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Clinical Challenges of IBD Management: A Team-Based Approach to IBD

Announcer:

Welcome to CME on ReachMD. This activity, titled *"Clinical Challenges of IBD Management: A Team-based Approach to IBD,"* is provided by the American Gastroenterological Association and Partners for Advancing Clinical Education, in partnership with Practicing Clinicians Exchange and Clinical Care Options, LLC.

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Ms. Meyers:

Hello, and thank you for participating in this educational program, titled "IBD Resource Center for Primary Care and Gastroenterology Professionals – Your One-Stop Shop for Managing IBD." This module is part of a core IBD curriculum provided by the American Gastroenterological Association and Partners for Advancing Clinical Education, in partnership with Practicing Clinicians Exchange and Clinical Care Options. This activity is supported by educational grants from Amgen, Ferring Pharmaceuticals, and Takeda Pharmaceuticals, U.S.A. This module is the last in the series of six medical minute presentations, and is titled "Clinical Challenges of IBD Management: a Team-Based Approach to IBD." I'm Abigail Meyers, a physician assistant, instructor in surgery at Mayo Clinic Rochester in the Department of Colon and Rectal Surgery. Today I am pleased to present with Dr. Bruce Sands. Dr. Sands is the Chief of the Dr. Henry B. Janowitz Division of Gastroenterology at Mt. Sinai Hospital, Chief of the Division of Gastroenterology at Mt. Sinai Health System, and the Director of the Digestive Disease Institute at the Icahn School of Medicine at Mt. Sinai in New York, New York.

The objectives for this medical minute are for you to be better able to apply recommended strategies for collaborative care and holistic patient care methodologies for IBD. (pause, 1:22-1:28)

When we're discussing importance of collaborative IBD care, we have to first understand that IBD care is very complex, and requires a coordinated, multidisciplinary approach to improve our patient outcomes. All members of the team should engage in care coordination to have success in the treatment of our patients. Success requires ongoing reflection and intentional quality improvement. There will be need for balance of standardized application of evidence-based medicine, and individualized care is important within that structure. Meeting the needs that impact healthcare utilization is important, and they should consider financial and insurance needs, psychosocial needs, as well as cultural influences or biases.

There are resources for improving IBD care. The Crohn's and Colitis Foundation offers IBD Qorus, which is – mission is to seek to find a cure for IBD by striving to improve health outcomes and quality of life for those with inflammatory bowel disease. They're involved in collecting patient-reported data, research and publications, education, and networking.

IBD Qorus collaborative helps to value measures for improving IBD care by using four domains, such as functional status, patient experience, cost and utilization, and clinical status. These help to promote shared decision-making, focus on care and satisfaction of our patients, as well as patient self-efficacy.

Dr. Sands will highlight the need for realignment of treatment goals.

Dr. Sands:

Thank you, Abigail. Yeah, it's very important for physicians to understand that their patients' goals may not be exactly the same as their patient goals. For example, patients often express the desire to measure things through social measures. The capacity to perform at work, and enjoy social and leisurely activities, experience of fatigue, and the overall impact that has on the ability to work. Physicians tend to focus on objective and scientific measures. We look at things like clinical and histologic remission, which patients may not really be able to appreciate. And so we try to reconcile these two sorts of goals through shared decision-making. We think about a treat-to-target paradigm, where we want to achieve objective goals, such as the Crohn's Disease Activity Index or the UC Disease Activity Indices, as well as subjective measures of disease, which might include inflammatory bowel disease questionnaire and its components. But overall, we want the physician to discuss these goals with the patient, and to have mutual goals, and for the patient to appreciate what your goals are for their care, that will help improve their outcomes over time. So, patients who are experiencing quality of life impacts often don't discuss these impacts during a typical visit with the gastroenterologist, and the gastroenterologist may find that the patient underplays the impacts of their quality of life impact. So, we really need to be mindful of this, and ask our patients about it.

Well, Abigail, we have a case study of a patient named Kate, who's 25 years of age. She has a 1-year history of Crohn's disease, and she's been on infliximab 5 mg per kg, every 8 weeks, since she was diagnosed, and she's calling your office now because she's feeling that she's having a Crohn's disease flare, with worsening symptoms over the last month, of abdominal discomfort, frequent bowel movements with pain and bleeding, fecal urgency, afebrile at home, but she has a five to six or so pound unintentional weight loss. And after you discuss things with her, she confirms that she has been adhering to her therapy. She has not had any recent travel or illnesses, and she's not had any other medication changes recently. As well, she is interested in your thoughts on the role of holistic integrative or complementary and alternative medicine, and the role that may play in the care of her Crohn's disease. And so this is not unlike a lot of patients that we may see in our office. This is a young woman in the prime of her life.

She's a functional person who's working, has a job, has a social life, and also has her own construct of how she may be conceptualizing her illness, and her own thoughts about what treatment should consist of. So, Abigail, how would you approach Kate's case in a collaborative manner, and if we're talking about collaborative care, which members of the team are available in your clinic that could help Kate get through this flare?

Ms. Meyers:

I would help to discuss with Kate in a collaborative manner, as to talking about her IBD, specifically, as to how that's impacting her life. What is she wanting to do that her IBD is limiting her to do, based upon the symptoms that she's experiencing? And then, in that way, also if she wants to know about holistic measures or integrative care plans, I would ask her what specifically does she have in mind, because she likely has looked at things on her own, and has some ideas of what she'd like to pursue first. And so, by opening the door for a mutual respectful conversation of hopes and goals and what she's already researched on her own, helps us to direct our conversation moving forward as to what resources we have available. First I like to talk about what medical resources we have available for disease reassessment. Is it time for her to have a disease reassessment? Does she need an endoscopy? Does she need drug levels? Does she need imaging? And then from there, we can discuss other things. How is she doing mentally? Is there a big life stress that's happening in her life at that time? What type of support does she have, with her family and friends around her? And then, based upon what her goals are, I do have resources in my clinic available, such as dietitians, if she's looking for dietary changes. We have GI psychologists that can help through some of our challenges. We have a pharmacist, if she'd like to talk a little bit more about maybe anxieties or fears that she has related to her medical regimen. We also have patient-supported connections available, too. If she's looking for that, you know, you don't really understand because you don't have this condition, but I'd like to speak to someone who does, and so we have resources that ___ (7:53). Now, beyond all that – beyond holistic, and beyond integrative therapies that exist, you know, if her disease indicates that she needs, you know, a surgeon, or she needs endoscopy or radiology, you know, we have those resources available to her, too. But I think, in collaboration with the patient specifically, first and foremost, we outline those goals, and what she's hoping to achieve.

Dr. Sands:

I think that's a wonderful answer, and it shows you the holistic approach that your office and your practice has built around the care of patients, because there are so many different aspects to what they will need, and different types of care providers, and different considerations, and how you tell her these for the individual patient. So that's really amazing.

Well, speaking of the infrastructure needed to treat a patient with IBD, there have been some thoughts in the literature about what IBD patients really should have around them. We believe that they need access to all kinds of healthcare professionals. Certainly, the access to a good pharmacist is going to be useful, if you have one. Ophthalmology comes up often because patients may have eye complications of their IBD, or of their medications, such as from their steroids. We often turn to the rheumatologists, because arthralgias and arthritis are the most common extraintestinal manifestation. And because our patients are relatively young, they may need

gynecologists and obstetricians to weigh in, dermatologists to weigh in when they have skin complications. You mentioned dietitians, Abigail, and those certainly can be very helpful for just about every patient, and because anxiety and depression are so common among our patients with IBD, and adjustment to the disorder can be so difficult, we also need access to mental health workers, psychologists, social workers, and occasionally we need a stomal therapist. So it takes a small village in many ways.

And we also think we need dedicated IBD nurses, who have the expertise to really manage these patients, and guide them through the care process, and also to educate them. Ideally, you'll have at least one gastroenterologist with specialized IBD training. If you're really fortunate, you have an endoscopy unit that has expertise as well, and you need cross-sectional imaging with expert radiologists, who know inflammatory bowel disease, and you need good pathologists who are familiar with Crohn's disease and ulcerative colitis.

If you're going to have patients who need a J-pouch surgery, a high quality surgical program should perform at least 10 ileal-anal pouch operations per year, to maintain that quality, and I would say probably much, much more northwards of that number. And these people, doing such surgeries, should have been trained as fellows to be colorectal surgeons capable of doing this. And then finally, hopefully the practice is integrated in a hospital with a very capable emergency department, because often our patients do end up in the emergency room. So there are a lot of different aspects to the care of these patients, and it can be very daunting to connect with all these different kinds of disciplines.

Ms. Meyers:

Dr. Sands, I like that you said it takes a small village to manage our patient population, and I think that extends outside of GI as well, and when we think about collaboration for improved patient outcomes, it really does demand a partnership with their primary care providers as well. And I really encourage my patients to strengthen that relationship with their primary care provider, to ensure this long-term management. You know, a lot of our patients are immunocompromised, so keeping vaccinations up to date, including COVID-19 and our annual flu vaccines, are imperative for overall health.

Household members can be treated in a primary care setting as well. You know, they can screen for osteoporosis at our time of diagnosis and periodically after diagnosis, but really have to understand who is going to manage that. Is that going to be the IBD provider, or can we work together with primary care to help optimize patient visits and decrease costs of overall healthcare demands? Patients should receive annual skin check, if on immunomodulators or TNF inhibitors. They'll need a surveillance colonoscopy and again, working together with primary care, who will be taking care of making sure the patient is on the appropriate schedules for their colonoscopy is a conversation. As Dr. Sands mentioned, ophthalmology examinations, and then depression/anxiety screening as well as smoking cessation. So one of the best ways to kind of manage all of these different facets of our IBD patient population that is so complex and, you know, extends beyond our GI tracts is really building something within our own EMR, or our own note system, to help us to remind what timeline our patient's on for these types of follow-ups. And the Crohn's and Colitis Foundation really has some great resources available, like a health maintenance checklist. This is an evidence-based checklist that's available for adult and pediatric patients, focuses on vaccines and infections, cancer screening and other protection, as far as timelines in our IBD population. We're going to go into depth in these three focus areas a little bit more.

When we're looking at vaccines and infection, in the red we have varicella and MMR, and these are live vaccinations that should ideally be given greater than or equal to four weeks prior to starting biologic therapy, as we try to avoid live vaccines in our immunocompromised population. The Zoster vaccination is a recombinant, and we can give if on a low dose of immunosuppressant. When we're looking at influenza and pneumococcal vaccinations, these are non-live vaccinations. The influenza vaccine should be given annually, and we should avoid the live intranasal version for immunocompromised patients. For pneumococcal vaccination, we would give the PCV13 followed by the PPSV23, or give the PPSV 23 first. It'll be important for our patients to screen for latent tuberculosis baseline, and then screening for any exposure annually in our IBD population.

Dr. Sands:

We also have to be mindful of the risk of cancer in some of our patients, not all of them, particularly colorectal cancer. And we know that surveillance colonoscopy should start at eight years after diagnosis, and then every one to three years after symptom onset, if the patient has extensive colitis of at least a third or more of the colon, in the case of a patient with Crohn's disease, or if they have left-sided or extensive ulcerative colitis. And we prefer that high-definition scopes should be used in colorectal cancer surveillance. Patients may also be at risk for cervical cancer. For example, if they're on systemic immunosuppression, we'd recommend PAP tests be performed annually, or every two years if HPV is negative.

And then, as you already mentioned, Abigail, skin cancer is another risk and we would recommend that an annual total body skin exam be performed, if a patient is at all on systemic immunosuppression – I would say if they've ever been on immune suppression. Particularly if they've been on thiopurines, they have a lifetime risk, and all of our patients should have some exposure precautions.

Ms. Meyers:

When we're considering bone health, we need to consider a DEXA scan in all of our patients with inflammatory bowel disease, if they have any of the following risk factors for osteoporosis, and then repeat this every five years. Some risk factors include a low bone mineral density, greater than three months of a cumulative steroid use, smoker, postmenopausal, hypogonadism, and then some serial monitoring as well as if patients are needing supplementation. Consider calcium and vitamin D prescriptions for those patients on oral steroids, if vitamin D is insufficient or deficient.

Dr. Sands:

And there are a few other things to keep in mind as well. We would prefer that all patients be screened for smoking and that they be counseled for smoking cessation. This is especially important for patients with Crohn's disease, as smoking actually exacerbates the disease. But really, for reasons of general health, we don't recommend that patients with ulcerative colitis smoke either, and some of them will have been – have activated their ulcerative colitis when they quit smoking, and will go back to smoking. We just don't recommend that they do that. It's not good for their general health. As we already mentioned, many patients may experience depression and anxiety. I always think of these things – these mood disorders as great magnifiers of their disease and their symptoms. Anyone who's depressed or anxious is going to experience the disease in a much more acute way than a patient who doesn't, so we would recommend that all patients be screened with the PHQ-9 depression instrument, and the GAD-7 anxiety instrument. And if we identify patients with depression or anxiety, we'd be able to refer them for counseling or therapy as needed. And then finally, we can't forget that these are GI disorders, and many of our patients may have nutritional deficiencies. Particularly if a patient has Crohn's disease and has had ileal resection or has extensive ileal disease, they may have poor vitamin B12 absorption – a very key vitamin. Many patients will be iron deficient, so we recommend checking iron panels on a regular basis. And then, we do not do enough screening of patients for malnutrition. It's far more common than we imagine.

Ms. Meyers:

Let's discuss another case. We have Frank, who is a 32-year-old black patient, with ulcerative colitis, diagnosed seven years ago. He's frustrated because he continues to have flares despite his use of anti-TNF therapy. He presents to our office with active, severe disease, despite adherence to therapy. His anti-TNF trough levels are below goal, and antibodies are present.

He's inquiring about the need for surgery, to help with his ulcerative colitis. When he starts discussing systemic therapy, you inquire about immunization status, and discover that he's not yet received a COVID-19 vaccination. He's hesitant to receive this because of his inflammatory bowel disease, but he also expresses concerns of low representation of racial and ethnic minorities in the clinical trials. Dr. Sands, how do you maintain an open and effective communication in collaborating with this patient, particularly when navigating discussions about medication access, adherence, and potential need for surgery?

Dr. Sands:

These are such important considerations and can be very difficult topics. I think my approach with challenging patients such as Frank really would be to listen very extensively to what their concerns are before framing a response. You need to understand where he's coming from, before you respond at all, and he's quite right that most studies of most medications have underrepresentation of people of color, so we can't argue with that. On the other hand, we can tell him in the case of COVID-19, that it's actually – people of color and people with a number of other risk factors, such as diabetes, overweight and so on, are at increased risk for severe disease. All we can do is present him the best evidence, and try to persuade him. But I think even more than that, if you have a very good doctor-patient relationship, or provider-patient relationship, with Frank, that you've built over time, then you'll have gained mutual trust, and you will have something to build on in terms of persuasion and bringing him around, and I think that that's really kind of a key thing. Sometimes, you can engage other members of the team to help you, such as your pharmacist, if they're a part of your team. They can spend a lot more time than you may have in your office, to be more detailed about the safety of different medications, as well as be realistic about the efficacy. You want to screen Frank for anxiety and depression as well, so your social worker might also be helpful to you. And I think you just have to keep the channels of communication open at all times. Regarding the need for surgery, it's never wrong to have a discussion with the surgeon on your team. The surgeon can frame for you what the outcomes of surgery are, as well as the indication, even if it isn't really the time yet to do that for this patient, as he has many other options. So, I think just introducing him to other members of the team, as a routine thing rather than when it's an urgent thing, can also be very, very helpful.

Ms. Meyers:

Thank you. I think you highlighted really well the relationship-building, and through that validation of the feelings, involving other members, actually creates more of an environment of mutual respect and trust, and helps to build and improve our patient outcomes. Thank you, Dr. Sands.

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