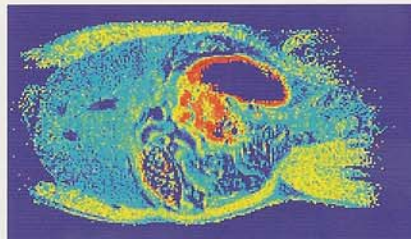
Be sure to ask your doctor if you qualify for the Restroom Access Card during your visit today!

	is a patient who suffers from inflammatory bowel disease and receives care from
Dr. _____ at the University of Michigan.	
Inflammatory bowel disease is a medical condition that requires	<b>IMMEDIATE ACCESS TO A TOILET.</b>
Providing immediate access to a toilet for this person is	<b>required</b> of all businesses in Michigan by state law, per HB 5046, December 31, 2008.

### Looking for Something Better? Ongoing Clinical Trials in IBD:

#### Is your intestine scarred?

Being able to tell whether the intestine is becoming scarred and narrowed in Crohn's disease before an intestinal blockage occurs is a major goal of the research of Dr. Zimmermann and Dr. Higgins. Two studies of different approaches to this problem are getting underway. Dr. Zimmermann's NIH-funded study uses a special kind of MRI to detect large molecules, like collagen, as they accumulate in scar in the intestines.



Dr. Higgins' study uses a special kind of ultrasound to measure the stiffness of intestines of patients. Both studies will be available for patients with narrowing in their intestines who are planning on surgery. The results of these imaging tests will be compared to the actual microscopic-level scarring found in the sections of the intestine removed at surgery to determine how accurate these non-invasive, radiation-free approaches to measuring scarring are.

**Measurement of ulcerative colitis and Crohn's disease** – This is how we find out if new drugs actually work. Unfortunately, all of our current measures require endoscopy, so clinical trials in ulcerative colitis require patients to undergo repeated endoscopies. The EMBARK study, sponsored by Genentech, will test whether measurement of blood markers, stool markers, and symptoms is as good as measurement with endoscopy. Subjects with active UC or Crohn's will be asked to answer questions about symptoms, provide stool and blood samples, and have a free colonoscopy with biopsies. If your doctor is thinking about doing a colonoscopy to evaluate your symptoms, you could have this procedure paid for by this study.

**IL17** – the hottest molecule in IBD, interleukin 17 (IL-17) is considered an important 'ON' signal for the immune system of the gut, and appears to be especially important in driving inflammatory bowel disease. New molecules to block IL-17 activity are considered the next frontier in IBD therapy. AIN-457, an anti-IL17 antibody made by Novartis, has been used in more than 100 patients with autoimmune diseases, including rheumatoid arthritis and psoriasis. The Michigan IBD Center, with Dr. Peter

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## How to Refer a Patient to one of our IBD Specialists

Call our GI appointment center at 888-229-7408 for the appointment line, and specify that you want an IBD Specialist.

Fax patient records to our GI Call Center at 734-936-5458. Please include most recent labs, recent imaging reports or CDs, endoscopy reports, and pathology reports.

IBD specialists available by day:

#### Monday

Ellen M. Zimmermann  
Peter Higgins  
Timothy T. Nostrant  
Leslie Aldrich  
Michael Rice  
Akbar Waljee

#### Tuesday

Grace Elta  
Michael Rice

#### Wednesday

Leslie Aldrich  
Michael Rice

#### Thursday

Leslie Aldrich  
Jason Grove, PA

#### Friday

Leslie Aldrich

## IBD Visiting Professors Series

Continuing in the fall, the IBD Visiting Professors Series at the University of Michigan will be co-sponsored by Shire, Centocor, Abbott, and UCB. Invited IBD researchers will present their cutting-edge results and discuss their research with our University of Michigan IBD group.

For the 2008-2009 year, the IBD Visiting Professors will be:

### September 15th

Dr. Eugene Chang  
University of Chicago

### October 14th

Dr. Fernando Velayos  
UCSF

### February 10th

Dr. Bruce Sands  
Massachusetts General Hospital

### March 10th

Dr. Ann Lowry  
University of Minnesota

### April 28th

Dr. Maria Abreu  
University of Miami

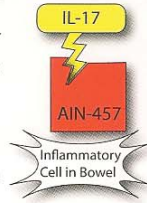
### July 28th

Dr. Jean-Fred Colombel  
University of Lille, France

Coming next year: **Marla Dubinsky** from Cedars-Sinai in Los Angeles, **David Binion** from the University of Pittsburgh, **Robin McLeod** from Mount Sinai in Toronto, **Steven Itzkowitz** from Mount Sinai in New York

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Higgins as the lead investigator, is a site for a study of this antibody in patients with active Crohn's disease. Please contact Jessica FunNell at 734-615-4843 if you have patients who are eligible.



**IL12p40** – another protein in the IL17 pathway, this molecule can be blocked by specific antibodies and reduce inflammation. A study of ustekinumab, an antibody against IL12p40, is being performed in patients with active Crohn's disease. Please contact Jessica FunNell at 734-615-4843 if you have patients with active Crohn's disease.



## IBD News You Can Use

The major European digestive disease research meeting was held in Vienna in October. The highlights in IBD Research included:

- Blood clots on the rise. Patients with active IBD have a 5 fold increase in the rate of blood clots in the legs and lungs, and this increases to 11 fold if they are also on steroids and hospitalized.
- Blood clots come back in IBD. Patients with previous blood clots are at risk of recurrent clots in the same vessel. Patients with IBD with previous blood clots are at an even higher risk of recurrence (2.7 fold more) than non-IBD patients.
- Recurrence of Crohn's after surgery. In one study, 85% of patients on no medication developed multiple intestinal ulcers by 1 year after surgery, while only 10% of patients on infliximab had multiple intestinal ulcers at one year. Going with no medication at all seems unwise.
- Opportunistic infections – of 192 consecutive IBD patients in one study who were all tested for C difficile bacterial infection and cytomegalovirus infection, 19% had an infection that contributed to their symptoms. People with IBD appear to be more likely to develop intestinal infections, which can act a lot like an IBD flare.
- Crohn's patients who did not have strictures or fistulas who were started on azathioprine (imuran, 6MP) were 8.6 fold less likely to need surgery by 9 years when compared to patients not on immunomodulators. Starting imuran before complications develop appears to reduce surgical complications.
- For patients with relatively new Crohn's disease (< 2 years), with active inflammation (high CRP, ulcers on colonoscopy), the combination of infliximab and imuran for the first 6 months works better than either medication alone. Longer-term data are being collected.



## On the Drawing Board

*This is a list of clinical studies we are currently designing, considering, trying to get funding for, or filing the paperwork to get institutional permission to do in the future:*

## Patient Question of the Quarter:

### Why is it now OK to be tested for genes that can cause IBD?

One of the largest advances in our understanding of IBD in the past 10 years has been from studies in the genetics of IBD. It is estimated that about half of the causation of Crohn's disease can be attributed to genetics, while ulcerative colitis is approximately 10% heritable. Certain genes, like NOD2, have been associated with more small intestinal Crohn's, with more stricturing and more fistula formation, compared to Crohn's patients without the NOD2 gene.

However, having the NOD2 gene, or other IBD associated genes, is no guarantee that someone will get IBD. In fact, most patients with these susceptibility genes will never develop IBD. It appears that in addition to genetic risk factors, patients need additional "hits" to develop IBD. These might include infections of the GI tract, use of medications that cause ulcers in the intestines (including aspirin, ibuprofen, naprosyn, etc.), and use of antibiotics that alter the intestinal bacteria.

Until recently, it was considered a bit risky to do genetic testing for IBD susceptibility genes and to place the results in the medical record. It was considered likely that insurance companies would use these results to raise the rates of insurance premiums, or even deny coverage to patients who had genetic markers for complicated IBD like NOD2.

This changed with GINA, the Genetic Information Non-discrimination Act of 2008. This federal law prevents insurers from changing coverage on the basis of genetic information in the medical record.



This allows us to track genetic markers of IBD without fear of bringing harm to our patients, and allows us to study questions like:

- Do certain medications work better in patients with particular genetic markers?
- Do patients with particular markers have more risk for complications of disease?

And many other questions in which we can use genetic markers to divide Crohn's disease and ulcerative colitis into different subtypes, which may have different symptoms and complications.

This is the focus of the ongoing IBD Databank Study underway at the University of Michigan, directed by Dr. Ellen Zimmermann. This study enrolls people with IBD and their unaffected relatives, and gathers information on genetics, environmental exposures, treatments for IBD, clinical severity of IBD, blood and stool markers of inflammation, and biopsies, and follows subjects over time. The goals of the study are to better understand (1) the causes of why certain people get IBD, (2) whether we can use data from blood, stool, biopsies, or genes to predict the disease course of IBD, and (3) whether we can use this data to predict which therapy will be most effective for particular patients. Study Coordinator Andrace DeYampert is enrolling subjects each week, and is particularly looking for patients with families that also live in Michigan. If you are interested in participating in this study to try to understand the causes of IBD, please contact Andrace at 615-0507.



## How to Refer a Patient to an IBD Clinical Trial

They do not need a clinic appointment – Just call our IBD Study Coordinator:



Jessica FunNell  
734-615-4843

- A study of the symptoms that bother UC and Crohn's patients during disease flares, followed by patient-guided development of survey items to measure these symptoms.
- A study of whether molecules (biomarkers) in the stool or blood can predict which IBD patients currently in remission will have a flare, and which patients will stay in remission.
- A study of whether infection with norovirus is associated with flares of IBD.
- A survey study of high school students to understand how having IBD affects their decisions about whether and where to go to college, and how they expect to adjust when they get there.



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**U-M Inflammatory  
Bowel Diseases Program**  
[www.med.umich.edu/ibd](http://www.med.umich.edu/ibd)

**U-M Division of  
Gastroenterology**  
[www.med.umich.edu/gi](http://www.med.umich.edu/gi)

For a physician to  
physician consultation, call  
M-Line at 1-800-962-3555.

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## M-Line – the Hotline to UM Doctors

Massive abdominal pain and vomiting wrenched EMU student Karyn Kozloff from her sleep in the middle of a Friday night in August of 2007. “I could not keep anything down for almost three days. I was in so much pain, I was doubled over,” she recalled. Since it was the weekend, she decided to wait until Monday to call her primary care physician, Dr. Hindi Ahmed of Linden Road Medical Group in Flint.

Karyn was diagnosed with Crohn’s disease in 2006. She was terribly ill, losing more than 40 pounds, developing large blood clots in both legs, and not responding well to steroids. In the summer of 2007, she came to the University of Michigan for a second opinion with Dr. Peter Higgins who became her gastroenterologist. She had a tightly narrowed section of her small intestine that Dr. Higgins hoped would respond to a new medicine, but he told her that that section would probably need surgical removal eventually.

Dr. Ahmed took Karyn as her first patient that Monday morning. After a quick assessment of the seriousness of Karyn’s condition, Dr. Ahmed called M-LINE to connect with Dr. Peter Higgins and discuss what to do next. Dr. Higgins explained that Karyn had either a complete intestinal blockage or a perforated bowel. In either case, she needed to go to the University of Michigan emergency room right away.

Karyn was rapidly diagnosed with an intestinal perforation, and required a four-hour surgery to remove part of her intestine. Her surgeon, Dr. Diane Simeone, later told Karyn that when she opened her up it looked like a bomb had detonated inside her body. After her surgery, Karyn spent a week recovering in the hospital and then went home with an ostomy bag. This past May, Dr. Simeone performed an ostomy reversal and Karyn has been doing great ever since. She has continued on her maintenance medication, returned to school, and stayed completely off steroids. “I love U-M. They saved my life. If I hadn’t gone there, I would be dead by now. They are amazing. They really are.”

Dr. Ahmed agrees with her patient, “Everything with Karyn’s surgery was so well arranged. The communication between myself, Dr. Higgins, and the surgeon was very good. They took good care of her at U-M, and now she is back to her normal self.”

Dr. Ahmed continues, “When I have difficult patients, I like to call M-LINE to get in touch with the specialists I need. Whether it’s related to the spine, cardiology, neurology, or as in Karyn’s case, gastroenterology, I never hesitate to call M-LINE to help me find a physician in that specialty.”

**The M-Line phone number is 1-800-962-3555.**



Karyn is very hopeful she will live symptom-free for many years to come. She plans to graduate in the spring with her bachelor’s degree in Communications and Marketing from Eastern Michigan University where she is currently a senior. Her dream is to find a job affiliated with the Olympics.



The Crohn’s and Colitis Foundation of America held their national research meeting in December 2008.

Among the many notable speakers were three from the University of Michigan. Dr. Peter Higgins delivered a presentation on “Practical Approaches to the Differential Diagnosis of IBD”.

Two research fellows in gastroenterology, Dr. Dahlia Awais, and Dr. Akbar Waljee, had their research selected for oral presentations at the meeting. Dr. Awais presented her research, “Renovating the domain structure of the inflammatory bowel disease questionnaire,” and Dr. Waljee presented his research on “Assessing the discount rate in patients with inflammatory bowel disease” as part of the Clinical Research Session. These presentations can be seen on our website: [www.med.umich.edu/ibd](http://www.med.umich.edu/ibd).