Symposium 218

Current Challenges of Inflammatory Bowel Disease

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Hyatt Regency Hotel
Mexico City, Mexico

Abstracts
Poster Abstracts

FALK FOUNDATION e.V.

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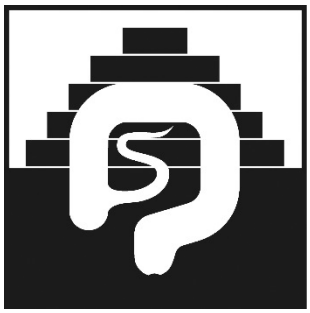
Abstracts of Invited Lectures
Poster Abstracts

Symposium 218

CURRENT CHALLENGES OF INFLAMMATORY BOWEL DISEASE



Mexico City, Mexico
March 6 – 7, 2020

Scientific Organization:
J.K. Yamamoto-Furusho, Mexico City (Mexico)

Scientific Co-Organization:
M.T. Abreu, Miami (USA)
F.J. Bosques Padilla, Monterrey (Mexico)
F. Gomollón, Zaragoza (Spain)

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The frequency of joints manifestations of inflammatory bowel disease in the practice of a rheumatologist

Olena Sulima (Dnipro, UA), Volodymyr Sulyma (Dnipro, UA)

Introduction: Joint manifestations of inflammatory bowel diseases (IBD) are observed in 30% of cases. Their largest share is in total forms of ulcerative colitis (UC) 85–90% and Crohn's disease (CD) involving the colon 30–35% or large and small intestines 60%. The pathogenesis of articular manifestations remains unclear. The importance of increased permeability of the intestinal wall, which is noted in patients with UC and CD, is discussed, as a result of which the components of the membrane wall of bacteria enter the bloodstream. These components act as peptide antigens that can lead to the development of arthritis. Contacting the molecules of histocompatibility complexes and further activating T-lymphocytes, peptides lead to joint inflammation. From the point of view of a rheumatologist, the articular manifestations of IBD are classified as seronegative spondyloarthropathies.

Methods: During 2013–2018, we studied the frequency of treatment of patients with IBD with extraintestinal articular manifestations for examination to a rheumatologist. We analyzed the ratio of the number of patients with IBD having joints manifestations, which were confirmed and diagnosed by a rheumatologist or consulted in the areas of a gastroenterologist and a surgeon-proctologist.

Results: All patients who turned to a rheumatologist with joints manifestations over the years were referred by a gastroenterologist (38%), surgeon-proctologist (14%) and these extraintestinal manifestations of IBD were suspected and confirmed by a rheumatologist (48%).

Discussion/Conclusion: The need for a differentiated approach to the treatment of peripheral arthritis and any axial skeletal lesions is noted, the role of 5-aminosalicylic acid (5-ASA) drugs, steroidal and non-steroidal anti-inflammatory drugs (NSAIDs), immunosuppressant and biological drugs in the treatment of articular syndrome in IBD is evaluated. It is indicated that patients with IBD having of joints manifestations should be observed jointly by a rheumatologist, gastroenterologist and a proctologist.