# Challenging IBD Cases: Common Myths and Misconceptions Dispelled

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# Disclosures

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# Myth #1 Active Symptoms = Active Disease
# Active Disease = Active Symptoms

**Active**

**Symptoms ≠ Disease ≠ Symptoms**

| Clinical remission<br>Endoscopic remission | Clinical response/remission<br>Biochemical inflammation | Clinical symptoms<br>Endoscopic remission |
|---|---|---|
| ↓ | ↓ | ↓ |
| | Subclinical inflammation | Non-inflammatory causes for symptoms |
| | | |
| | ↓ | |
| | Optimize treatment | |

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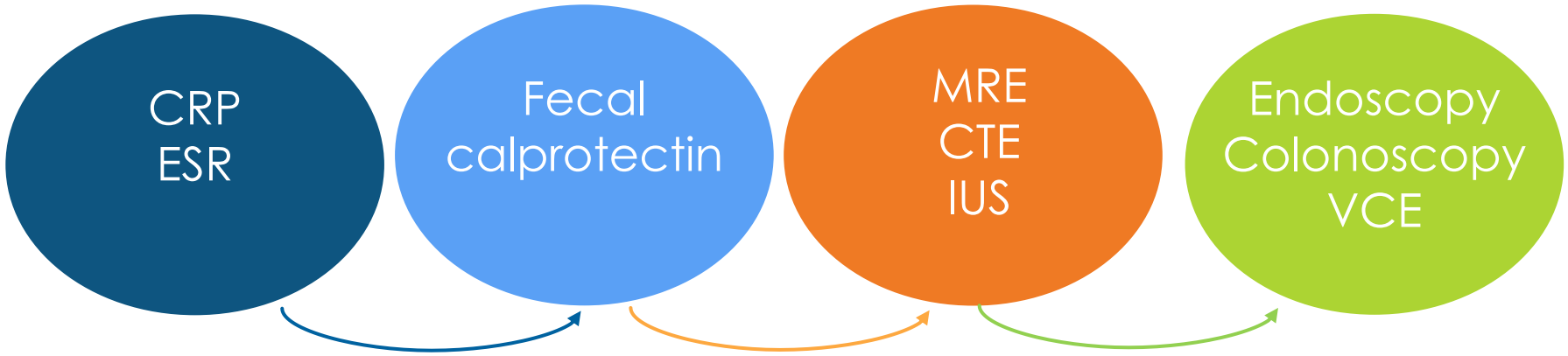
# Myth #1 Symptom Monitoring Alone is Sufficient For Disease Assessment

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# Myth #2 IBD Patients Need Imaging if They Present to the Emergency Room

**Ulcerative colitis**

- Imaging only indicated if concerns about toxic megacolon or perforation

**Crohn's disease**

- Consider clinical presentation and what you are trying to exclude on imaging
- Consider last imaging
- Not all CT scans are created equal

**Non-oral contrast CT imaging has limited utility in evaluation of luminal mucosal inflammation**

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# Myth #3 All IBD Patients Require Annual Colonoscopy

- IBD patients with colonic inflammation > 8 years
  - Ulcerative colitis: extent past ulcerative proctitis
  - Crohn's disease: > 1/3 colonic involvement

IBD with primary sclerosing cholangitis- start immediately at the time of diagnosis

**C** **Timing of next colonoscopy when no dysplasia detected at present colonoscopy**

Physicians should err towards the more frequent surveillance category if at least one higher risk factor exists. Timing based on past and ongoing CRC risk factors and mucosal features that may obscure dysplasia.

| 1 year | 2 or 3 years | 5 years |
|---|---|---|
| • Moderate or severe inflammation (any extent)<br>• PSC<br>• Family history of CRC in first degree relative (FDR) age < 50<br>• Dense pseudopolyposis<br>• History of invisible dysplasia or higher-risk visible dysplasia < 5 years ago | • Mild inflammation (any extent)<br>• Strong family history of CRC (but no FDR < age 50)<br>• Features of prior severe colitis (moderate pseudopolyps, extensive mucosal scarring)<br>• History of invisible dysplasia or higher-risk visible dysplasia > 5 years ago<br>• History of lower risk visible dysplasia < 5 years ago | Continuous disease remission since last colonoscopy with mucosal healing on current exam, plus either of:<br>• ≥ 2 consecutive exams without dysplasia<br>• Minimal historical colitis extent (ulcerative proctitis or < 1/3 of colon in CD) |

Note: Isolated ileal Crohn's disease without colonic inflammation should undergo CRC screening with colonoscopy same as average-risk population. Guidance for endoscopic severity, Simple Endoscopic Score for Crohn's (SES-CD) and Mayo endoscopic score for UC. Moderate-severe: SES-CD ≥ 7/ Mayo 2/3; Mild: SES-CD 3–6/ Mayo 1; No active disease: SES-CD 0–2/ Mayo 0.

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Murthy et al. AGA CPU. *Gastroenterology*. 2021.

Myth #4

# Steroids Should be Used as Maintenance Therapy

- Steroids should not be used >3 months
- For the treatment of inflammation, steroids have been the only treatment linked to increased mortality
- If a patient has been steroid dependent, it is time to review their maintenance therapy
  - Optimize further?
  - Adding combination?
  - Consider changing mechanism?
  - IBD referral consult
- Have you done a bone density?

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# Myth #5 Mesalamine Is Approved for the Treatment of Crohn's Disease

- Cochrane review
  - 20 studies
  - 2367 participants
- Sulfasalazine is only modestly effective with a trend towards benefit > placebo and inferior to steroids in treatment of mild to moderate Crohn's disease

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Lim W et al. *Cochrane Database of Systematic Reviews*. 2016, Issue 7.

# Myth #6 Anti-TNF Therapy Should Always be Used First in Bio Naive Patients

- Individualized approach to biologic selection is key incorporation of shared decision making with the patient
- Considerations for patient disease characteristics, risk factors, comorbidities, efficacy, safety, patient preference

| Anti-TNF | Anti-integrin | Anti-IL 12/23 |
|---|---|---|
| Infliximab<br>Adalimumab<br>Certolizumab<br>Golimumab | Natalizumab<br>Vedolizumab | Ustekinumab<br>Risankizumab |

- Newer small molecules that can be used in bio naive patients with UC

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# Myth #7 Surgery Should Only be Reserved as Last Resort When All Medicines Fail

- Partnership with specialized colorectal surgeon is key in the treatment paradigm for IBD patients
- Surgery should always be on the treatment menu when addressing Shared Decision Making
- Prepare patients for surgery introduction, prefer outpatient/ stable setting
- Non-inflammatory fibrostenotic Crohn's disease does not respond to escalation of medical therapy

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# Myth #8 Patients Can Only Have Iron Deficiency if They Have Anemia

- Refer to the Crohn's and Colitis Foundation Anemia Care Pathway

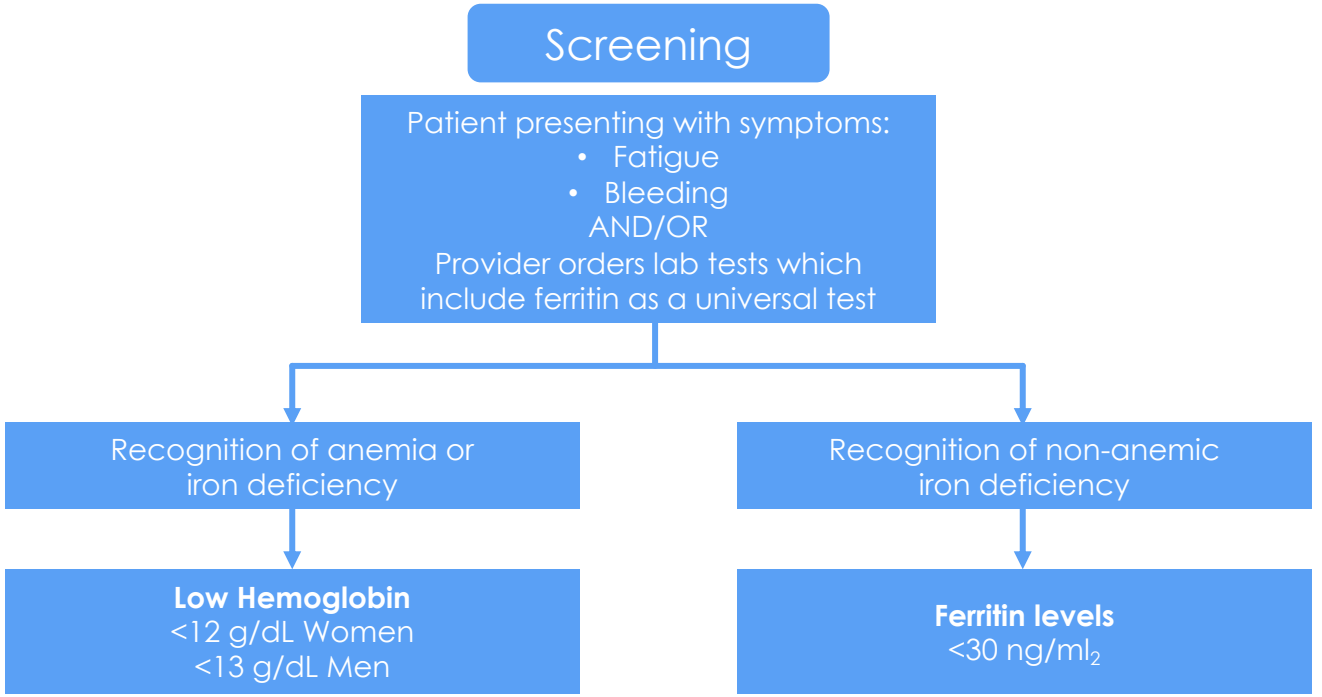


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Figure adapted from Crohn's and Colitis Foundation Anemia Care Pathway.

# Myth #9 A Patient's Weight Is Adequate Screening Tool for Malnutrition

- BMI and weight alone are not adequate screening tools for evaluation of malnutrition
- Patients who have elevated BMI can still be malnourished

| Screening Tools |
| --- |
| Malnutrition Screening Tool (MST) |
| Malnutrition Universal Screening Tool (MUST) |

| Concern for Malnutrition Labs |
| --- |
| *Dietitian referral |
| Calorie count |
| Prealbumin |
| Iron studies |
| Vitamin A, E, D, K (INR) |
| Folate |
| Vitamin B12 |
| Thiamine |
| Selenium |
| Zinc |
| Copper |

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Kinnucan JA et al. *Gastroenterology*. 2020.

Myth #10

# It's Time Consuming to Diagnosis Anxiety and Depression in IBD

- Up to 40% of IBD patients have anxiety or depression, impact on quality of life and disease outcomes
- Identification of those patients is key to offer supportive services and is associated with improved outcomes

**PHQ-2** | Over the past 2 weeks, how often have you been bothered by any of the following problems?

| | Not at all | Several Days | More than one half the days | Nearly every day |
|---|---|---|---|---|
| **1.** Little interest or pleasure in doing things | **0** | **1** | **2** | **3** |
| **2.** Feeling down, depressed, or hopeless | **0** | **1** | **2** | **3** |

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Kinnucan JA et al. *Gastroenterology*. 2020.