IL6 blocking drugs

Actemra (tocilizumab)

Giant cell arteritis
6 mg/kg IV once every 4 weeks (maximum 600 mg per dose)

Tyenne
Kevzara (Sarilumab)

Cosentyx(secukinumab)

Dose

Psoriatic arthritis: IV: 2 mg/kg at weeks 0, 4, and then every 8 weeks thereafter (in combination with methotrexate).

SUBQ: 50 mg once a month (in combination with methotrexate).

IL17 and inflammatory bowel disease

UpToDate does not specifically list secukinumab as a medication associated with microscopic colitis in the microscopic colitis topic.

However, IL-17 inhibitors have a reported low incidence of new-onset inflammatory bowel disease or exacerbation of preexisting inflammatory bowel disease. In psoriasis management, this concern leads UpToDate contributors to routinely avoid IL-17 inhibitors in patients with inflammatory bowel disease.

Practically, if biopsies confirm microscopic colitis and there are no endoscopic features of inflammatory bowel disease, that supports treating as microscopic colitis rather than attributing symptoms to an IL-17 inhibitor–associated inflammatory bowel disease phenotype. If endoscopic features of inflammatory bowel disease are present, or if biopsies suggest Crohn disease or ulcerative colitis rather than microscopic colitis, management should pivot accordingly.

Focal areas of histologic findings as typically associated with microscopic colitis have also been described in patients with established inflammatory bowel disease (IBD) . However, endoscopic features of IBD are frequently present. They may also precede the development of overt clinical and histologic evidence of IBD, particularly Crohn disease.

References

Microscopic (lymphocytic and collagenous) colitis: Clinical manifestations, diagnosis, and management. Uptodate.