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Crohn's Disease: Latest Diagnosis, Treatment & Management Strategies

ReachMD Announcer: You are listening to ReachMD, the Channel for Medical Professionals. Welcome to **"GI Insights"** where we cover the latest clinical issues, trends and technologies in gastroenterological practice. GI Insights is brought to you by AGA Institute. Your host for GI Insights is Dr. Jay Goldstein.

Dr. Goldstein: I am your host, Dr. Jay Goldstein, and with me today is Dr. Sunanda Kane, Professor of Medicine in the Department of Gastroenterology and Hepatology at Mayo Clinic. She is the author of a book entitled, *IBD Self-Management: The AGA Guide to Crohn's Disease and Ulcerative Colitis,* now in its second edition. Today's discussion will focus on the latest in Crohn's disease, diagnosis, management and treatment.

Welcome, Dr. Kane.

Dr. Kane: Thank you for having me on, Jay.

Dr. Goldstein: It's a pleasure to be talking to you. Well, let's get right to it. What is Crohn's disease? Can you define it for us?

Dr. Kane: Crohn's disease is a chronic condition whereby there is inflammation and ensuing damage to the GI tract that occurs anywhere from the mouth all the way to the anal canal, and that Crohn's disease is a condition that inflammation affects all layers of the bowel wall, so not just the superficial lining but there's deep ulceration through each of the layers and can actually affect the outside of the bowel as well.

Dr. Goldstein: You emphasize that. Why is that so?

Dr. Kane: It's important to understand the difference because a lot of times there are inflammatory conditions that can affect the small intestine or the large intestine, also called the colon, that can look like Crohn's disease but because it's just superficial and not all the way thick through each of the layers of the bowel, that it's not Crohn's disease.

Dr. Goldstein: Tell me a little bit about the epidemiology of Crohn's disease. Who gets it?

Dr. Kane: Sure. So it's interesting because even in my career, which now spans about 23, 24 years, that the epidemiology has changed. This historically was considered a "Jewish white disease," and I put that in quotes, where we only saw it in Northern Europe and in certain parts of the US. And interestingly, over the span of a relatively short amount of time, meaning 25 years, which is an eye blink of time for most things to occur in nature, that we see it now worldwide, and so this is no longer considered just a white man's disease or just occurring in the Jewish population. And we think that's because of the high industrialization rates that are occurring around the world. So, what do I mean by that? That our environment is getting cleaner and that when our environment is getting cleaner, there aren't bugs around that our GI tracts have to live with and contend with; and thus, we end up with disruption of our immune system, and something then sets off our insides, if you will, our microbial environment, and other external environmental triggers like cigarette smoking, nonsteroidal antiinflammatories, getting food poisoning or traveler's diarrhea, certain other medications like antibiotics, can then trigger and be the inciting event for which then the Crohn's takes off.

Dr. Goldstein: I see. And that becomes self-perpetuating?

Dr. Kane: Correct. So Crohn's disease is chronic, meaning that it is not something that we can stop or cure, and that it's not like a sinus infection where once you get rid of the bug that you no longer have it. So once we make a diagnosis of Crohn's, it's something that you're always going to have.

Dr. Goldstein: Can you talk a little bit about the gender distribution and age distribution?

Dr. Kane: Sure. So there is a very, very slight female predominance, so when I say slight, it's probably 1.2 or 1.3 women for every 1 man, so it really isn't very much of a gender difference, that it really is in the big picture 50/50 between males and females. And then in terms of age, while we've seen this in kids as young as below a year in age, and my oldest patient is now 93 and I made his diagnosis when he was 89, so it really does run the entire lifespan; but we do consider that this is more likely to get diagnosed in early adulthood, meaning 18 to 25. If you look at the Olmsted County Data for all-comers, the average age at diagnosis is actually in the early 30s because of our aging population; but certainly, we make the diagnosis over all age ranges. But it's interesting that there's what we call a bimodal peak so that it's early in your life, early adulthood, and then again there's a second peak in 55 to 65 age range.

Dr. Goldstein: Well, let's move on then to symptoms. What are the common presenting symptoms of newly-diagnosed Crohn's disease?

Dr. Kane: So, it's very interesting that Crohn's disease isn't cookie cutter at all, and that's why it can be really hard to diagnose, and it's considered a great imitator within medicine. So really, your symptoms are going to be driven by where the disease is; so if I say that it's anywhere from the mouth to the anus, that if you have it in your mouth, which you're going to get as mouth ulcers and it's going to be very painful to eat or to swallow, so maybe you're going to have weight loss and painful mouth. Well, that's going to be something completely different than a patient who has Crohn's disease in their large intestine where they're going to have bleeding and diarrhea, a lot of urgency, and that's the way that they're going to present, as opposed to a third way, which is somebody who has it in their small intestine, that they get abdominal pain and that they will have weight loss because they stop eating, whether it's consciously or subconsciously, because that helps not get pain. They also may have diarrhea, but they usually don't have bleeding, but they may have fatigue. And then there are a whole host of what we call extraintestinal manifestations, meaning that there are symptoms that are associated with Crohn's disease that don't happen to the bowel or the GI tract but happen to the rest of the body, and those are things like certain kinds of skin rashes and joint symptoms. Some will have osteoporosis as their first presenting symptom or sign. And so, really you have to have an astute and alert clinician who can ask the right questions to sort of solicit whether Crohn's disease is a possibility to explain what a patient is presenting with.

Dr. Goldstein: Well, assuming that we have an astute physician, how do you establish the diagnosis?

Dr. Kane: So, Jay, it is very interesting that you ask that because there are patients who believe that a diagnosis can be made based on a blood test, and that's just simply not true. There are certain antibodies that are found in the blood that are associated with having the disease, and certainly, there are certain genes and mutations of those genes that are associated with having the disease, but it's not a perfect match like you would say a pregnancy test where if it's positive you're pregnant. It doesn't work that way. There are patients who walk around who don't have these markers, and there are plenty of people who don't have Crohn's disease who have these blood markers and don't have Crohn's, so that's not the way to make the diagnosis.

The diagnosis is based on having the right symptom constellation, then a combination of endoscopy where we're using flexible lighted tubes and cameras to look at the tissue, and then getting biopsies and looking at that under the microscope for very characteristic changes under the microscope that suggests that this is ongoing chronic inflammatory process. So you want to make sure that it's not a cancer, that it's not an infection, that it's not just a lack of blood flow or due to a medication. And because the small intestine is 13 or so feet long and we don't necessarily have scopes that are standard for scoping that much, we use x-rays as well, so certain kinds of CAT scans and MRI scans to complement what we can look at with an upper endoscopy and a colonoscopy.

Dr. Goldstein: If you are just tuning in, you're listening to GI Insights on ReachMD. I am Dr. Jay Goldstein and I'm with Susie Kane, Professor of Medicine in the Department of Medicine and Gastroenterology and Hepatology at Mayo clinic.

Let's turn our attention to the primary care physician. When they suspect that they have a patient who might have Crohn's disease, what would be the key findings that they would need to see to send them to a gastroenterologist?

Dr. Kane: I would say that any time a primary care physician is thinking that Crohn's might be in the differential, it's worth consulting and getting the opinion of a gastroenterologist, and the reason is because, as I said, the diagnosis does depend on having a tissue sample and biopsies showing chronic inflammation and damage, and that could only be done either with a gastroenterologist or, in certain parts of the country, a surgeon who does these kinds of endoscopic procedures.

Dr. Goldstein: So endoscopy is a key component of the diagnostic workup.

Dr. Kane: Absolutely, correct. Now, there are certain, like I said, blood tests that can be done by a primary care physician, but those are just suggestive, and then certainly, routine blood work that would show active inflammation is sensitive but not specific for the diagnosis and then coupled with evidence of malabsorption, and on patient history the diarrhea or abdominal pain, that's fairly evident and simple. There are certainly patients who have isolated abdominal pain and have Crohn's disease in their small intestine without the bleeding, without a lot of diarrhea, and those can be hard to pick up and diagnose. So any patient who, for sure, has a constellation of GI

symptoms and evidence for chronic inflammation should be referred.

Dr. Goldstein: Okay. Before we go on to treatment options, I just have a quick question for you about family history. Does that help the primary care physician consider the diagnosis of inflammatory bowel disease?

Dr. Kane: It does. And as I said, that genetics are not the way that we diagnose this, but we do know that there's a genetic predisposition. Crohn's is not a genetic disorder like you would think about sickle cell disease or something like Tay–Sachsor cystic fibrosis. So a family history makes the patient's GI symptoms raise the concern for Crohn's, but certainly irritable bowel syndrome, something like celiac disease, whether this is just temporary dyspepsia from stress, peptic ulcer disease, gallstone disease, all have to be taken into consideration, and those are much more common than Crohn's disease is.

Dr. Goldstein: All right, let's turn our attention to treatment options. We could spend hours talking about this, but why don't you give us the hierarchy of approaches?

Dr. Kane: So actually, treatment includes lots of different kinds of care, so there's medical care but there's also surgical care, and it's really important to not forget about when a surgeon may be very important, and that can be in the light of an abscess or infection or obstruction or severe hemorrhage where a patient needs a body part taken out. And there's this stigma of surgery in Crohn's disease where if you take something out then it will come right back. Well, that's true, but there is still room for the surgeon to play a part here. So medical therapy but with the surgeon in mind for certain indications; but then I would also say complementary therapy which includes things like Yoga, regular exercise, meditation, which are complementary to what we do to help with self improvement and with symptom control. And medications, as you pointed out, could be a whole discussion in and of itself for an hour, hour and a half, but just suffice it to say that there's a hierarchy of aggressiveness for what we can use to treat Crohn's. We talk about whether it is targeted towards a certain part of the body, whether it is meant for the short term, acute symptoms, versus a long-term therapy, versus that it could be used for either one of those things.

Dr. Goldstein: I was intrigued by the title of your book, *IBD Self Management.* You're not suggesting we don't need physicians, are you?

Dr. Kane: Not at all, but a patient who is informed helps guide decisions. And in this era of shared decision-making, that a patient who understands their disease and can actually understand the difference between a small intestine and a large intestine, where their disease is and how it behaves, what their triggers are versus somebody else who has it that doesn't necessarily have the same triggers, is all a part of self-management. If you don't know your own body and what it's telling you and trying to talk to you, then you won't ever be better.

Dr. Goldstein: What motivated you to write this book?

Dr. Kane: I was asked, and I was so flattered and honored I couldn't say no.

Dr. Goldstein: Okay, very good. And it's your patient experience that really got you going, isn't it?

Dr. Kane: Absolutely. My patients teach me things every day, and the fact that I could just sit down and write out what I would tell a patient in plain terms in English, as we say, as opposed to medical speak, it wasn't hard to do at all and it really turned into a labor of love.

Dr. Goldstein: The last question I really have for you is: We have mistakes made, misdiagnoses, wrong diagnoses. What are the common pitfalls in making the diagnosis and managing patients with Crohn's disease? What have you seen as a consultant to many different physicians?

Dr. Kane: Sure. So I would say the first is that the diagnosis is incorrect, that based on an abnormal CAT scan and the blood test is how some patients get the diagnosis. There's never been tissue confirmation of chronic inflammation. So a patient can present with joint pain and diarrhea and abdominal pain from an infection, have an abnormal CT and they get called Crohn's disease, especially if they have a family member with it. So as we had talked about, you have to have a heightened awareness, but certainly, that's not a slam dunk diagnosis. So making the wrong diagnosis based on some circumstantial evidence is something that I see.

I also see patients who are treated too aggressively, so high doses of steroids, and they don't get better. And then they're put on other biologic medicines, which are great to treat active inflammation and active Crohn's, but if you don't have active Crohn's, then they are risky therapies to use. And what patients will have is maybe very mild or moderate Crohn's disease treated with a hammer. They have another symptom like fatigue or abdominal pain and the hammer now turns into a cannon, where actually a sit-down thoughtful discussion of, “Okay, what's really going on?” can help you tell inflammatory symptoms from irritability symptoms. So a lot of patients get overtreated for symptoms that are due to something else because Crohn's disease doesn't necessarily exist in and of itself and is

not the driver for all GI symptoms. Unfortunately, patients who have Crohn's can also get traveler's diarrhea. They can also get food poisoning. They can also get irritable bowel syndrome. So you have to make sure that you can understand which is driving the patient's symptoms.

Dr. Goldstein: We don't want to leave off clostridium difficile.

Dr. Kane: Oh yes, thank you. Yes, that again, also in my career lifetime we thought of it only after everything else in our patient who had diarrhea, and now it's standard of care to check it any time that a patient calls, and it really has turned into quite a scary epidemic.

Dr. Goldstein: Dr. Kane, I thank you so very much for being with us today. Unfotunately, we've run out of time.

Dr. Kane: All right, thank you.

Dr. Goldstein: I am Dr. Jay Goldstein, and you've been listening to GI Insights, produced in partnership with the AGA on ReachMD. Be sure to visit our website at ReachMD.com/AGA featuring podcasts of this and other series. Thank you for listening.