Printed from Kanta service 25.12.2023 11.51.30

Date of visit 20.2.2023 - 22.2.2023

Service unit HUS Group

Research results

Timing

	Research
30.3.2023 20:08	Abdominal computed tomography examination Statement 6 April 2023 / Kurdo, Gora's ward doctor / Final statement Pancreas imaged as a multistage pancreatic tumor protocol and stomach in venous stage. In comparison, 20.2.2023 abdominal CT examination. The liver is diffusely thicker than normal, the parenchyma is dense and homogenously enhanced with contrast, no tumor-like expansion or changes suggestive of pancreatitis are seen, the thickness of the pancreas has decreased slightly compared to the previous description, the maximum thickness at the border of the corpus/cauda of the pancreas has decreased from 3.7 cm to 3 cm . There is no fat swelling around the pancreas. Pancreatic chamber dilatation is not seen. As stated previously, the finding is primarily suitable for autoimmune pancreatitis, in order to rule out the other option, i.e. lymphoma, an MRI would provide additional information. No abnormalities are seen in the other parenchymal organs of the upper abdomen. There are no X-ray-positive gallstones in the gallbladder, no evidence of cholecystitis, and no biliary dilatation. Beneath the diaphragm, enlarged lymph nodes and fluid collections are not visible. The wall of the ileum terminale at a distance of about 5.5 cm is thickened and enhances well with a contrast agent, suggestive of active ileitis, this raises the suspicion of Crohn's disease. In other respects, the bowels appear regular. There is no abnormality in the basal parts of the lungs, no focal changes are visible in the bone in the described area. RL: The diffuse thickness of the pancreas is slightly reduced, there is no tumor-like expansion in the pancreas, and there is no swelling around the pancreas. The finding is primarily autoimmune pancreatitis, to rule out pancreatic lymphoma, an MRI would provide additional information. The wall of the ileum terminale is thickened and enhanced with contrast, this raises the suspicion of Crohn's disease. In other respects, the stomach area does not appear topical.

Printed from Kanta service 25.12.2023 11.51.30

Timing

Research

21.2.2023 10:15	Ultrasound examination of the upper abdomen Statement 21/2/2023 / Guss, Tomas Ext specialist / Final statement The gallbladder is stoneless. The ductus choledochus is described as slender. No intrahepatic bile duct dilatations. Vena Porta is open. No peripancreatic fluid accumulations or free fluid are seen. The ductus pancreaticus is narrow. - No gallstones or anything else to explain
20.2.2023 14:40	Abdominal computed tomography examination Statement 20 February 2023 / Hurme, Hannes specialist doctor / Final statement Abdominal CT as a multistage pancreatic tumor protocol, no comparison studies. Emergency statement: The pancreas has a diffusely abnormally thick appearance, cigar-like in shape. Peripancreatically, there is no edema or fluid retention, which would indicate, for example, acute pancreatitis. Also, the expansive appearance is not demarcated and dilatation of the pancreatic ducts is noted. The pancreatic duct is poorly distinguished in the corpus and cauda region. In my opinion, the finding is primarily suitable for diffuse autoimmune pancreatitis. There is no other indication of IgG4 disease. Retroperitoneally nothing abnormal. There is no dilatation in the bile ducts. Gallbladder walls are normal, no CT positive stones. Not suggestive of cholecystitis. No current is seen in the kidney, adrenal glands or spleen. There is no image of difficulty in pulling or pathological looking segments in the intestine. Appendix calm. No ascites. No lymphadenopathy. Nothing special in the basal parts of the lungs or the skeleton. No pleural fluid or pericardial fluid supplementation. RL: The pancreas looks diffusely thick. Primarily suspected diffuse autoimmune pancreatitis. In terms of differential diagnosis, it could mainly be diffuse B-cell lymphoma of the pancreas. Statement 21.2.2023 / Ruskola, Jasmine specialist doctor / Additional statement Additional statement: As stated in the emergency statement, the pancreatic finding suggests autoimmune pancreatitis. Terminal ileum about 5 cm thick-walled and abnormally strongly enhancing. On the cranial side of the terminal ileum, another segment of the ileum with wall thickening and greater enhancement. The finding raises the suspicion of Crohn's disease.

Name: Md Adnan Amin | Date of birth: 20.12.1991 | Hetu: 201291-3733 | Personal contact: | Official Name: Md Adnan Amin

Summary of the visit

Markings

Markings

Outpatient treatment entry, by Kalle Jokelainen at 08:15 on 7 March 2023

Author: Kalle Jokelainen | Service: SIS-Gastroenterology | Author Type: Doctor
Recorded: 03/07/2023 16:52 | Service date: March 7, 2023 | Status: Addition
Edited by: Kalle Jokelainen (doctor)
Related entries: The author of the original entry is Kalle Jokelainen (doctor), saved on 03/07/2023 16:47

Computed tomography images of the patient were reviewed today as agreed at the radiology meeting of the gastroenterology clinic at Meilahti Hospital.
Corresponding to the previous statement, the pancreatic parenchyma is seen to be somewhat thickened, however, the cauda seems to have been spared. There is no edema in the surrounding fat, the pancreatic duct is of normal size. In the terminal ileum, a finding suitable for ileitis. Fistulas are seen perianally .
It is possible that the patient has ileocolic Crohn's disease with type 2 autoimmune pancreatitis. Ended up scheduling the patient for an ileocolonoscopy, blood tests (possible exposure to tuberculosis is important to rule out before possible immunosuppressive medication) and an appointment at the gastroenterology outpatient clinic. Control imaging programmed by the surgeon according to the previous plan.

There is no patient phone number in the files. Let's mail this text to the patient's home address for information.

Distribution : FYI, patient

Name: Md Adnan Amin | Date of birth: 20.12.1991 | Hetu: 201291-3733 | Personal contact: | Official Name: Md Adnan Amin

Summary of the visit

Markings

Markings

Outpatient treatment entry, author Matti Tolonen at 6 April 2023 1:00 p.m

Author: Matti Tolonen
Service: KIR-Sirurgia
Author Type: Doctor
Saved: 6/4/2023 1:58 PM
Date of service contact: 6 April 2023
Status: Acknowledged
Editor: Matti Tolonen (doctor)

A student who moved to Finland from Bangladesh, speaks English. In previous studies, the idea of autoimmune pancreatitis and Crohn's disease arose. Extensions to internal medicine gastroenterology already programmed. Now there is no diarrhea or stomachache, but he is still losing weight, already 8 kg per month, even though he says he eats well. Slim already. The control CT of the pancreas still shows a picture of ai pancreatitis, but we want to rule out pancreatic lymphoma with MRI. Called the gastroenterologist about the weight loss, will see if the colonoscopy can be brought up. Also asked to take a thx-rtg with a tube idea, no respiratory symptoms.

Let's ask for a thx-rtg within a week, the answer will be checked with hidden calling time with jäpäpkl in 1 week. In addition, MRI of the pancreas 1 month in to rule out lymphoma, this answer is requested to be processed in connection with csk by sis-ge.

Printed from Kanta service 25.12.2023 11.47.55

Date of visit 17/04/2023

Service unit HUS Group

Research results

Timing	Research
17/04/2023 14:46	Magnetic resonance imaging of the biliary and pancreatic ducts (MRCP) Statement 18 April 2023 / Heiskanen, Emma specialist doctor / Final statement MK of the upper abdomen: Description with native and enhancer sequences. For comparison, previous abdominal CT examinations 2-3/2023. The pancreatic parenchyma is described as homogeneous in terms of signal and it is still slightly thicker than usual, but slightly less than in the previous study. There is no fat edema around the pancreas. No abnormal focal changes, steady enhancement. No areas of restricted diffusion. No pancreatic or bile duct dilatation. In other respects, the parenchymal organs of the upper abdomen do not appear topical. Spleen normal size, intact. No lymphadenopathy, no ascites. - The finding of the pancreas is primarily suitable for autoimmune pancreatitis and is still slightly less than in the previous study.
17/04/2023 14:46	Extensive magnetic examination of the upper abdomen Statement 18 April 2023 / Heiskanen, Emma specialist doctor / Final statement MK of the upper abdomen: Description with native and enhancer sequences. For comparison, previous abdominal CT examinations 2-3/2023. The pancreatic parenchyma is described as homogeneous in terms of signal and it is still slightly thicker than usual, but slightly less than in the previous study. There is no fat edema around the pancreas. No abnormal focal changes, steady enhancement. No areas of restricted diffusion. No pancreatic or bile duct dilatation. In other respects, the parenchymal organs of the upper abdomen do not appear topical. Spleen normal size, intact. No lymphadenopathy, no ascites. - The finding of the pancreas is primarily suitable for autoimmune pancreatitis and is still slightly less than in the previous study.

Printed from Kanta service 25.12.2023 11.47.55

Timing	26.4.2023 - 16.5.2023
Service unit	HUS Group
Diagnoses	K50.0 Crohn's disease of the small intestine

Laboratory studies

Imaging studies

Patient report

NURSING WORK
Plekhanov, Alexander nurse
Endoscopy unit, Meilahti
16/05/2023
Treatment implementation
Physiological measurements
Beat; 16.5.2023 08:30; 78/min; Normal
Oxygen saturation, by pulse oximeter at rest; 16.5.2023 08:30; 98%; Normal

Printed from Kanta service 25.12.2023 11.38.36

INTERNAL DISEASES
PROCEDURES
Haapamäki, Johanna specialist
Endoscopy unit, Meilahti
16/05/2023

Printed from Kanta.fi on 25.12.2023 11.38.36

Procedures

Procedures:

UJF30 - OBSERVATION OF THE SMALL INTESTINE THROUGH THE COLON

Personal information:

Md Adnan Amin, 31 years

Diagnoses:

No diagnosis found.

Operating physician:

HAAPAMÄKI, JOHANNA

Background information (anamnesis)

A Bangladeshi-born man with a recent history of autoimmune pancreatitis. Pain in the anus, suspected fistula. No specific bowel symptoms. On imaging, the terminal ileum appeared abnormal.

ILEOCOLONOSCOPY

Study progress: the study progressed normally

Premedication: Midazolam 1 mg iv, Fentanyl 0.25 ug iv

The examination findings are normal.

Clearing result BBPS (3+3 +3 =9) good.

We proceed to the caecum as usual. The valve looks deformed and has an ulcer. However, the valve is passable by the scope.

Further, the mucosa of the small intestine is normal for 10 cm.

Cecum, appendix are normal.

The general view of the large intestine is normal,

the rectum is normal, nothing special in the internal turning. Longitudinal fissure-like wounds in the anal canal. There is no obvious fistula opening, no perianal abscess.

A mycobacterial sample was also taken from the ileum.

Samples: 1) ileum 2) ascendens, transversum 3) descendens, sigma, rectum

Finding:

Inflammation in the terminal ileum and anal canal. The finding raises the suspicion of Crohn's disease.

Plan

Magnetic resonance imaging of the perianal area is programmed. 1.6 is reserved for the patient. reception visit to the polyclinic. Laboratory tests first. a referral to a proctologist has already been made.

Printed from Kanta service 25.12.2023 11.38.36

INTERNAL DISEASES
Haapamäki, Johanna specialist
Endoscopy unit, Meilahti
16/05/2023
Treatment implementation
Procedures
Procedure (16/05/2023): UJF30; VIEWING THE SMALL INTESTINE THROUGH THE LARGE INTESTINE
Treatment evaluation
Diagnosis
Dg: K50.0; Crohn's disease of the small intestine

Name: Md Adnan Amin | Date of birth: 20.12.1991 | Hetu: 201291-3733 | Personal contact: | Official Name: Md Adnan Amin

Summary of the visit

Markings

Markings

Outpatient treatment entry, by Laura Kariola at 1.6.2023 10:45

Author: Laura Kariola
Service: SIS-Gastroenterology
Author Type: Doctor
Recorded: 1/6/2023 12:19 p.m
Date of service contact: June 1, 2023
Status: Acknowledged
Editor: Laura Kariola (doctor)

Result reason
First visit, suspected inflammatory bowel disease. With my brother at the reception, we talk in English.

Prerequisites
Long-term illnesses:
2023-02: Unspecified acute pancreatitis
This is a Bangladeshi-born 31 years man. 2/23 pancreatitis, does not use alcohol. No known allergies. Pain in the anus, suspected fistula. No specific bowel symptoms.

16.5.23 ileocolonoscopy, with **macroscopic findings of inflammation in the terminal ileum and anal canal.** Raised suspicion of Crohn's disease. MRI of the perineal region has not yet been answered.

PAD: Sample 1 has four ileum biopsies, two of which show ulceration and a dense monocytic inflammatory cell infiltrate in the lamina propria. Suitable for Crohn's disease, but this must be related to endoscopic and clinical findings. No atypical changes are observed. Samples 2 and 3 colonoscopy samples show no diagnostic changes.

Yt moderate. The bowel works 2x/day (usually in the morning), sometimes also at night. Stool loose. Sometimes there is also blood in the stool, drop by drop. No stomach pains but pain on the outside of the anus. Painkillers help a little. Xylocain helps for a few hours.

Family:No

Smoking:does not smoke

Medication

Current home medication:
• lidocaine 2% gel, for the mucous membrane if necessary reason: for anesthesia. 10ml twice a day to the anus.,
• paracetamol 1000 mg tablet, 1 tablet (1000 mg) orally 1-3 times a day if necessary.,

Studies
Hb 117, Leuk 11.9, Lymph 1.86, Neut 8.16, Trom 381, CRP 39, Alat 10, Afos 69, Albumin No results for the last 6 weeks, Calpro 1,573. MCH 77, iron deficiency anemia. AmylP still elevated 608, TT 96. HIVAgAb neg, HBVPA K neg , HCVAb neg .

Chest X-ray 4/23 not suggestive of tuberculosis or other abnormality.

Current state
Yt good. Let's talk in English. Heart and lung auscultation is not abnormal. Abdomen palpate soft, compliant, non-tender, no abnormal resistances, no organomegaly. Bowel sounds normal. Clean skin, no swelling. At the mouth of the anus, a couple of irritating fistula openings.

Weight 56.5kg. He says that the weight dropped in the spring, previously weighing about 70 kg.

Plan
Let's start mercaptopurine 50mg/day, after two and four weeks safety tests, a call about how you are feeling and an MRI report at two weeks , after that every 2 weeks according to the mercaptopurine safety lab protocol for the first 2 months if the medication continues . Advised to go to the emergency room if severe upper abdominal pain occurs and to contact the gastro-pkl if new symptoms appear or the condition otherwise deteriorates.

Let's make a B statement. In the future, due to the fistulizing disease , the start of infliximab , Zessly 300mg iv, induction weeks 0, 2 and 6 and every 8 weeks in the future. Lab tests at the beginning of every other biological drug infusion.

The next appointment is scheduled after 6 months, before laboratory tests and fecal calprotectin.

Consulted about follow-up treatment by gastro consultants Henna Rautiainen and Johanna Haapamäki.

Event diagnosis

	Diagnosis	Plan
1.	**Other Crohn's disease**	

Name: Md Adnan Amin | Date of birth: 20.12.1991 | Hetu: 201291-3733 | Personal contact: | Official Name: Md Adnan Amin

Summary of the visit

Markings

Markings

Outpatient treatment entry, by Tiina Ponkilainen at 15.6.2023 12:15

Author: Tiina Ponkilainen | Service: HOI-Hoitotyö | Author type: nurse
Recorded: 15/06/2023 15:07 | Date of service contact: 15 June 2023 | Status: Addition
Edited by: Tiina Ponkilainen (nurse)
Related entries: Author of the original entry Tiina Ponkilainen (nurse), recorded 15.6.2023 15:03

Reason for treatment

Comes to the IBD nurse's office for IBD guidance. Guided through in English.

Prerequisites

Born in Bangladesh, moved to Finland 9/2022. Studying software production. 2/2023 had pancreatitis. Ileocolonoscopy performed on May 16, 2023, with inflammation in the terminal ileum and anal canal. Suspected Crohn's disease.

The patient has no other established basic diseases or allergies .

There is no family history of IBD.

Health

He describes his health as quite good . Self-care questionnaire filled out at the reception, with disease activity index 1 and impact on everyday life 2 . Stool frequency x1-2/day, firmer stool (says it was more diarrhea-like before starting mercaptopurine), no stomach pains. Just had some blood today, but not sure if it was from the fistulas. The fistulas bother me, the operation is coming.

Factors affecting health

As a child and teenager, received the normal vaccinations according to the vaccination program in Bangladesh . The timing of diphtheria-tetanus effect is unknown, maybe got it as a child . Not sure if you have had chicken pox. Received the hepatitis B vaccine series.

Received three corona vaccines . It is known that he has not been sick with the coronavirus .

Eat mixed food . Uses some dairy products, not daily.
Does not smoke. No alcohol is used.
The last dental check-up was at the end of 2022 . Root canal treatment of one tooth and, according to the patient, root canal treatment of another tooth is still planned.

Treatments

Go through what IBD and Crohn's disease mean, as well as the etiology and prevalence of the disease. Go through the treatment methods of the disease with an emphasis on medical treatment. Briefly went through associated diseases. Discussed in which situations it is good to bring up the disease and the medication in use and take it into account: during health care visits, during procedures and when prescribing new medications. Special considerations related to travel were reviewed. Received the guide "Getting to know IBD", the IBD guides "Crohn's disease" and "IBD in everyday life" and the guide "IBD and travel".

Discussed diet . Got the IBD guide "Nutrition". It has been reviewed that the basic painkiller suitable for an IBD patient is paracetamol, anti-inflammatory drugs should not be used.

Discussed the mechanism of action of infliximab. The possible side effects of the drug and the risk of infection related to biological medication were also discussed. Go through the issues related to the timing of the medication (how to schedule vaccinations and procedures in relation to the administration of the medication). Received the "Zessly (infliximab)" guide intended for the patient, the HUS instruction "Infliximab" and the Zessly patient card. Also received English instructions for "Remicade". In addition, I went through the general instructions for mercaptopurine medication, and received the HUS instruction "Mercaptopurine medication patient instructions". We also discussed cortisone medication and received the HUS instruction "Patient instructions for cortisone medication".

Go through the vaccination recommendations for a patient using immunosuppressive medication, instructions on food-borne infection risks, and recommendations on calcium and vitamin D intake. He also received written instructions from them. I also received instructions on vaccinations in English printed from the IBD Passport website and the THL website. Discussed social security issues and gave the patient this year's social security instructions.

The patient was told about the patient association and given the brochure of the IBD and other intestinal diseases association . Go over with the patient in which situations he should contact the Gastroenterology

outpatient clinic or apply for an emergency assessment at the Meilahti emergency outpatient clinic. Given the contact information of the IBD nurse. In addition, I received the Stay in Remission and Self-care cards.

Plan

Doctor's call booked for tomorrow. The patient is asked to confirm the importance of the ongoing root canal treatment for the initiation of infliximab treatment. Also ponders the necessity of infliximab, but is not against starting the drug.

It is recommended to take the tetanus effect at your own health center.

Printed out for the patient to take with them the first three appointments for Zessly infusions and arrival instructions at the Day Hospital.

Name: Md Adnan Amin | Date of birth: 20.12.1991 | Hetu: 201291-3733 | Personal contact: | Official Name: Md Adnan Amin

Summary of the visit

Markings

Markings

Outpatient treatment entry, author Antti Turunen at 9 June 2023 11:00

Author: Antti Turunen
Saved: 9/6/2023 11:27 AM
Editor: Antti Turunen (doctor)
Service: KIR-Sirurgia
Date of service contact: 9 June 2023
Author Type: Doctor
Status: Acknowledged

Result reason
Perianal fistulas and Crohn's

Diagnosis	Code
• Unspecified acute pancreatitis	K85.9
• Other Crohn's disease	K50.8
• Unspecified Crohn's disease	K50.9

Prerequisites
A 31-year-old previously healthy man. No alcohol is used. Perianal fistula diagnosed in the ward due to pancreatitis. Had a colonoscopy on 16.5. there was inflammation of the ileum, a finding suggesting Crohn's disease in PAD, and treatments were started at Meilahti's gastroenterology outpatient clinic. So, for about 3 months, I had a troublesome pain in the area of the anus and a draining fistula. After defecation, severe pain and need painkiller. Describes stool retention as normal. There is no constipation.

Current state
General condition good, normal body structure. On inspection, it is found that the external openings of the fistula are secreting in the region of 2 and 9 o'clock. Tutoring hurts. The inner mouth can be felt at least around one o'clock. Proctoscopy is not done because of the pain. The abscess is not palpated. Previously viewed on MRI, there were two intersphincteric fistulas.

Plan

Let's program LP one with urgency to place Seton wires in the day surgery unit. The procedure with its complications was reviewed with the patient in general, and the treatment of fistulas related to Crohn's disease was discussed. Medication is the cornerstone of treatment, and complications are prevented with Seton threads. After placing the threads, after 6 months, a new MRI and a rvio .

Name: Md Adnan Amin | Date of birth: 20.12.1991 | Hetu: 201291-3733 | Personal contact: | Official Name: Md Adnan Amin

Summary of the visit

Markings

Markings

Surgery report, author Antti Yrjönen at 21.6.2023 13:31

Author: Antti Yrjönen
Recorded: 21/06/2023 14:22
Editor: Antti Yrjönen (doctor)
Service: KIR-Gastrosurgery
Service date: 21.6.2023
Author Type: Doctor
Status: Acknowledged

Procedure indication:

This is a 31-year-old man with suspected Crohn's disease . Diagnosed with two perianal fistulas and now coming in for insertion of a sethoni e .

Procedures :

JHD30 - PARTIAL OPENING OF THE ANUS

Diagnoses:

* Unspecified Crohn's disease [K50.9]

Action factors:

Procedure doctors and role:
* Yrjönen, Antti, ward doctor - Primary operator of the procedure

Form of anesthesia:

general anesthesia

Description of the procedure:

Gynecological position, Checklist, in anesthesia induction Cefuroxime 1.5 g and Metronidazole 500 mg iv Around the anus Ropivacaine anesthesia. At 3 o'clock and 9 o'clock, about 1 centimeter from the anus, are the external openings of the fistula , from which the inserted probe travels rather superficially to the inner openings at 3 o'clock and 9 o'clock as well . On palpation, there are no abnormal resistances, looking at the proctoscope, there is some internal prostatic tissue, the tissues feel slightly irritated and bleed easily. Comfort drains Eton are inserted into both fistula corridors and the external openings of the fistula are excised a little with diathermy.

Plan :

The patient can be discharged according to day surgery criteria, sick leave for a week, Para-Tabs for pain if necessary. Treatment continues in internal medicine gastroenterology. According to colleague Turunen's previous plan, a check-up at the outpatient clinic will be arranged for us in about 6 months, before a recent MRI examination of the perianal area.

Name: Md Adnan Amin | Date of birth: 20.12.1991 | Hetu: 201291-3733 | Personal contact: | Official Name: Md Adnan Amin

Summary of the visit

Markings

Markings

Outpatient care entry, by Johanna Haapamäki at 4 August 2023 2:00 p.m

Author: Johanna Haapamäki
Saved: 4/8/2023 07:57
Editor: Johanna Haapamäki (doctor)

Service: SIS-Gastroenterology
Date of service contact: 4 August 2023

Author Type: Doctor
Status: Acknowledged

Remote contact (treatment letter)

Other Crohn's disease [K50.8]

31.7.2023: B - Hb 111 (M); B - Leuk 5.8; B - Diff machine diff; B - Ly 1.13 (M); B - Neut 3.49; B - Trom 280; P-CRP 20 (K); P -Crea 76; Pt-GFRe 115; P-FIELDS 11; P -AFOS 58; P-Ferrit 27

Laboratory tests are fine. Merkaptopur 75 mg x 1 can be continued. Iron parameters in the reference range, although ferritin in the lower limits. At this stage, monitoring the hemoglobin level and not yet the essential need for an iron supplement.

Name: Md Adnan Amin | Date of birth: 20.12.1991 | Hetu: 201291-3733 | Personal contact: | Official Name: Md Adnan Amin

Markings

Outpatient treatment entry, by Anna Mäkinen at 04.12.2023 09:45

Author: Anna Mäkinen	Service: SIS-Gastroenterology	Author Type: Doctor
Saved: 4/12/2023 11:59	Date of service contact: 4 December 2023	Status: Addition

Edited by: Anna Mäkinen (doctor)
Related entries: The author of the original entry is Anna Mäkinen (doctor), saved 4.12.2023 11:58

Result reason
Control of Crohn's disease

Prerequisites
Long-term illnesses:
2023-02: Unspecified acute pancreatitis
2023-06: Other Crohn's disease

31-year-old Bangladeshi-born man, speaks and understands English moderately.

2/23 acute pancreatitis. No alcohol is used at all, radiologically compatible with autoimmune pancreatitis. In the images, the terminal ileum also looked abnormal. The patient had pain in the anus region and suspected fistula. Raised suspicion of Crohn's disease.

On May 16, 2023, colonoscopy showed inflammation in the terminal ileum and anal canal, consistent with Crohn's disease, no abnormality in the colon.
5/23 in the MRI of the perianal area, two intesphincteric fistula passages leave from the level of the anus.
6/23 Seton threads.

As medication, mercaptopurine as monotherapy. Not willing to start infliximab, despite recommendations, so far.

Considering possibly AIP type 2 IBD, IgG4 was only marginally elevated at 1.56-1.73, no indication of other IgG4 disease elephansia in CT .

Medication
Mercaptopurine 75mg/day

Studies
Hb 123, Leuk 7.3, Lymph 1.40, Neut 4.58, Trom 288, CRP 20, Alat 13, Afos 76, ferrit 21, Albumin 36, **D-25 34.** , **Calpro 621.**

Current state
Yt good. Arrives 10 minutes late for the reception time, we have time to go through things very superficially. Says that he stopped mercaptopurine about 1 month ago, when the package ran out, a misunderstanding here.

He says that the stool is loose, UF 2-4x/day, no blood, no significant abdominal pain. There is no problem with fistulas.
He says the weight is unchanged, 58-59 kg.

Plan
Discussed Crohn's disease and the importance of regular medication. In case of disease affecting the perianal area, the initiation of biological medication, infliximab, is recommended. I'm still thinking about it, I'm not really willing to start. Given guides on the subject.

Return to mercaptopurine use 50mg/day. 2-week safety tests and a possible dose increase. Also checking VZVAb and PGX-D. **In this context, we would like to remind you about taking a vitamin D supplement** .

Instructed to contact the gastroenterology polyclinic if the symptoms worsen, or if you want to start biological medication. Contact information provided. 5/23 initial tests of biological medication OK, 4/23 thorax image shows no evidence of tuberculosis.

Next week there will be a check-up time on the surgery side regarding perianal fistulas.

3 months of security tests + treatment letter and 6 months of reception with pre-programmed tests.

Event diagnosis

	Diagnosis	Plan
1.	**Other Crohn's disease**	