UC Health

IN SCIENCE LIVES HOPE.

Management of IBD in Primary Care

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Disclosures

- Abbvie: Advisory board, Honorary Speaker
- BMS: Advisory board, Honorary Speaker
- Janssen: Advisory board, Honorary Speaker

Objections

1. **Identify Key Management Strategies:** Identify key management strategies for inflammatory bowel disease (IBD) in the primary care setting, including initial diagnosis, treatment, and ongoing care.

1. **Discuss Coordination with Specialists:** Discuss the role of primary care providers in coordinating care with gastroenterology specialists, including referrals and collaborative management approaches.

1. **Review Patient Education and Support:** Review best practices for patient education and support in managing IBD, including addressing patient concerns, adherence to treatment plans, and lifestyle modifications.

Inflammatory Bowel Disease (IBD) Overview

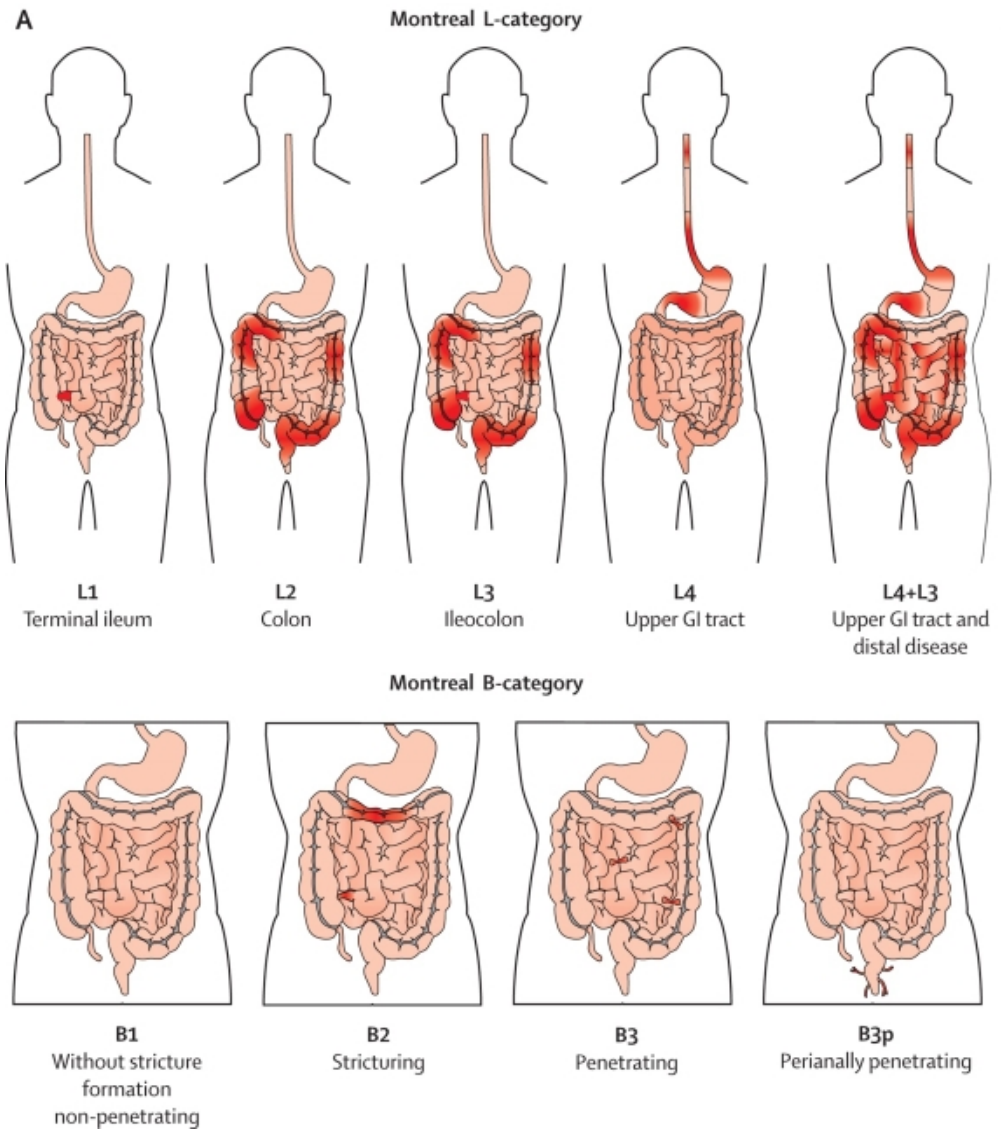
- IBD consists of two diseases
  - Crohn's Disease (CD)
  - Ulcerative Colitis (UC)
- Chronic inflammation that targets the gut
  - Crohn's Disease – anywhere from the mouth to the anus
  - Ulcerative Colitis – limited to parts or entire colon
- Associated with inflammation in other organs – eyes, skin, joints
- Bimodal age distribution (15-30's and 50-70's)

Crohn’s Disease

CD Phenotype

Location

Behavior



Baumgart et al. Lancet 2012

Crohn's Disease Symptoms

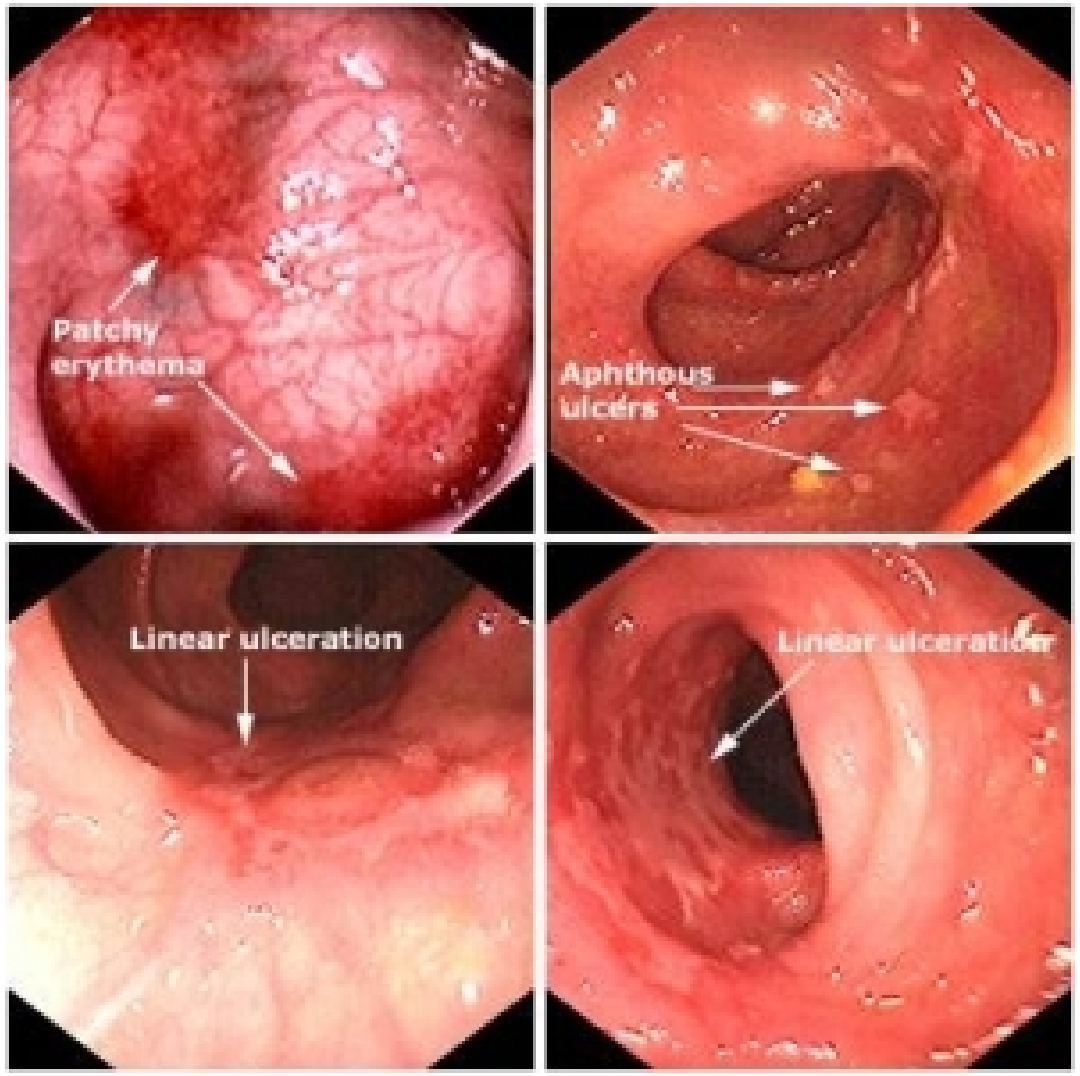
Depends on the location and if there is a complication

- Diarrhea with nocturnal stools
- Abdominal pain
- Weight loss
- Obstructive symptoms: nausea, vomiting, distention, bloating
- Dysphagia
- Perianal pain/drainage/fluctuance

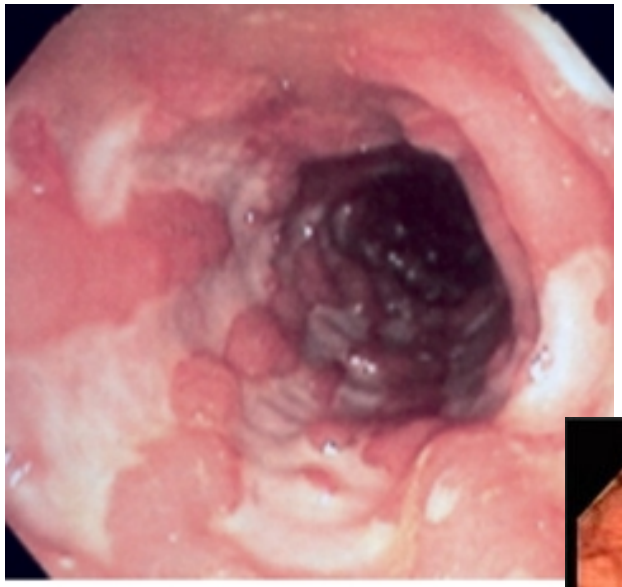
Diagnosis

- Endoscopy
- Histology
- Imaging
- Labs
- Stool

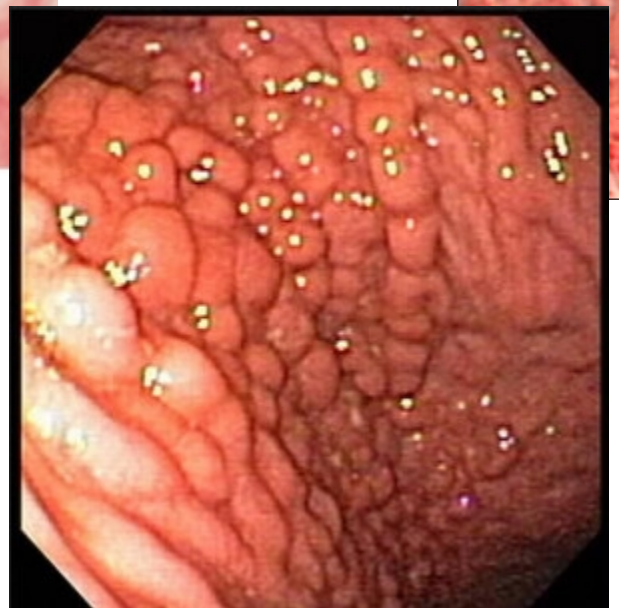
Endoscopic CD

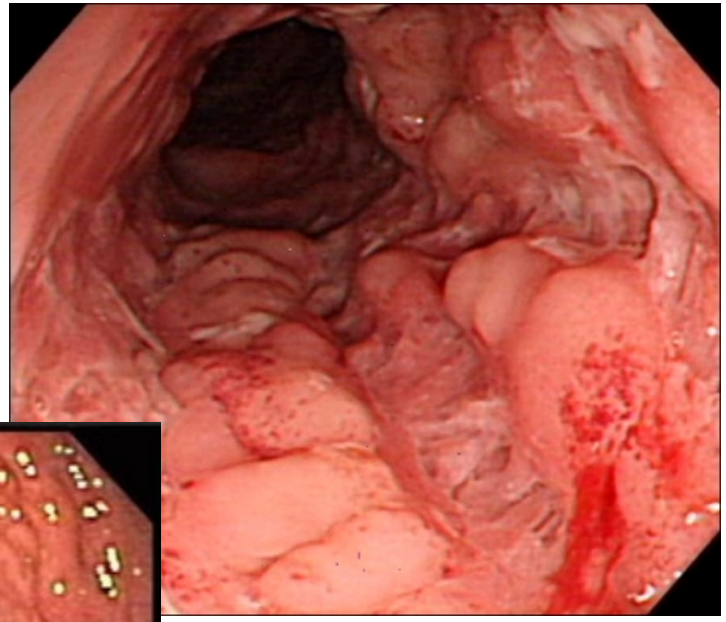


Endoscopic CD



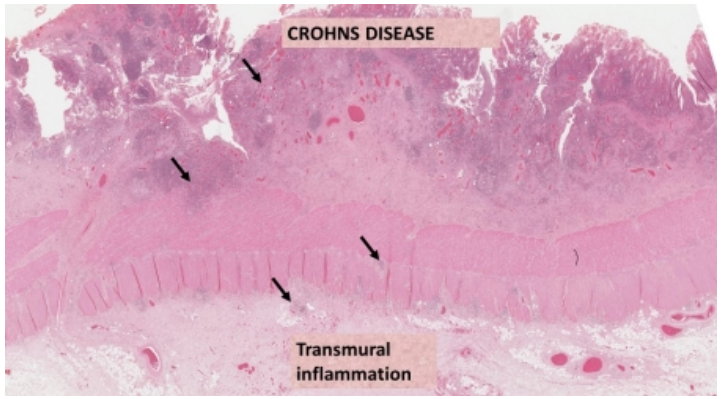
Longitudinal or serpiginous ulcers

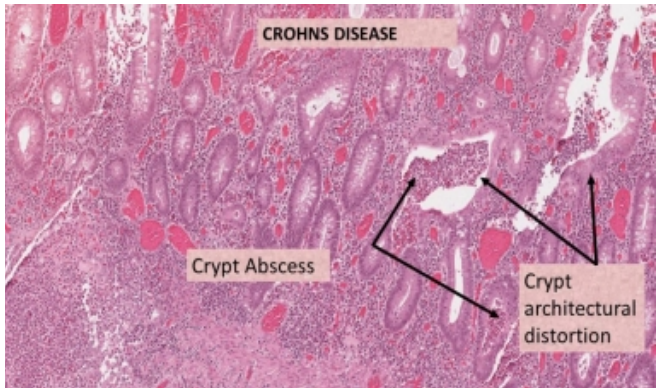


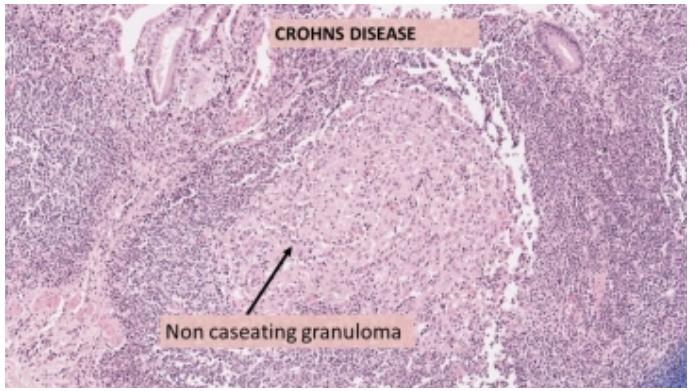


Cobblestoning

Pathology: CD

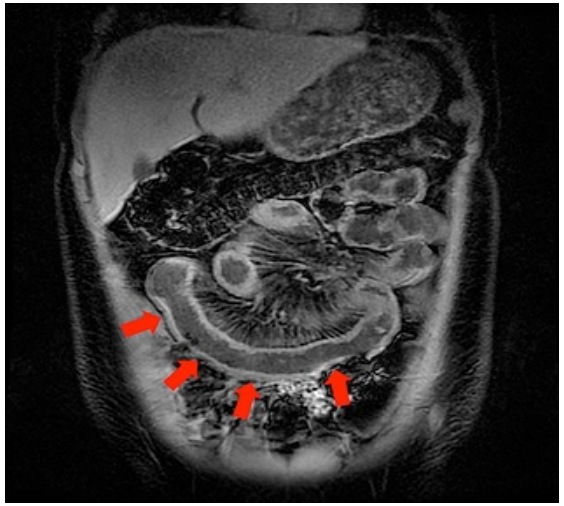




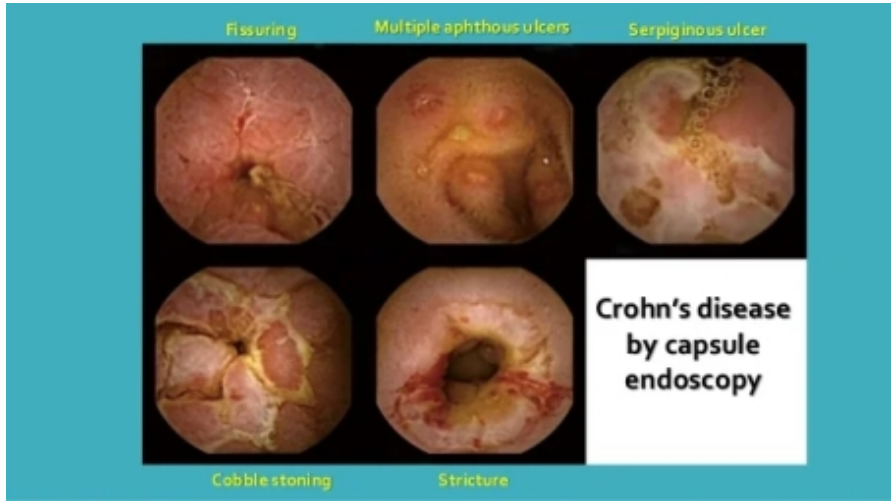


Imaging

- MRI of the pelvis
  - To assess perianal disease
- Enterography (CTE or MRE)
  - To assess small bowel inflammation



- Capsule endoscopy
  - Usually ordered after EGD, Colonoscopy, and enterography to look for disease in the small bowel (especially proximal small bowel)



Labs and stool

Disease activity

- CRP
- CBC – anemia, elevated platelets
- CMP – low albumin
- Fecal cal

Prepare for advanced therapies

- TB QuantiFERON
- Lipid panel
- Hepatitis B serologies

Nutritional Deficiencies

- Vitamin D
- Vitamin B12
- Ferritin and iron panel
- Folic acid
- Zinc

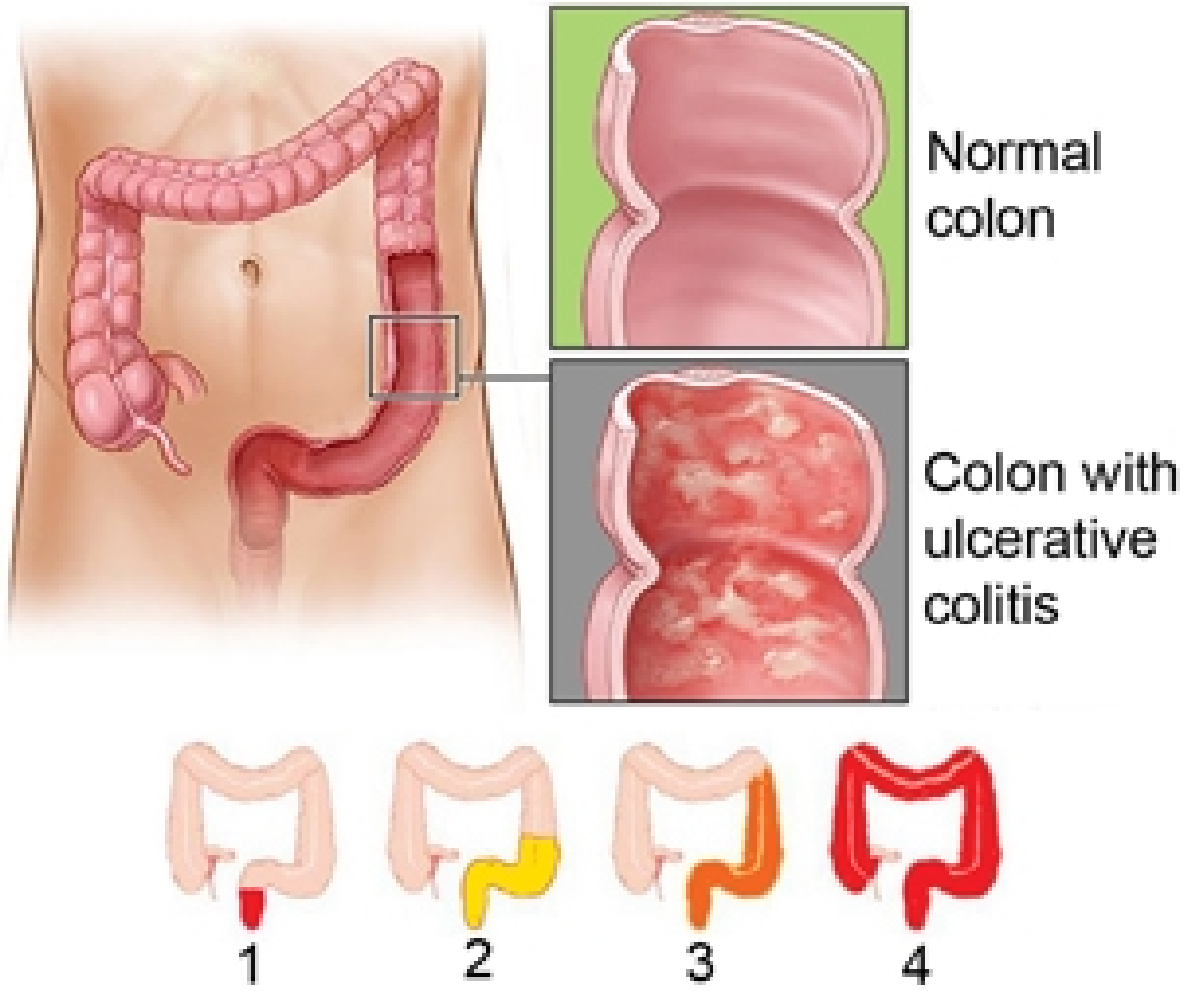
Rule out infections

- C.diff
- Enteropathic stool panel

Ulcerative Colitis

UC Phenotype

- Proctitis
- Proctosigmoiditis
- Left sided colitis
- Extensive colitis



Ulcerative Colitis Symptoms

Diarrhea with nocturnal stools

Bloody stools

Urgency

Tenesmus

Abdominal cramping

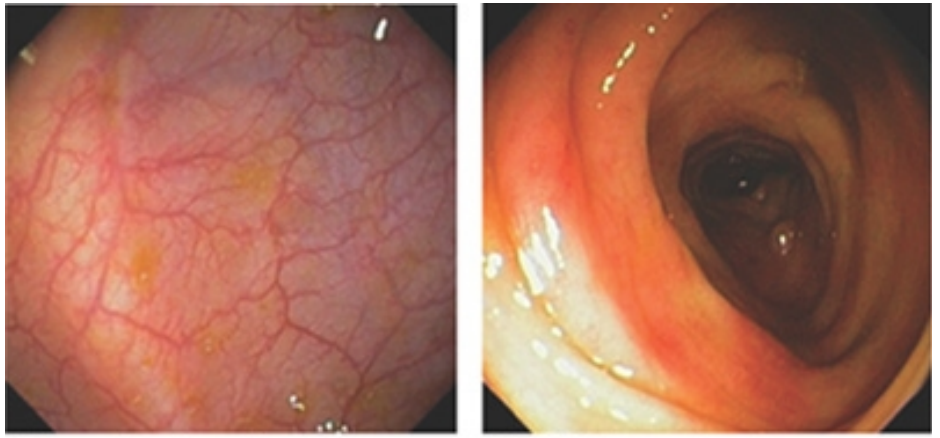
Urge incontinence

Diagnosis

- Endoscopy
- Histology
- Labs
- Stool

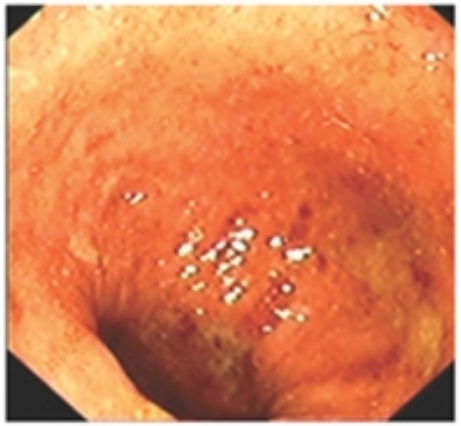
- Imaging – should only be used to exclude small bowel Crohn's Disease. Not needed for the diagnosis of ulcerative colitis.

Endoscopic UC (Mayo Score)

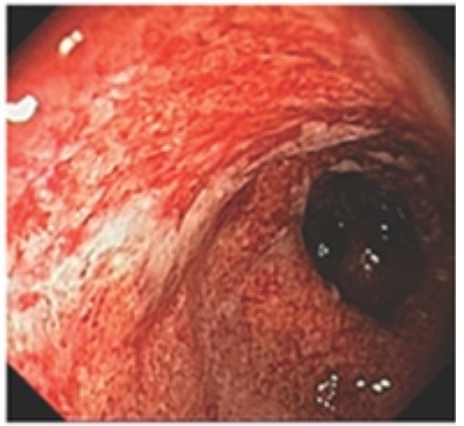


0 Normal or inactive disease

1 Mild disease (erythema, decreased vascular pattern, mild friability)



2 Moderate disease (marked erythema, absent vascular pattern, friability, erosions)



3 Severe disease (spontaneous bleeding, ulcerations)

de Lange, T. et al. BMC Gastroenterol 2004

Labs and stool

Disease activity

- CRP
- CBC – anemia, elevated platelets
- CMP – low albumin
- Fecal cal

Prepare for advanced therapies

- TB QuantiFERON
- Lipid panel
- Hepatitis B serologies
- EKG

Nutritional Deficiencies

- Vitamin D
- Vitamin B12
- Ferritin and iron panel

Rule out infections

- C.diff
- Enteropathic stool panel

Natural History

Crohn's Disease

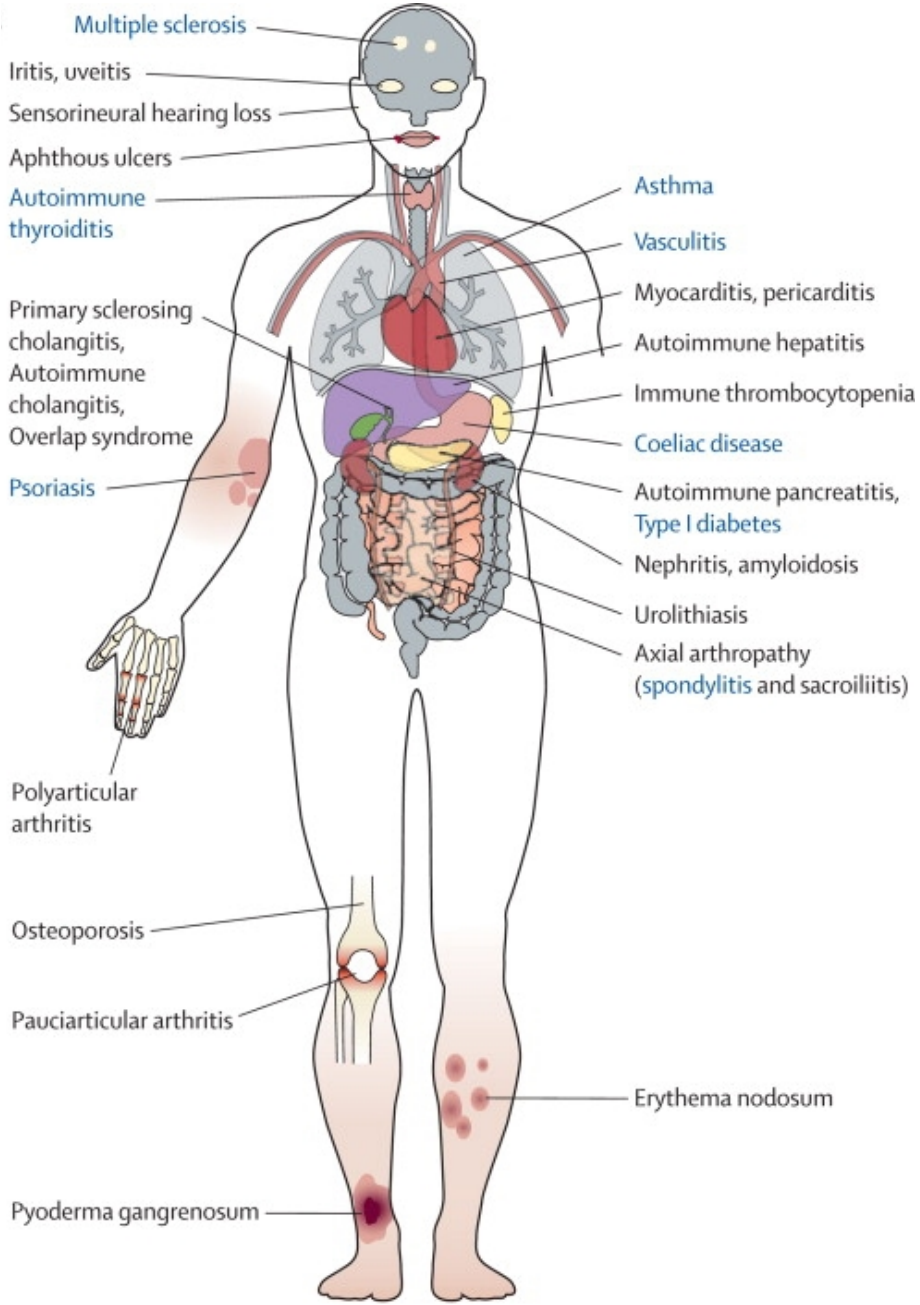
- Progressive
- Complications
  - Strictures
  - Fistulas
  - Abscesses
  - Cancer
- Not curative with surgery
- Requires life long medical therapy

Ulcerative colitis

- Progressive
- Complications
  - Dysplasia
  - Cancer
  - Shortened colon with loss of functionality
- Requires long term medical therapy
- "curable" with surgery

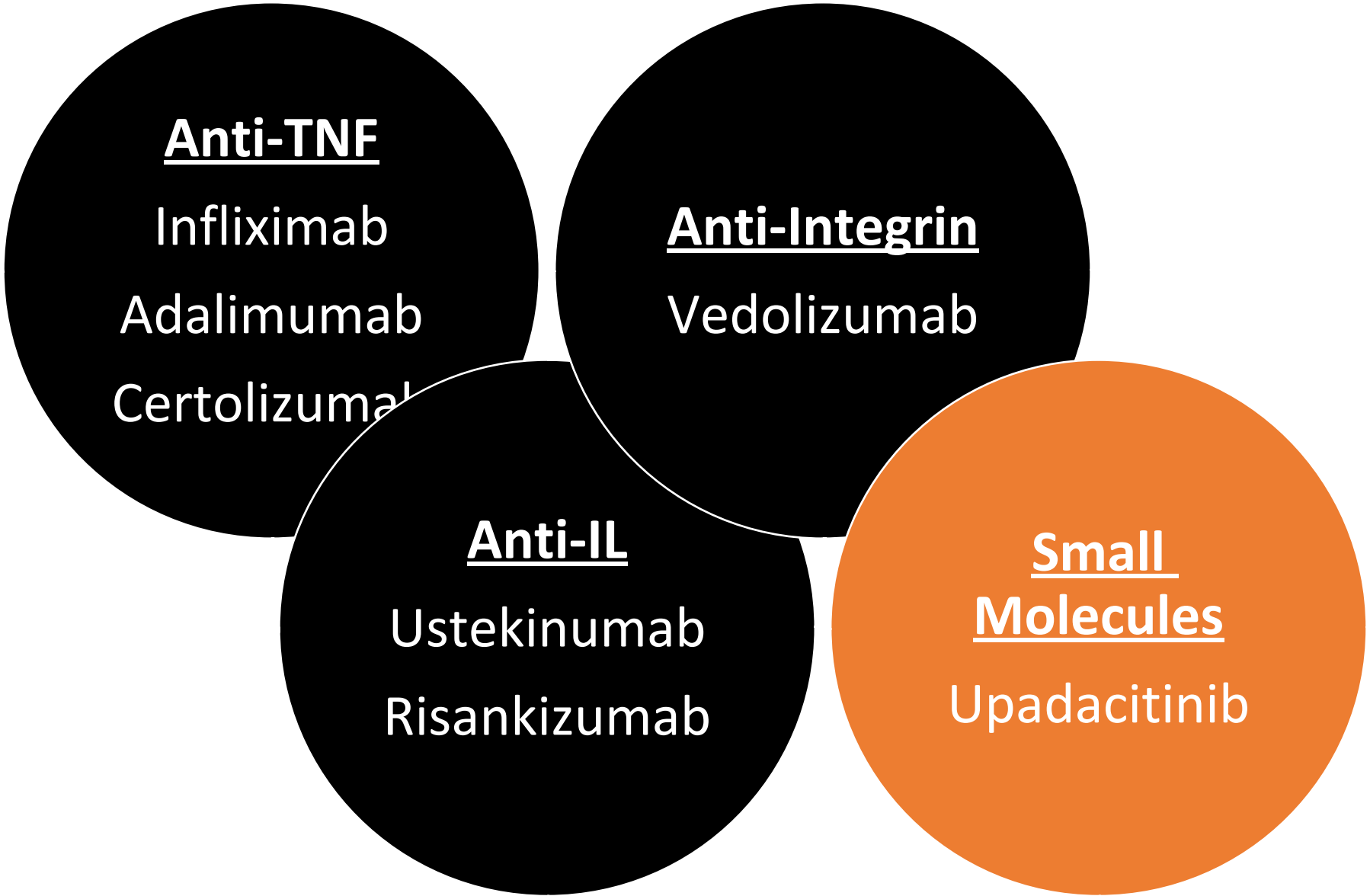
Predictors of more severe disease

- **CD**
  - Young age of onset (<40)
  - Fistulizing disease
  - Need for surgery
  - High IBD serology titers
  - Smoking
  - Deep ulcerations
  - Need for steroids
- **UC**
  - Pancolitis
  - Early need for steroids
  - Early need for hospitalization
  - Elevated CRP or fecal calprotectin
  - Low albumin

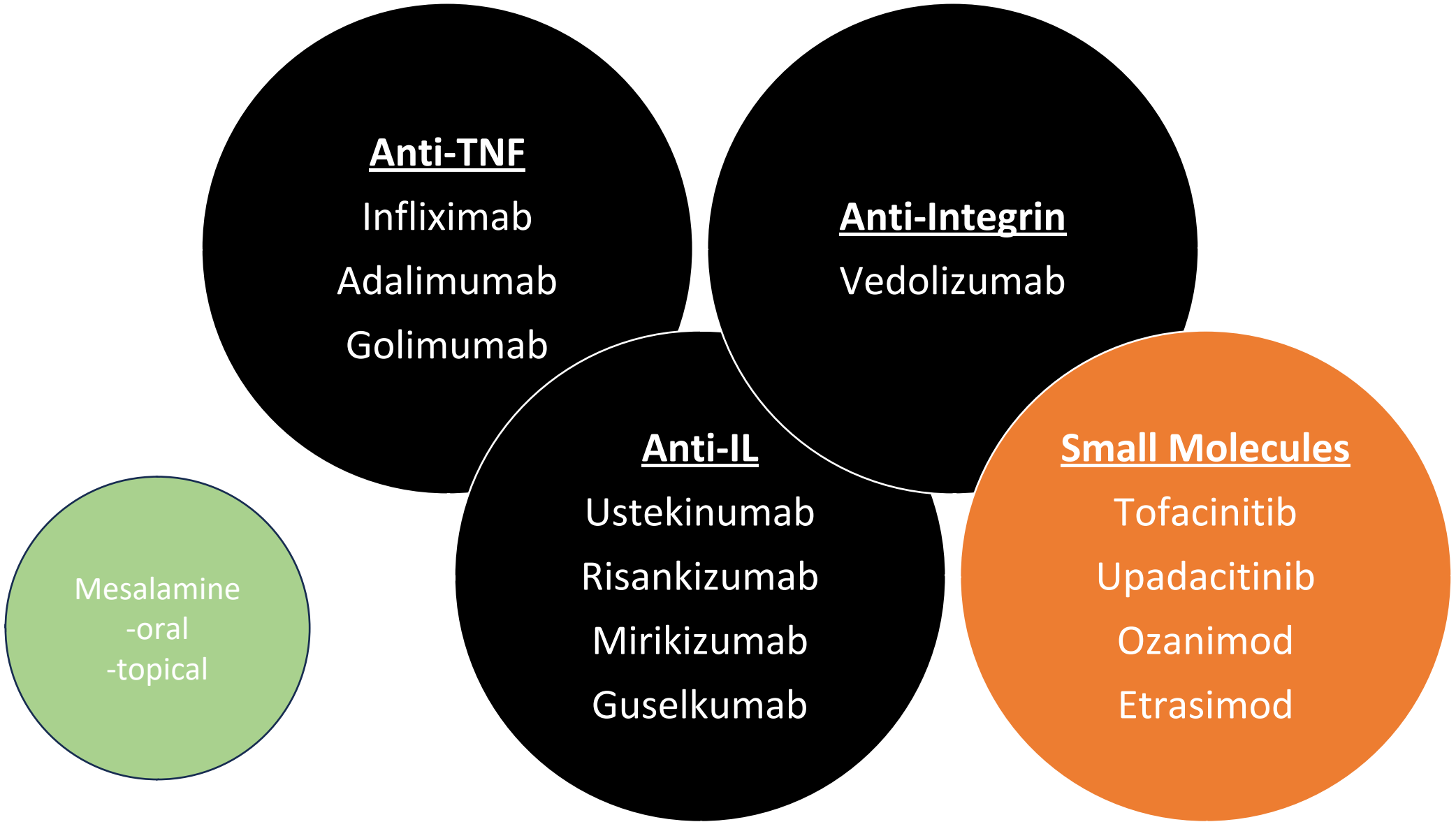


Extraintestinal manifestations (EIM)

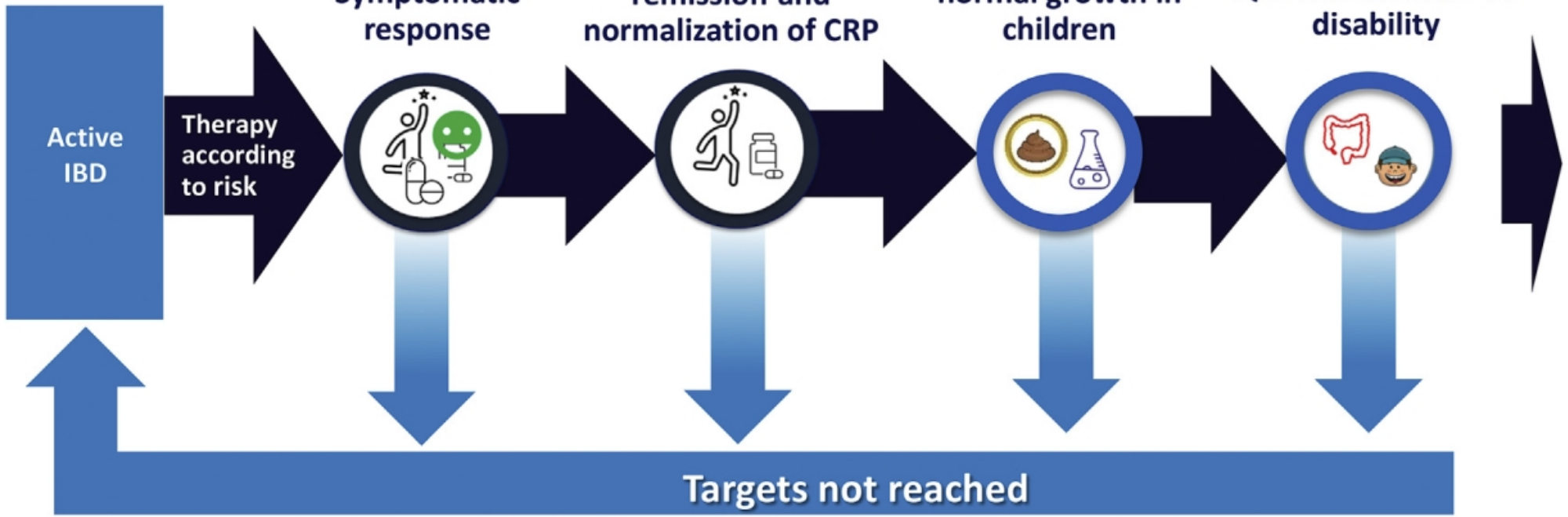
Treatment: Crohn's Disease



Treatment:Ulcerative Colitis

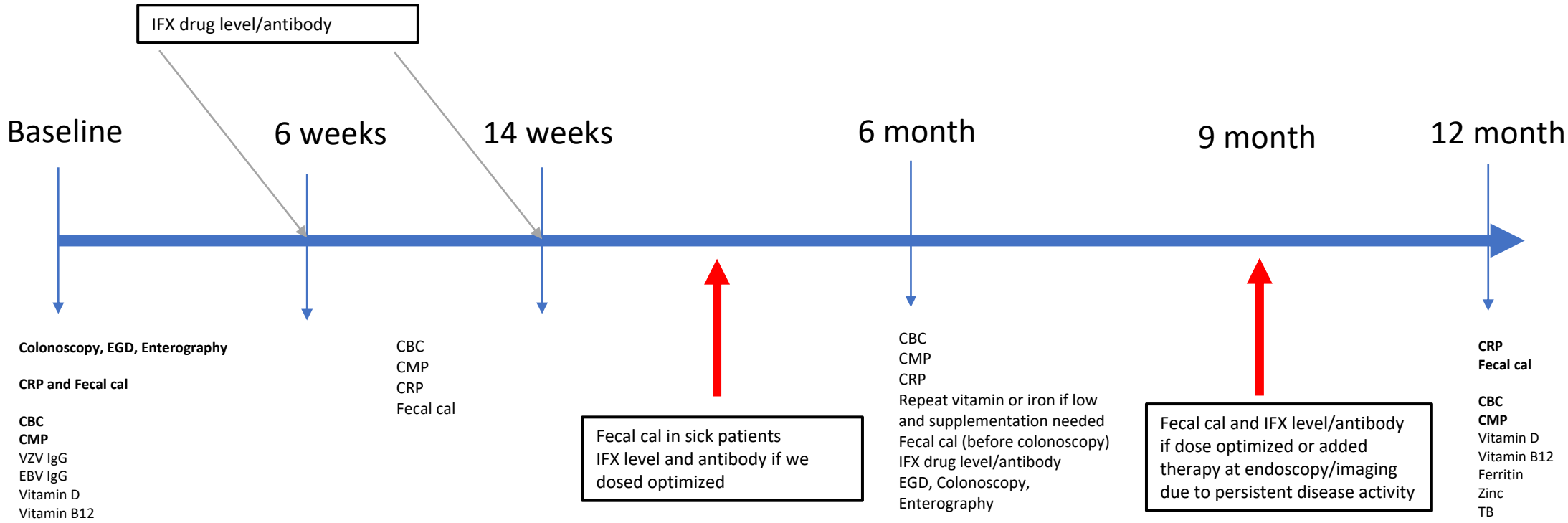


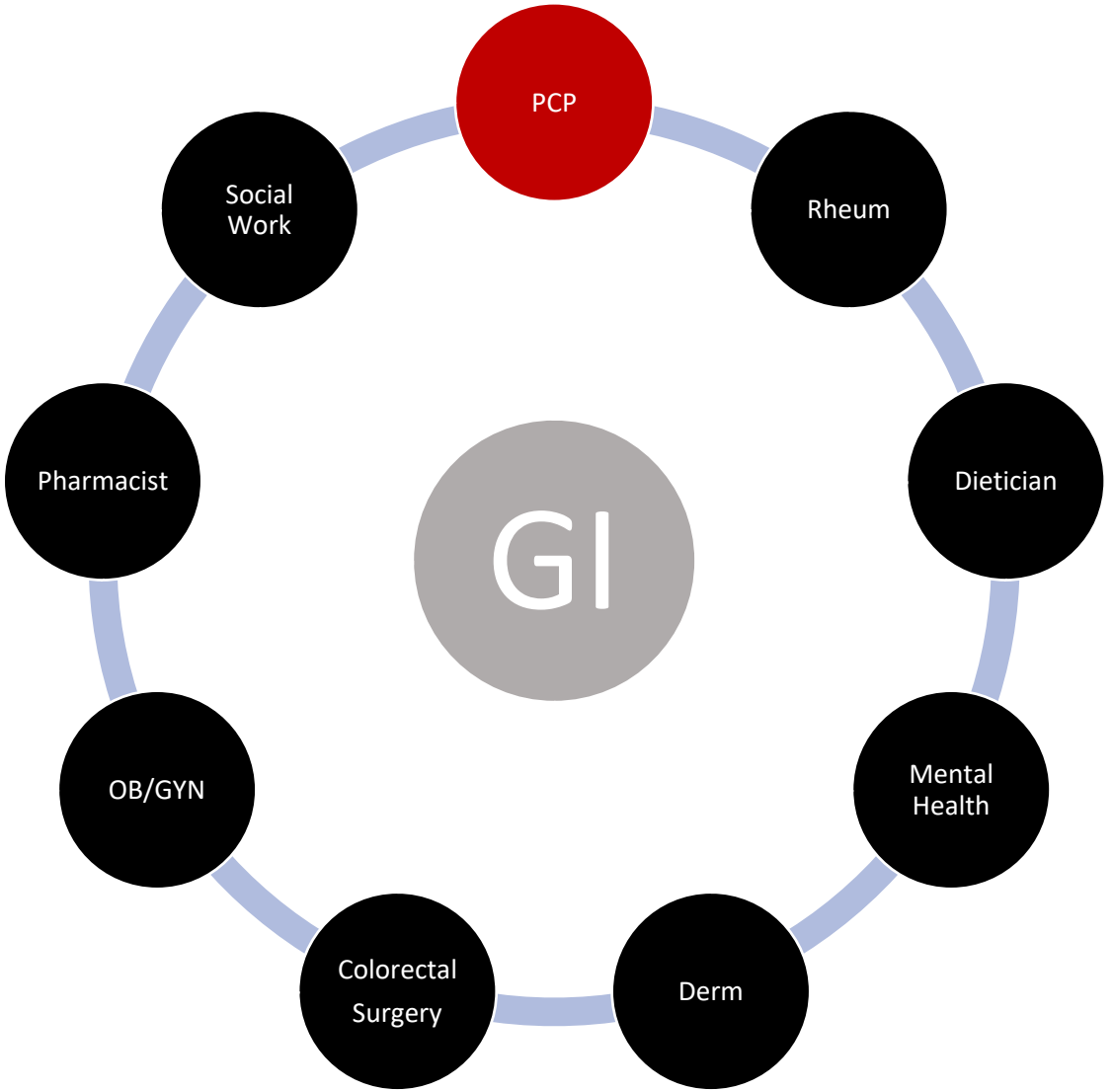
The Selecting Therapeutic Targets in Inflammatory Bowel Disease (STRIDE) initiative of the International Organization for the Study of Inflammatory Bowel Diseases (IOIBD) - **consensus among international IBD experts on treatment targets** for adult and pediatric IBD patients after careful review of existing evidence



Turner et al. Gastroenterology 2021

Example: infliximab




PCP
Rheum
Dietician
Mental Health
Derm
Colorectal Surgery
OB/GYN
Pharmacist
Social Work
GI

General considerations

- Primary GI should guide treatment
  - All IBD medications should only be prescribed by GI

- Do not initiate corticosteroids or any other therapies without consultation with GI
  - Corticosteroids increases morbidity and mortality in IBD patients
  - Corticosteroids are not maintenance therapy. It is purely a bridge to more appropriate medical therapy. If written, one should be intentional about a taper.
  - Remember that budesonide is a corticosteroid and not considered maintenance therapy in IBD patients

General considerations

- Avoid narcotics
  - Narcotics increases morbidity and mortality in IBD patients
  - Short courses of NSAIDs allowed
  - Acetominophen best
  - Work with pain medicine team to focus on non-narcotic options
  - Don’t overlook physical therapy as a great options for those with IBD related joint pains

General considerations

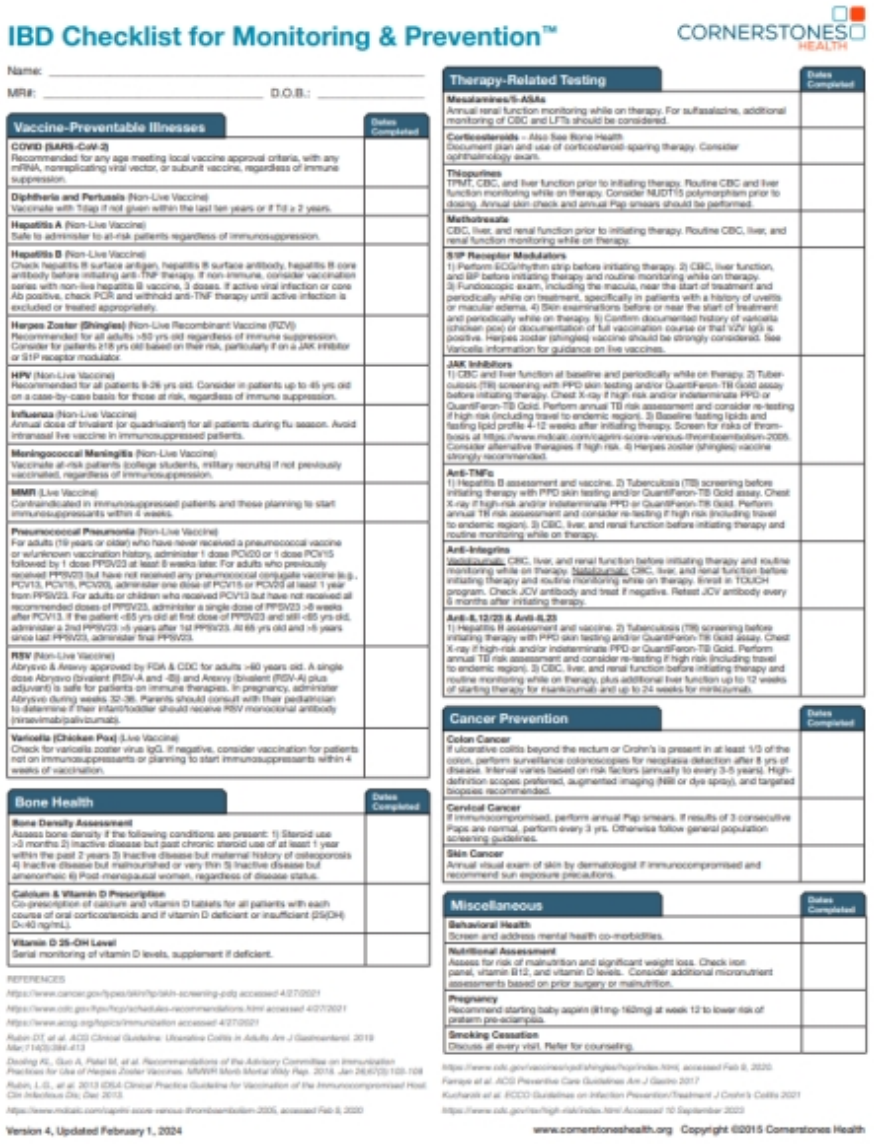
- If a patient calls about a “flare”

- Make sure you are dealing with IBD related inflammation

  - Obtain stool studies: fecal cal , c.diff, and enteric pathogen panel
  - Obtain labs: CBC, CMP, CRP
  - Update: TB, hepatitis B serologies, and lipid panel (if not done within the last 6 months)
  - Enterography (CT or MR) is preferred for small bowel evaluation. Be mindful if patients have had a lot of CT scans done
  - MRI of the pelvis is the best test for perianal fistulas and abscesses. Low threshold to get colorectal surgery involved ASAP

Health Maintenance

- Vaccines
- Bone density
- Skin exam
- Pap smears
- Smoking cessation
- Mental Health
- Pregnancy



IBD Checklist for Monitoring & Prevention™

CORNERSTONES HEALTH

Name: _____

MR#: _____ D.O.B.: _____

Vaccine-Preventable Illnesses — Dates Completed

- **COVID (SARS-CoV-2)** — Recommended for any age meeting local vaccine approval criteria, with any mRNA, nonreplicating viral vector, or subunit vaccine, regardless of immune suppression.
- **Diphtheria and Pertussis** (Non-Live Vaccine) — Vaccinate with Tdap if not given within the last ten years or if Td ≥ 2 years.
- **Hepatitis A** (Non-Live Vaccine) — Safe to administer to at-risk patients regardless of immunosuppression.
- **Hepatitis B** (Non-Live Vaccine) — Check hepatitis B surface antigen, hepatitis B surface antibody, hepatitis B core antibody before initiating anti-TNF therapy. If non-immune, consider vaccination series with non-live hepatitis B vaccine, 3 doses. If active viral infection or core Ab positive, check PCR and withhold anti-TNF therapy until active infection is excluded or treated appropriately.
- **Herpes Zoster (Shingles)** (Non-Live Recombinant Vaccine (RZV)) — Recommended for all adults >50 yrs old regardless of immune suppression. Consider for patients ≥18 yrs old based on their risk, particularly if on a JAK inhibitor or S1P receptor modulator.
- **HPV** (Non-Live Vaccine) — Recommended for all patients 9-26 yrs old. Consider in patients up to 45 yrs old on a case-by-case basis for those at risk, regardless of immune suppression.
- **Influenza** (Non-Live Vaccine) — Annual dose of trivalent (or quadrivalent) for all patients during flu season. Avoid intranasal live vaccine in immunosuppressed patients.
- **Meningococcal Meningitis** (Non-Live Vaccine) — Vaccinate at-risk patients (college students, military recruits) if not previously vaccinated, regardless of immunosuppression.
- **MMR** (Live Vaccine) — Contraindicated in immunosuppressed patients and those planning to start immunosuppressants within 4 weeks.
- **Pneumococcal Pneumonia** (Non-Live Vaccine) — For adults (19 years or older) who have never received a pneumococcal vaccine or who/known vaccination history, administer 1 dose PCV20 or 1 dose PCV15 followed by 1 dose PPSV23 at least 8 weeks later. For adults who previously received PPSV23 but have not received any pneumococcal conjugate vaccine (e.g., PCV13, PCV15, PCV20), administer one dose of PCV15 or PCV20 at least 1 year from PPSV23. For adults or children who received PCV13 but have not received all recommended doses of PPSV23, administer a single dose of PPSV23 >8 weeks after PCV13. If the patient <65 yrs old at first dose of PPSV23 and still <65 yrs old, administer a 2nd PPSV23 >5 years after 1st PPSV23. At 65 yrs old and >5 years since last PPSV23, administer final PPSV23.
- **RSV** (Non-Live Vaccine) — Abrysvo & Arexvy approved by FDA & CDC for adults >60 years old. A single dose Abrysvo (bivalent (RSV-A and -B)) and Arexvy (bivalent (RSV-A) plus adjuvant)) is safe for patients on immune therapies. In pregnancy, administer Abrysvo during weeks 32-36. Parents should consult with their pediatrician to determine if their infant/toddler should receive RSV monoclonal antibody (nirsevimab/palivizumab).
- **Varicella (Chicken Pox)** (Live Vaccine) — Check for varicella zoster virus IgG. If negative, consider vaccination for patients not on immunosuppressants or planning to start immunosuppressants within 4 weeks of vaccination.

Bone Health — Dates Completed

- **Bone Density Assessment** — Assess bone density if the following conditions are present: 1) Steroid use >3 months 2) Inactive disease but past chronic steroid use of at least 1 year within the past 2 years 3) Inactive disease but maternal history of osteoporosis 4) Inactive disease but malnourished or very thin 5) Inactive disease but amenorrheic 6) Post-menopausal women, regardless of disease status.
- **Calcium & Vitamin D Prescription** — Co-prescription of calcium and vitamin D tablets for all patients with each course of oral corticosteroids and if vitamin D deficient or insufficient (25(OH) D<40 ng/mL).
- **Vitamin D 25-OH Level** — Serial monitoring of vitamin D levels, supplement if deficient.

REFERENCES

https://www.cancer.gov/types/skin/hp/skin-screening-pdq accessed 4/27/2021

https://www.cdc.gov/hpv/hcp/schedules-recommendations.html accessed 4/27/2021

https://www.acog.org/topics/immunization accessed 4/27/2021

Rubin DT, et al. ACG Clinical Guideline: Ulcerative Colitis in Adults Am J Gastroenterol. 2019 Mar;114(3):384-413.

Dooling KL, Guo A, Patel M, et al. Recommendations of the Advisory Committee on Immunization Practices for Use of Herpes Zoster Vaccines. MMWR Morb Mortal Wkly Rep. 2018 Jan 26;67(3):103-108

Rubin, L.G., et al. 2013 IDSA Clinical Practice Guideline for Vaccination of the Immunocompromised Host. Clin Infectious Dis; Dec 2013.

https://www.mdcalc.com/caprini-score-venous-thromboembolism-2005, accessed Feb 9, 2020

Therapy-Related Testing — Dates Completed

- **Mesalamines/5-ASAs** — Annual renal function monitoring while on therapy. For sulfasalazine, additional monitoring of CBC and LFTs should be considered.
- **Corticosteroids** – Also See Bone Health — Document plan and use of corticosteroid-sparing therapy. Consider ophthalmology exam.
- **Thiopurines** — TPMT, CBC, and liver function prior to initiating therapy. Routine CBC and liver function monitoring while on therapy. Consider NUDT15 polymorphism prior to dosing. Annual skin check and annual Pap smears should be performed.
- **Methotrexate** — CBC, liver, and renal function prior to initiating therapy. Routine CBC, liver, and renal function monitoring while on therapy.
- **S1P Receptor Modulators** — 1) Perform ECG/rhythm strip before initiating therapy. 2) CBC, liver function, and BP before initiating therapy and routine monitoring while on therapy. 3) Fundoscopic exam, including the macula, near the start of treatment and periodically while on treatment, specifically in patients with a history of uveitis or macular edema. 4) Skin examinations before or near the start of treatment and periodically while on therapy. 5) Confirm documented history of varicella (chicken pox) or documentation of full vaccination course or that VZV IgG is positive. Herpes zoster (shingles) vaccine should be strongly considered. See Varicella information for guidance on live vaccines.
- **JAK Inhibitors** — 1) CBC and liver function at baseline and periodically while on therapy. 2) Tuberculosis (TB) screening with PPD skin testing and/or QuantiFeron-TB Gold assay before initiating therapy. Chest X-ray if high risk and/or indeterminate PPD or QuantiFeron-TB Gold. Perform annual TB risk assessment and consider re-testing if high risk (including travel to endemic region). 3) Baseline fasting lipids and fasting lipid profile 4-12 weeks after initiating therapy. Screen for risks of thrombosis at https://www.mdcalc.com/caprini-score-venous-thromboembolism-2005. Consider alternative therapies if high risk. 4) Herpes zoster (shingles) vaccine strongly recommended.
- **Anti-TNFs** — 1) Hepatitis B assessment and vaccine. 2) Tuberculosis (TB) screening before initiating therapy with PPD skin testing and/or QuantiFeron-TB Gold assay. Chest X-ray if high-risk and/or indeterminate PPD or QuantiFeron-TB Gold. Perform annual TB risk assessment and consider re-testing if high risk (including travel to endemic region). 3) CBC, liver, and renal function before initiating therapy and routine monitoring while on therapy.
- **Anti-Integrins** — Vedolizumab: CBC, liver, and renal function before initiating therapy and routine monitoring while on therapy. Natalizumab: CBC, liver, and renal function before initiating therapy and routine monitoring while on therapy. Enroll in TOUCH program. Check JCV antibody and treat if negative. Retest JCV antibody every 6 months after initiating therapy.
- **Anti-IL12/23 & Anti-IL23** — 1) Hepatitis B assessment and vaccine. 2) Tuberculosis (TB) screening before initiating therapy with PPD skin testing and/or QuantiFeron-TB Gold assay. Chest X-ray if high-risk and/or indeterminate PPD or QuantiFeron-TB Gold. Perform annual TB risk assessment and consider re-testing if high risk (including travel to endemic region). 3) CBC, liver, and renal function before initiating therapy and routine monitoring while on therapy, plus additional liver function up to 12 weeks of starting therapy for risankizumab and up to 24 weeks for mirikizumab.

Cancer Prevention — Dates Completed

- **Colon Cancer** — If ulcerative colitis beyond the rectum or Crohn's is present in at least 1/3 of the colon, perform surveillance colonoscopies for neoplasia detection after 8 yrs of disease. Interval varies based on risk factors (annually to every 3-5 years). High-definition scopes preferred, augmented imaging (NBI or dye spray), and targeted biopsies recommended.
- **Cervical Cancer** — If immunocompromised, perform annual Pap smears. If results of 3 consecutive Paps are normal, perform every 3 yrs. Otherwise follow general population screening guidelines.
- **Skin Cancer** — Annual visual exam of skin by dermatologist if immunocompromised and recommend sun exposure precautions.

Miscellaneous — Dates Completed

- **Behavioral Health** — Screen and address mental health co-morbidities.
- **Nutritional Assessment** — Assess for risk of malnutrition and significant weight loss. Check iron panel, vitamin B12, and vitamin D levels. Consider additional micronutrient assessments based on prior surgery or malnutrition.
- **Pregnancy** — Recommend starting baby aspirin (81mg-162mg) at week 12 to lower risk of preterm pre-eclampsia.
- **Smoking Cessation** — Discuss at every visit. Refer for counseling.

https://www.cdc.gov/vaccines/vpd/shingles/hcp/index.html, accessed Feb 9, 2020.

Farraye et al. ACG Preventive Care Guidelines Am J Gastro 2017

Kucharzik et al. ECCO Guidelines on Infection Prevention/Treatment J Crohn's Colitis 2021

https://www.cdc.gov/mcv/high-risk/index.html Accessed 10 September 2023

Version 4, Updated February 1, 2024

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https://cornerstoneshealth.org/wp-content/uploads/2024/02/IBD-Checklist-for-Monitoring-Prevention-2024.pdf

Resources - Patient

Gutless & Glamorous

CROHN'S & COLITIS FOUNDATION

[Crohn's & Colitis Foundation]
A volunteer-fueled organization

COLOR OF CROHN'S & CHRONIC ILLNESS

[Color of Crohn's and Chronic Illness]
For Black, Indigenous, and people of color with IBD

IBD DESIS

[IBDesis]
For South Asian people with IBD

LIVING WITH IBD

Connecting to Cure
Crohn's and Colitis

Ulcerative Colitis Support Group

CROHN'S DISEASE WARRIORS

Resources - Physician

https://cornerstoneshealth.org/wp-content/uploads/2024/02/IBD-Checklist-for-Monitoring-Prevention-2024.pdf

https://www.ibdiq.com/

Take Home Points

- IBD is a chronic illness that requires a lifelong multidisciplinary treatment team
- Primary care plays a crucial role in the management IBD
  - Early Recognition and Referral
  - Coordination of Care
  - Management of Comorbidities and Health Maintenance
  - Lifestyle and Wellness Support
  - Patient Education
  - Emotional Support