LETTER TO THE EDITOR

Natural history of inflammatory bowel disease patients submitted to solid organ transplantation

Dear sir,

Studies on the natural history of patients with inflammatory bowel disease (IBD) submitted to solid organ transplantation (SOT) reported contradictory results. Most studies report a more aggressive course of the intestinal disease after transplantation.1,2 There are factors which have been associated with the development of IBD "de novo" after transplantation, such as CMV infection (i.e., patients with negative CMV serology receiving organs from CMV positive donors appear to have increased risk for developing IBD).3,4 Other factors have proven, in published series, to be risk factors for worsening of pre-existing IBD, they are: symptoms of IBD at the time of transplantation, liver transplantation for primary sclerosing cholangitis (PSC) and immunosuppression with tacrolimus.2,4,5 The use of azathioprine after transplantation appears to be a protective factor for both, worsening of pre-existing IBD, and IBD onset.2

We performed a retrospective analysis of IBD patients attending our clinics with two objectives: to evaluate the characteristics of patients with IBD that had undergone SOT and to analyze the impact of SOT on the natural history and therapy of IBD. Patients were divided into two groups: IBD diagnosed before SOT and IBD diagnosed after SOT.

Eleven patients were included in the analysis:

IBD diagnosed before SOT (n = 8): six patients had ulcerative colitis (UC) and 2 had Crohn's disease (CD). The organ transplanted was the liver in seven patients (3 for PSC, 2 for autoimmune hepatitis–PSC overlap syndrome, 1 for hepatitis B virus fulminant hepatitis and 1 for amyloidosis) and the kidney in 1. Fifty percent experienced worsening of IBD following SOT (2 patients developed corticoidependence and 2 became cortico-resistant and were later submitted to colectomy). Of the patients that experienced IBD exacerbation, 2 were transplanted for PSC and 2 for PSC/AIH overlap. The immunosuppressive regimen was changed in 2 patients (one driven by SOT, and the other by the course of IBD).

IBD diagnosed after SOT (n = 3): two patients with CD and one with UC. All patients were kidney transplant recipients (mean time between SOT and the diagnosis of IBD was 6 years). In one patient the immunosuppressive regimen was changed because of IBD.

We concluded that the follow-up of these patients requires a multidisciplinary approach because a modification in the immunosuppression is often necessary (27% in our series) and can be motivated by either the IBD or the SOT. The course of IBD was more severe following liver transplantation for PSC or PSC/AIH overlap.

References


Paulo Salgueiro
Paula Lago
Isabel Pedroto
Gastroenterology Department, Hospital Santo António, Porto, Portugal
*Corresponding author. Tel.: +351 917209020.
E-mail address: paulosalgueiro@gmail.com
(P. Salgueiro).

28 November 2012