Letter to the Editor

Management of Ulcerative Colitis Using Vedolizumab After Liver Transplantation for Primary Sclerosing Cholangitis

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The therapeutic approaches for treating inflammatory bowel disease (IBD) after liver transplantation (LT) are greatly debated. There are some studies about the effectiveness of using corticosteroids, 5-aminosalicylates (5ASA), and immunomodulators, such as azathioprine, methotrexate, or ciclosporine, but there is still little experience in using biological therapies to treat liver transplant recipients. 1

To date, in the literature there have only been 28 patients treated with anti-tumour necrosis factor [TNF] for IBD relapse following LT; this number includes patients with ulcerative colitis [UC], Crohn’s disease, indeterminate colitis, and pouchitis treated effectively with infliximab or adalimumab. 2,4 Recently vedolizumab, a recombinant monoclonal antibody that inhibits the adhesion and migration of leukocytes into the gastrointestinal tract, was proven to be more effective than placebo in induction and maintenance therapy for ulcerative colitis. 5 To our knowledge, there are no data in the literature on the safety and efficacy of using vedolizumab in the management of active UC in patients undergoing LT for primary sclerosing cholangitis [PSC].

We present the case of a 40-year-old male who was admitted to our hospital in 1994 when pancolitis [UC] and PSC were diagnosed. Biliary cirrhosis developed in the course of the PSC and he was referred for the first LT in 2002. A second LT was performed in 2003 for ischaemic cholangitis. All this time UC was in remission, until in 2008 he presented with a flare-up of moderately active pancolitis. He continued to have frequent relapses between 2008 and 2009 and developed steroid-dependent colitis, so azathioprine 2.5 mg/kg/day was introduced. He achieved remission until 2012, when immunomodulatory refractory colitis was diagnosed. Infliximab at 5 mg/kg was started as an induction and maintenance protocol, and azathioprine was stopped. For the next 2 years, the UC remained in remission.

In 2014, in spite of well-conducted treatment, he presented a relapse of moderately active colitis; therefore we optimised the infliximab treatment to 10 mg/kg every 6 weeks. For the next 5 months he had persistent symptoms of active UC and developed an infliximab-refractory ulcerative colitis. We decided not to start using another anti-TNF drug like adalimumab but to switch to a drug with a different mechanism of action. Infliximab therapy was stopped and switched to vedolizumab administered at 300 mg at Weeks 0, 2, and 6 and then every 8 weeks. Vedolizumab was very well tolerated, and the patient achieved remission 7 months later.

In 2015, as he had a relapse of the disease, we optimised the treatment to 300 mg of vedolizumab every 4 weeks. Five months later, the patient is still in remission.

We concluded that vedolizumab would be an effective and safe option for treating refractory ulcerative colitis in liver transplant recipients.

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Conflict of Interest

The authors do not declare any conflict of interest.

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