Low dose naltrexone for ulcerative colitis: two case reports
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Background
Naltrexone is approved for use by the United States Food and Drug Administration as an adjunct treatment in patients with alcohol and opioid dependence.1 Additionally, it has been investigated and shown effective for off-label uses, such as Crohn’s disease, including pediatric Crohn’s disease,2 multiple sclerosis,3,4 various forms of pain,3,5 fibromyalgia,5 and even autism.6 Low-dose naltrexone (LDN) frequently has side effects but is well tolerated in most.7

While several well-designed trials support the use of LDN for Crohn’s disease, at this time data are sparse to support use in another form of inflammatory bowel disease – ulcerative colitis (UC).8,9 To date, only a single case study has been presented about the use of LDN in a young female with ulcerative colitis. The potential benefits of LDN as a last-line option in ulcerative colitis were demonstrated in the report.10

Methods
The following includes case reports regarding two patients treated within a primary care clinic. They were also managed by outside gastroenterology specialists.

In the summer of 2017, each patient’s electronic health records were obtained including progress notes and all other pertinent medical information for two patients with UC who were treated with LDN.

In addition to the collection of the computer documented patient histories, the primary researcher conducted in person verbal interviews with both patients in order to further clarify documented medical information.

The primary objective was to report the use of low dose naltrexone in two patients with ulcerative colitis who have tried other standardized treatment approaches and highlight potential benefits of therapy.

Case Report 1

Case 1 is that of a 46-year-old female who initially presented in 2010 with a 10-year history of distal UC. At that time, she was taking mesalamine (Asacol) 400 mg, azathioprine (Imuran) 50 mg, prednisone 20 mg taper, and folic acid 1 mg. She had a 10-year smoking history, ending in 2004. In Mar 2011, naltrexin (Remicade) 1000 mg was added to her UC regimen due to...

Case Report 2

Case 2 is that of a 43-year-old female diagnosed with proctosigmoiditis UC at age 26. Initially, the patient was treated with mesalamine (Asacol) and steroids (specifics unknown) with each flare. The patient self-discontinued mesalamine due to side effects. Oral LDN 4.5 mg once daily at bedtime was initiated in 2006. Within 6 months, remission was achieved and maintained until 2011, at which time she discontinued LDN due to the desire to breastfeed. At this point, remission was maintained for an additional four years; however, her specific regimen throughout this period is unknown. In Apr 2015, she began experiencing 2-3 bloody bowel movements per day, which gradually worsened. Around this time, she was initiated on mesalamine (Canasa), which was discontinued by her gastroenterologist after three weeks due to a lack of improvement.

Case Report 1 continued

...increasing frequency of bloody stools to 3-4 times daily. In July 2011, a colonoscopy showed persistent rectal inflammation and hydrocortisone/iodoquinol 1-1% suppositories were started and mesalamine was discontinued. Three years later, naltrexin was stopped due to an allergic reaction in Mar 2014. Adalimumab (Humira) was initiated next, but was discontinued after three months at which time the patient experienced a flare characterized by abdominal pain and loose bloody stools. Vedolizumab (Entyvio) 300 mg and a prednisone taper were then added to her regimen of mesalamine (Asacol HD), azathioprine, mesalamine rectal enema, and hydrocortisone 25 mg rectal suppository (Asacol-HC). Approximately a year and a half later, the patient’s symptoms remained unimproved on vedolizumab. Oral LDN 4.5 mg once daily was initiated in Jan 2016. She was admitted to the hospital for a UC flare in Feb 2017 and discharged on budesonide (Entocort) 3 mg capsules, mesalamine (Asacol HD) 800 mg, and naltrexone 4.5 mg once daily.

Endpoint Findings
Between discharge and the patient interview in May 2017, she reports good disease control on a regimen that was changed by an outside specialist to include naltrexone 4.5 mg once daily, azathioprine 800 mg, and golimumab (Simponi, dose unknown), and a nicotine patch.

Case Report 2 continued

Discussion
It appears both women also experienced disease flares after recent colonoscopies. One study has shown that one in eight patients with UC had flare-ups after a colonoscopy and one in ten patients had to increase their 5-ASA medication after a colonoscopy.11 This could be a potential area of further study due to the significance and timing of the flare-ups after colonoscopies.

In a meta-analysis of randomized controlled trials (RCTs), the placebo response rate in UC was shown to vary from 0% to 76%. The study concluded that remission and response rates in RCTs in patients with UC were quite variable.12 This may be the case in Case 2 due to the variability of flares, medications, and overall disease presentation.

Regardless, these case reports add to the growing body of evidence to support the use of LDN for UC. As they are confounded by the use of other medications, well-designed clinical trials are needed to determine the safety and efficacy of LDN in a controlled population.

References
10. Kais S. Low-dose naltrexone therapy improves active ulcerative colitis: a single case report. Poster Session at the Advances in Inflammatory Bowel Diseases Conference. 2015.