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Remission: Can You Prove It?

Announcer:
Welcome to CE on ReachMD. This activity is provided by Prova Education and is part of our MinuteCE curriculum.

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Ms. Orleck:
This is CE on ReachMD. I'm Kimberly Orleck, physician assistant, and Dr. David Rubin is joining me today.

Dr. Rubin, we obviously talk about remission all the time in IBD—different types of remission: the clinical remission, the endoscopic remission, histologic remission, transmural remission. Can you explain a little bit what does remission really mean? And is endoscopic healing enough? Or what should we truly be aiming for? What's that real deep remission goal?

Dr. Rubin:
Hi, Kim, thanks for this important question. Remember that treating people with IBD is about quality of life first and foremost. So if our ultimate goal is to improve their quality of life and to provide them with what I call a sustained, unencumbered, high quality of life, we need to control their disease process.

And it's not just about symptom control. Of course, we start with wanting people to have no symptoms, and in ulcerative colitis, that means no urgency, no bleeding, normalized stool frequency, sleeping through the night without waking up to have a bowel movement, and being able to pass gas without fear of leaking.

But in order for that to be sustained and for it to keep them well over time, we need to pair that with other markers. And the ones that have been best studied and now are included in our clinical trials include endoscopic remission—that means that when we put a scope in, the bowel looks normal—and fortunately, we can use some surrogates like calprotectin to assess what that might be

And even under the microscope, histologic remission, which is not yet a standard endpoint, but when we get there, when we look under the microscope at a biopsy, if it's healed, we know that it's a very good thing.

The other point of this is that we want to make sure we're not ignoring other factors that contribute to people's poor health, which would include if they have joint pain or if they've become depressed or anxious related to their colitis, and those are all parts of understanding remission.

When you ask patients about remission, they will say that it has to do with being off medicine—and that is not the right goal. Of course, we'd like them to be off medicine, but we recognize that both Crohn's disease and ulcerative colitis are chronic conditions, and

maintenance usually requires some amount of medical therapy to prevent relapse or progression of their condition.

In Crohn's disease, it's similar. We want them to have none of the symptoms, but we might also use cross-sectional imaging—whether it's a CT or MRI—to look at the bowel, and increasingly intestinal ultrasound, as a way to measure whether they're healing and whether we're getting there.

There are multiple trials going on right now that are exploring histologic remission in ulcerative colitis and transmural healing with intestinal ultrasound and MRI in Crohn's. So the field is moving forward, and people should keep that in mind.

But remember that you need to tell a patient to expect good health and great control. That is what remission is about. Don't let them settle, and you shouldn't either.

Ms. Orleck:
Dr. Rubin, that was so helpful, and I feel like you really summarized the STRIDE recommendations so well. Can you share, in your personal experience—obviously there's not the same timeline for every patient—but when do you kind of hope to achieve and start to re-scope these patients and look for that endoscopic healing, etc.?

Dr. Rubin:
Yeah, it's a really important question. I start by explaining to patients that whatever therapy we've agreed to start should make them feel better within a week or 2. That doesn't mean perfect; it means they're on their way. They should know it's doing something. What shouldn't happen is we start a new therapy and they get worse. That's not supposed to occur. What might happen in some cases is they start the therapy and they can't tell if they're getting better yet.

What I routinely do, though, is I schedule the patient for a 6-week reassessment. That can be a phone call, can be a televisit, it might be in person, but it also always includes something objective. If they make CRP—remember, not everyone does—we repeat the CRP. If they have an elevated calprotectin at baseline, we'll repeat the stool marker. And in our practice and in others that I know, we use an intestinal ultrasound to reassess.

So the timing for me is making sure patients know it doesn't happen overnight in most cases, but that they should be generally moving towards wellness. And then at 6 weeks is when I really reassess. I don't do a scope usually until 3 to 6 months down the road, and that depends on the individual case. But you're not supposed to wait 6 months just to find out the drug isn't working. That's not how we do it anymore. We've got to compress our time. And the patients, of course, appreciate that.

Ms. Orleck:
So many great pearls, Dr. Rubin. I just want to kind of recap a few points you made, that the persistent microscopic inflammation, even in our patients who are symptom free and feel good, we really want to focus on those objective markers, knowing that if we're able to get those patients really in that endoscopic and, as you mentioned, ideally histologic remission, that really predicts decreasing for steroids, hospitalization, complications, and surgery.

And we thankfully have a lot of data and trials to support that, including the KALM trial and post hoc analyses.

As always, I wish I had more time with you, but thank you for this great but brief discussion. Hopefully all of our listeners can put some of these tips into their own practice tomorrow and every day going forward, and thank you all again for listening.

Dr. Rubin:
Thanks so much, Kim.

Announcer:
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