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Severity Assessment: Can You Pin the Stage on the Patient?

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Ms. Geremia:
This is CE on ReachMD, and I'm Jennifer Geremia. I'm a physician assistant in gastroenterology at Brigham and Women's Hospital in Boston.

Ms. Hodnick:
Hi. My name is Brooke Hodnick. I'm a practicing physician assistant in the North Texas area with GI Alliance.

Today in this episode, we're going to define disease activity versus disease severity and how this can help us assess the risk of complications with inflammatory bowel disease.

First, disease activity. I like to think of it more as a snapshot of the current inflammation of what's actually going on at that time. Think of it as how is the patient presenting in front of you versus the disease severity, which is more of a measure of the cumulative or long-term impact of the disease. Think of it more as the historical disease behavior of the disease.

Jen is going to go into more detail for us.

Ms. Geremia:
Thank you, Brooke. So looking at both diseases, Crohn's and ulcerative colitis, there are some specific characteristics that will give us that ability to assess phenotypically and tell us the severity in these patients.

So in Crohn's disease, typically what we would deem as low-risk characteristics for surgery or hospitalization would be a disease onset over 30 years old; therefore, onset less than 30 years old is considered high risk. If there's limited anatomic involvement, so either how much involvement of a particular part of the GI tract or multiple locations within the GI tract for Crohn's. Also, no perianal or severe rectal disease as a low risk. Are the ulcerations more superficial versus transmural? Has this patient had surgery? And is there any characteristics of fibrosing disease, strictures, or penetrating behaviors, such as fistulas on imaging or scopes?

So conversely, in a high-risk patient, they tend to have more extensive anatomic involvement of one area or multiple sites, perianal involvement, really deep ulcers, dire need for resection, and evidence of stricturing or penetrating behaviors.

Now, with ulcerative colitis, because this is a large bowel disease, we're going to see limited anatomic extent. Now, that's not to imply that patients with more distal disease, with proctitis or maybe rectal sigmoiditis are necessarily less thick than their counterparts with pancolitis, but pancolitis is deemed to be a higher risk for colectomy, specifically. Mild endoscopic disease, so their Mayo score, and seeing how much involvement, again, how extensive those ulcers are. If they have deeper ulcers, they're at higher risk for colectomy. Patients that were diagnosed at a younger age, less than 40. Do they have systemic biomarker elevations such as CRP and ESR? Have they required steroids for a prolonged period of time or repeatedly? Have they been hospitalized for their disease and needing IV steroids, or do they have concomitant *C. diff* or CMV infection, specifically in UC?

We do know that in Crohn's disease, most cases are chronic and progressive, destructive disease per ACG guidelines. So any presence of Crohn's disease, because of its transmural nature, does warrant more advanced therapies.

Other things to consider in looking at high-risk complications are going to be extraintestinal manifestations of skin, joint, or the liver; again, steroid dependency on either disease state; delayed growth or failure to thrive in a pediatric population. Do they have concomitant mental health disorders?

And also what their insurance status is, which is going to infer what access they have to medication and whether they can stay on advanced therapies that are rather expensive.

I would also like to call out what their overall nutritional status is and whether or not they have adequate albumin levels, especially when we're looking at biologic therapies like TNFs, which we often leverage in these sicker patients, and the albumin level does factor into that as well.

Jen, one of the things I like to do when I see my patients is actually I like to write down in their notes what age they were diagnosed, previous surgeries, previous failed medications, and as to why they failed the medications, if we have a compliance issue. Do you do any of these to kind of help get medications approved or assess your potential risks for your patients?

Ms. Geremia:
Oh, absolutely. That's all part of a good comprehensive IBD history, to document all of that. It certainly plays a role in shared decision-making on subsequent therapies, but also helpful, I think, for payers in reviewing why we are deciding on a therapy at that particular point in time.

I also make the note to document if they do have any extraintestinal manifestations or concomitant autoimmune disease, because, again, it gives the reader of that note some insight onto how we ended up at the place we are with a particular therapy.

Ms. Hodnick:
Yeah, that's just such great advice. Thank you so much, Jen.

Well, this was brief, but I'm glad that we had the opportunity to share with you. Thanks for listening.

Announcer:
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