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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Counteracting Chronic Pain in Patients with IBD

Announcer:
Welcome to Crohn's & Colitis Foundation Perspectives on ReachMD. Here's your host, Dr. Jennifer Caudle.

Dr. Caudle:
Pain management is a critical unmet need in inflammatory bowel disease, or IBD, as many patients suffer from abdominal pain, a symptom that can be caused by various mechanisms, including blockages, gut distension, and even severe intestinal inflammation. With so many patients living with this debilitating symptom, how can we help them manage their chronic pain safely and effectively?

Welcome to Crohn's and Colitis Foundation Perspectives on ReachMD, and I'm your host, Dr. Jennifer Caudle. Joining me today is Dr. Matthew Coates, Physician Scientist at Penn State Health Gastroenterology who has a longstanding research interest in the interplay between IBD and neuroendocrine signaling systems. Dr. Coates, it's great having you with us.

Dr. Coates:
Thank you for having me.

Dr. Caudle:
So to start us off, Dr. Coates, what's our current understanding of the causes of abdominal pain in IBD?

Dr. Coates:
That's a very important question. There are a lot of different causes of abdominal pain in IBD. Most of the time, we think of inflammation as the primary driver and that's probably true. However, inflammation can lead to a variety of other complications that can drive pain as well, including strictures, fistulae, and abdominal abscesses. Beyond that, even when the disease is not particularly active and/or these complications don't exist, there are a variety of other factors that may play a role – patients' diet, so an intolerance to certain types of foods; alterations in motility; changes in the way that the nerves running to and from their gut are working; a host of signaling factors in and outside of the gut; and patients' mental state. Those, to name just a few, all of those factors can play an important role in pain generation in this setting.

Dr. Caudle:
Thank you for that. And can you share some of the latest research around the biological drivers of chronic pain?

Dr. Coates:
Absolutely. There's been a lot of study over the years looking at pain in IBD and related conditions. What we've learned over time is that there're several signaling systems that have a potential for modulating pain perception from the gut in inflammatory bowel disease and, and other similar disorders. Beyond that, more recently, there's been increased interest in the potential role that the microbiome may be playing in pain and symptom generation in IBD. The epithelial barrier may also be playing an important role in that regard. There are a host of potential contributors, there isn't a particular one that seems to be driving pain more than another, but there are a lot of potential targets that we could go after.

Dr. Caudle:
And what are some potential future directions that investigators may follow to further understand abdominal pain in IBD and to find better treatments?

Dr. Coates:
So, what's very clear is while we've learned a lot over the years about pain and pain management in IBD, there's a lot we don't know,

and unfortunately a lot of the lessons we've learned this far have been borrowed from other conditions, such as irritable bowel syndrome. That may or may not be appropriate in certain types of patients. Moving forward, it will be very important for us to pursue larger-scale studies, most likely involving more than one center, that look at not only validated survey responses to pain and other related symptoms but also concurrently assess a host of biological markers, including looking at protein, DNA, RNA, a variety of signaling factors that may influence pain experience.

Dr. Caudle:
Well, you know, that's really interesting, and, and let's delve into that a little bit more if you don't mind. You mentioned some of these potential biomarkers, but can you share more about some of these potential biomarkers being researched to assess and predict chronic pain?

Dr. Coates:
Yeah. At this point, everything is still in a particularly early stage. There's nothing ready to be applied in the clinical setting just yet, but potential biomarkers include assessments of physiologic function, so there are some primarily research but some clinically-based tools that assess autonomic nervous function that may be applicable to visceral pain disorders, including those associated with IBD. Beyond that, there are also some potential blood tests. For example, my lab and my collaborators are looking into the possibility of using a particular polymorphism associated with a sodium channel gene to predict pain responses and, and sensitivity to pain in inflammatory bowel disease patients.

Dr. Caudle:
For those of you who are just tuning in, you're listening to Crohn's and Colitis Foundation Perspectives on ReachMD. I'm your host, Dr. Jennifer Caudle, and today I'm speaking with Dr. Matthew Coates about how we can address pain in our patients with inflammatory bowel diseases, such as Crohn's disease and ulcerative colitis.

So now, Dr. Coates, if we look at this from a practical standpoint, can you share some diagnostic approaches providers can take with their IBD patients? What kind of work-up is appropriate here?

Dr. Coates:
Yeah, the same type of work-up that goes into every patient so what that means is a very careful history as well as a physical examination. It's really important to perform a careful exam, particularly of the abdomen, of course; in most cases the primary contributor and/or primary contributors of pain can be identified in, in these ways. If those approaches aren't helpful, there are a variety of other standard tests that we employ in gastroenterology that can also be useful in this setting, and that includes performing endoscopies, both upper endoscopes and colonoscopies, imaging studies to assess for things like not just active inflammation but some of the complications I previously mentioned, stool studies to look for signs of infection or inflammation as well as a variety of blood tests that can also help look for inflammation, along with some other potential contributing factors.

Dr. Caudle:
Excellent. And once the patient is diagnosed, how can providers relieve their patients' IBD pain? And what are your thoughts about taking an integrative approach?

Dr. Coates:
It's really important that we as providers are straightforward with our patients, that, sometimes we don't have all the answers. In most cases, we're able to help out quite a bit here, and as I mentioned previously, you know, our first priority in the setting of inflammatory bowel disease is to make sure that the disease itself is under reasonable control, and while, there are a variety of other factors that can contribute to pain, in particular abdominal pain in IBD, that's always our, our, our first concern. More often than not, there is, there's more than one issue that causes pain in this patient population, and while gastroenterologists are an important part of this whole process, it's usually really important to approach pain as a multidisciplinary issue, and that means bringing in other providers preferably who have training in inflammatory bowel disease, and that includes, colorectal surgeons, psychiatrists, dieticians, pain management specialists, and sometimes a host of other,, medical specialists, so letting the patient know upfront, "I may not have all the answers, and I may not be the only one involved in your care, but I think with time, careful assessment, and the involvement of some of these other specialists, we're usually pretty successful." In regards to the question about taking an integrative approach, if you mean taking a, a more holistic approach, I think that goes along with what I was just saying is, you know, I think your going to fail as a, a provider if you just look at this as an inflammatory bowel issue. Obviously, the patient brings with them not just that diagnosis but all of the other experiences that they have in relation to that disease and their life in general, and so oftentimes taking a step back, getting a picture as to where they are personally, emotionally, is really critical in assessing what direction to go in and what types of interventions the patient, themselves are really ready for.

Dr. Caudle:

Our next question is really talking about therapeutic options, so, you know, I'd love it if you could share the current therapeutic approaches that providers should consider for pain management and what role might psychotropics and narcotics play here?

Dr. Coates:
Well, as I mentioned previously, the primary concern with IBD is whether or not we've got the disease itself under control, so making sure that patients are on an appropriate regimen to address the inflammatory activity associated with that is really important. Additionally, it's important to assess for, and manage appropriately, complications that can arise with IBD that may or may not be associated with pain. That includes development of strictures fistulae, abscesses, so if you've evaluated for those things and you've optimized their therapy in that regard both from a medical and surgical standpoint, then you start to move on to other potential contributors to pain. In regards to the addition of potential psychotropics and narcotics, there's a potential role for each of those classes of medications, but we need to be careful. In brief, there's not a lot of current evidence for, to support the use of either of those types of agents, specifically for pain control. That doesn't mean we don't do it. In fact, it's very common to employ both psychotropics and/or opiates in the setting of IBD. However, there are potential risks, particularly with opiates. We know that not only are they not particularly effective at controlling the pain, they are associated with a host of complications related to IBD and pain perception itself. Ideally, you would avoid those types of agents if you can. There are circumstances where they're more appropriate, such as immediately after surgery or during more acute severe flares of disease. However, we really try to avoid opiates if we can. The psychotropics are, are being evaluated and have been evaluated for years. There are a whole slew of different medications that fall under that category, some of which seem to hold more promise both from a pain management and even a anti-inflammatory perspective, but really we need more time to study all of those agents in the setting of IBD.

Dr. Caudle:
Well, unfortunately that's all the time we have for today's discussion, but this has been very informative, and I'd like to thank our guest, Dr. Coates, for joining me today. Dr. Coates, thank you so much.

Dr. Coates:
Thank you.

Announcer:
This episode was brought to you in collaboration with the Crohn's & Colitis Foundation. To learn more about the Crohn's & Colitis Foundation, please visit crohnscolitisfoundation.org. And if you have missed any part of this discussion, or to find others in the series, visit ReachMD.com/foundation, where you can Be Part of the Knowledge. Thanks for listening!