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Diagnosing IBD: Is It IBD or Something Else? Can You Tell?

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Ms. Orleck:
This is CE on ReachMD, and I'm Kimberly Orleck, a physician assistant practicing out of Atlanta, Georgia.

Ms. Geremia:
Hi, I'm Jennifer Geremia. I'm a physician assistant in gastroenterology at Brigham and Women's Hospital in Boston.

Ms. Orleck:
In this episode, we're helping you sort through the complexities of inflammatory bowel disease from subtypes to diagnosis. Let's start by breaking down the major subtypes of IBD.

Jen, if you don't mind, maybe you can share with us, how do you differentiate Crohn's disease and ulcerative colitis in terms of how they present as well as how they show up differently in the GI tract?

Ms. Geremia:
Certainly. So although these are both autoimmune conditions of the GI tract and there is crossover in our therapies, there are some differentiating factors in both how we identify and monitor patients but also their presentations.

So first is site of disease. So colonic disease exclusively happens in UC, there is no small bowel involvement, and it is continuous, starting in the rectum through the entire large intestine, potentially causing pancolitis, where Crohn's disease can affect anywhere mouth to rectum and historically is categorized as skip lesions or patchy disease with healthy disease then inflamed tissue, and so on, most commonly being typically the terminal ileum in the small bowel and also the perianal area.

Also how deep this inflammation goes—our patients with UC tend to have mucosal and submucosal involvement, where the inflammation in Crohn's is transmural, so it goes straight through the muscularis in these patients. As indicated before, there's always rectal involvement in UC, but there is not typically rectal involvement in Crohn's, and that is differentiating from perianal disease—rectal and perianal areas are two different areas.

Because of the fact of the mucosal nature and the fact that the rectum is involved, common symptoms in UC are predominantly bloody diarrhea, mucus, urgency, and tenesmus, where we see much less visible blood in the diarrhea with our Crohn's patients. They tend to

have a lot of abdominal pain, in particular with ileal involvement, weight loss from malabsorption from small bowel disease, potentially mouth ulcers, also with the risk factors for fistulas, strictures, and abscesses because of that transmural nature. So that is not seen in UC, where you'll see much more visible blood or hematochezia on those patients.

If we look at a pathology sample of colonoscopy, granulomas are going to be more commonly seen in Crohn's disease, and rarely in UC, but it is not necessarily pathognomonic to Crohn's. And if you don't see it, doesn't mean it's not Crohn's, but if we see them, much more commonly in Crohn's.

Risk factors would encompass genetics, family history of inflammatory bowel disease, other autoimmune disease; as we know, the immune system is not discriminatory. Smoking is a risk factor in Crohn's. There's potentially a protective value in UC patients, but I say that lightly because we certainly don't encourage this in patients. Cancer risk is fairly equal in both, especially if they've had long-standing disease with low-grade inflammation for not just cancer but also low-grade mucosal dysplasia that's flat.

And imaging is much more utilized in Crohn's disease with patients that have the potential for fistulas and abscesses. We leverage enterography in these patients, and possibly small bowel capsule with caution, where there's very little utility beyond colonoscopy for imaging in our UC patients.

So, Kim, I'm curious. What do you look for as far as disease mimickers? Or based some of these presenting features, what do you find can overlap with IBD?

Ms. Orleck:
Yeah, such a great question, Jen. And as you mentioned, really the symptoms from UC and Crohn's differ, but also how each patient presents is really different. So when I think about these differentials, it's really what's that patient's major symptoms? So obviously, if diarrhea is a key complaint, I'm going to think about the infectious colitis as be it bacterial, viral, and also thinking about STIs. I'm going to think about vascular conditions like ischemic colitis, particularly in our older patients with vascular risk factors. We want to take a great history and have a high index of suspicion for drug or medication-induced colitis. I know we see fairly often NSAIDs and immune checkpoint inhibitors that can really mimic IBD.

Functional, like IBS, is certainly very common. And so if a patient is presenting, for example, with diarrhea, we might think about IBS-D. We're really going to use the fact that, as you mentioned, IBD patients have alarming symptoms, elevated calpro, versus our IBS-functional patients do not have any alarming symptoms and normal calpro and biomarkers. We want to keep neoplastic, like colorectal cancer, in our differentials, particularly, again, if they have alarming symptoms. And then the last one I'll mention is what I call kind of the other. So again, based on their symptoms, particularly here thinking about diarrhea, but EPI, microscopic colitis, lactose intolerance, celiac disease, and diverticulitis.

Ms. Geremia:
Well, this has been a great bite-sized discussion, but our time is up, and thank you all for listening.

Announcer:
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