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

2020 Crohn's & Colitis Congress: IBD Care Outside the Gut

Announcer:
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Here's your host, Dr. Matt Birnholz.

Dr. Birnholz:
Coming to you from the 3rd Annual Crohn's and Colitis Congress in Austin, Texas. This ReachMD. I am Dr. Matt Birnholz. Joining me to talk about some key takeaways from a session presented at the Congress titled "IBD Beyond the Gut" is Dr. James Lewis, Director of Clinical Research and Associate Director of the Inflammatory Bowel Diseases Program at the Perelman School of Medicine at the University of Pennsylvania. Dr. Lewis, welcome to you.

Dr. Lewis:
Well, thank you for having me join you today.

Dr. Birnholz:
It's great to have you here. So, to start, I'd love to just get a little clarification around what "Beyond the Gut" meant in the context of this session. It seems like you had a number of presenters. You, yourself, were one of the organizers, and a number of subjects were touched upon, but what were some of the key takeaways from your vantage point?

Dr. Lewis:
The title "Beyond the Gut" really referenced the fact that IBD is not just an intestinal disease. Patients with IBD suffer from all sorts of extraintestinal manifestations ranging from those which we can see to those which patients experience, psychological experiences, etc. And so, the real goal of the program was to touch on this multidisciplinary approach that is needed to care for patients in a more holistic fashion.

Dr. Birnholz:
And you, yourself, in your practice, you have touchpoints in a number of facets within that holistic care period. And one of them, as I understand, is nutritional counseling, which is an area that perennially gets a ton of attention, but little is actually, I think, known. The evidence is sort of back and forth. Some of the evidence is becoming increasingly high quality; some is not so high quality, and there is a lot of gaps in understanding about where nutrition plays a role in good paradigms of care for IBD. Can you walk us through just where you sit with nutrition in terms of quality of evidence, the amount of research that is out there to weigh in on best practices, and how you like to counsel patients or even initiate conversations about nutrition?

Dr. Lewis:
Well, I think nutrition is relevant to every patient because if nothing else, when we see patients, it's important to just assess are they malnourished. But I often say to trainees and colleagues, you know, we really shouldn't forget our basics. We want to jump to nutrition as therapy, but we shouldn't forget the basics of just making sure that patients aren't malnourished, and if they are, decide whether this is something that we can handle ourselves or do we need help of a specialist; meaning a registered dietician or nutritionist. And then you start moving into the question of can you use nutrition as therapy? Either to treat active disease or as a maintenance therapy. And here, I think, is where your reference to experience over the course of the last decade of a number of more high-quality studies starting to be done and come to the forefront to really try and answer this question. Research in nutrition is incredibly difficult. And if you try and

compare it to doing, for example, a study of a medication, there are so many additional variables that you have to deal with that adds to this challenge, and I'll just give you one quick example. If you're studying a medication the biggest issue you're trying to study is did the person actually, did they take the medication? That's the confounder that can sort of ruin your study of the medication, other than, you know, were the two groups similar and, you know, in a large enough trial that's usually not a problem. If you're studying diet, there is all sorts of other issues about where do people get their food? How did they prepare their food? Is the food the same quality, etc., and an example I like to give is, you know, fine, you told people they should eat potatoes, but is the potato from Idaho the same as the potato from Ireland and, or is the white potato the same as the red potato, and if you baked it versus boiling it versus frying it – all of these things play in that make studies of nutrition just so much more difficult to execute than the standard drug trial.

Dr. Birnholz:
Right and difficult to double blind a nutritional research study. Anything short of, I'm guessing, exclusive enteral nutrition would be really hard to, to fool the patient and say, "Am I taking this or am I taking that?"

Dr. Lewis:
Yeah. Essentially the moment they consume their first meal, they know what type they're on.

Dr. Birnholz:
Not so blinded anymore.

Dr. Lewis:
Yeah.

Dr. Birnholz:
Well, why don't we shift from that? I want to keep asking you questions on the role of nutrition in this case. You know, can it ultimately replace certain forms of medical therapy? Some experts we've spoken have said, "You know, it's time for certain nutritional therapies to become more reflexive than for instance, in a rescue situation of putting somebody on prednisolone, there might be another alternative, like an exclusive enteral nutrition you know, bolus." Where are your thoughts on that?

Dr. Lewis:
One of the examples that came up in our session today is for example, the role of nutrition in the preoperative patient. We know that going to surgery with significant malnutrition puts you at much higher risk of complications, particularly infectious complications and wound healing complications. And that's a perfect example of a scenario where delaying the surgery and using nutrition as a therapy, not so much that you're healing their IBD, but your correcting that profound nutritional deficiency is allowing them to have better surgical outcomes. Sometimes that's going to be parenteral nutrition, sometimes that is going to be enteral nutrition. A really nice example that one can think about is the patient who's on high dose of steroids, which is the other factor that we can control that also dramatically increases the risk of surgical complications and you can think about using, for example, exclusive enteral nutrition as a mode over the course of several weeks for the elective surgery patients to wean down their steroids, and I typically say if you can just get them down to say 20 mg a day of prednisone, you've probably dramatically risk, reduced that risk of surgical complications. If you can get them even lower than that's great, but you know, if you can postpone that surgery for four weeks or so that can be really helpful.

Dr. Birnholz:
So, it's not simply just an either/or situation. It's a complimentary form of treatment through which you can get a good synergistic result if you actually pair good nutritional therapy alongside the medications and other preoperative-related things that you are doing.

Dr. Lewis:
Yeah. There's actually some interesting data from the Far East where they had looked at the idea of combining dietary therapy, particularly exclusive enteral nutrition, with anti-TNF therapy and, at least in these observational studies, suggesting that the anti-TNF therapy was more effective when coupled with exclusive enteral nutrition than when given with a regular diet, which is not hard to imagine, if you believe that exclusive enteral nutrition is effective and we have a lot of evidence to believe that that's true, but it's really a nice example of using it as sort of an ancillary therapy there.

Dr. Birnholz:
Excellent. Why don't I change because we are talking "Beyond the Gut" I would be remiss if I didn't bring up some of the other subjects that came up in your session. Psychosocial needs. You brought them up early on. A lot of factors that go into that but improving care coordination seems to be one of the biggest issues when it comes to when to integrate psychosocial counseling, when, who is ultimately responsible as an IBD-ologist verus bringing in specialists, psychologists, and social workers to help with that dimension of patient care. What are your thoughts on where we are currently at regarding holistically caring for patients from that end?

Dr. Lewis:

These are difficult diseases for any patient to deal with, and when you tell them "I have no cure; you're gonna have this for the rest of your life. Our goal is to try and manage your disease so that it doesn't interfere with the rest of your life," that's a great goal, but there are still, you know, people who experience a really hard time with their disease. Some of the data that were presented in the session today pointed out that somewhere between 20% to 30% of patients suffer either from symptoms of anxiety, about 20% with true anxiety disorders, and 20% with depressive symptoms. If you think of it, that's a huge proportion of your patients. In fact, I was seeing patients with one of our fellows the other day, and they said to me – we have this standarized questions that we ask them about, do they feel blue or depressed, and they said "Oh my God, everybody answers yes to this." It wasn't truly everybody, but it is this concept that, you know, 20%, 30% of the patients really have this as a major health need. And, you know, finding that psychological support for them to come up with coping measures; some of them actually need to be on medications, but for many of them, it's really finding the appropriate counseling that gives them strategies for how to cope with the anxiety and depression that comes with their disease and sometimes just getting them through that tough period and then they won't need further counseling down the road.

Dr. Birnholz:
And considering that response that you got which I'm sure many of our audience will agree with that, "Oh my God, they all, feel this way, of course, they all feel like they need counseling." Is there a disparity in how often we, as the healthcare professionals right on the frontlines with these patients, are asking, how they're doing from a psychosocial need standpoint? Do you feel like that's being asked enough?

Dr. Lewis:
I can only talk about my own practice. Like, I don't have data on what other peoples' practice patterns are. What I do think is almost certainly true, and this is just my gut instinct, is we don't do a very good job of providing them with the psychosocial support that they need and this relates to really having access to the right people who can provide the right counseling to patients. And there was some excellent discussion in the symposium today with some resources provided. The Crohn's and Colitis Foundation's website provides some resources that patients can use, and some websites where patients can go to identify psychologists who have been vetted through the Rome Foundation for treating patients who have gastrointestinal disorders and so that's a great resource for patients to reach out to, as well as for physicians to find health mental health specialists in their area who specialize in caring for patients with gastrointestinal diseases.

Dr. Birnholz:
Excellent. And we'll will have to do our part, I think, in being able to help disseminate some of those resources on your team's behalf through the programming that we're doing here. So, thank you for mentioning that. Continuing on just with your own session, there were some other areas that that became focus zones. One of them involved dermatologic conditions in the treatment of IBD and some of the considerations that go into that. Anything or any takeaways that came out of this session from that vantage point?

Dr. Lewis:
Yeah. I think the dermatology issue is interesting. As gastroenterologists, we spend a lot of time doing endoscopy and describing what we see. Yet as soon as somebody shows up with a rash or a skin lesion, suddenly we have no ability to recognize what it is, describe what it is, and much less know how to treat it. And in all honestly, we should understand the basics of managing peristomal lesions. We're really probably not in the business of treating diffuse skin diseases. That being said, it's all the more reason to partner with gastroenterologists, rather with dermatologists, and I thought that some of the discussion around four broad categories of dermatologic diseases was useful. There are those that are just a manifestation of inflammatory bowel disease, and I think we should all be able to recognize those knife-like lesions that are really dermatologic manifestations of Crohn's disease. The sort of extraintestinal manifestations, things like Erythema nodosum and then there's, for example, the complications of medical therapy and, lastly, we should be cognizant of there's nothing that says you can't have things that are completely unrelated to your inflammatory bowel disease that show up as skin lesions. And then the other aspect that I think is really important for people to remember is that skin cancer, particularly nonmelanoma skin cancer, is amazingly common many of the medications that we are giving suppress the immune system, likely increase the risk of patients having nonmelanoma skin cancer. And while most of these are basal cell carcinomas, and we think of this as an innocuous disease, sometimes in the setting of immunosuppression, you can have rapidly spreading, basal cell carcinomas that require rather large surgeries and we're also increasing their risk of squamous cell carcinomas, which can be fatal at times. And so, we really need to be vigilant about recommending that our patients who are getting immunosuppressant therapy that they are seen by dermatologists on a regular basis.

Dr. Birnholz:
And you raise a really good point in general because your session also touched upon on the idea of care coordination when to bring in a broader team, who to bring in, how often. Any thoughts with respect to that? You touched upon that from the side of dermatology and knowing kind of when you're out of your depth, but also taking some onus, taking some charge of the dermatologic manifestations of

IBD, for instance. What are your thoughts on improving care coordination to make long-term outcomes better for patients?

Dr. Lewis:
Well the keynote speech was given by Miguel Regueiro, and he gave a beautiful lecture on the future of medical homes for the care of patients with IBD. He acknowledged this is not happening in most places around the country, but it may be part of the future. And he showed some incredible data that by bringing together this multidisciplinary team having occasional meetings, you know, sort of your weekly huddle to discuss the more difficult patients and know where you're going. When he was at University of Pittsburgh, they were able to significantly reduce, unplanned care, so ER visits, hospitalizations. This would have a huge impact not just on, you know, the cost of care, but keeping patients out of emergency rooms, keeping them out of the hospital. That's all part of improving their quality of life, and I think for that, not all physicians are practicing in a setting where this makes sense, but even if you're not, sort of having your team of go to, this is my surgeon, this is my health care professional, this is my dermatologist – that sort of broad team that you refer to. I mean, those were just three examples. There's obviously many others that would fit in there, and you've created your sort of virtual network, and you work together, you know what to expect when you refer to them, you know what's coming back, you can get timely visits for your patients. I think that's really important.

Dr. Birnholz:
That seems like perfect parting comments for our closing of the discussion. Have your A-team, identify them, and sustain them. Nurture those relationships in that network. I very much want to thank my guest, Dr. James Lewis, for sharing insights gleaned from the session that he helped oversee, "IBD Beyond the Gut" at this year's Crohn's and Colitis Congress. Thanks so much, Dr. Lewis. It was wonderful having you on the program.

Dr Lewis:
Great. It was really my pleasure. Thank you.

Announcer:
This program was brought to you in collaboration with the Crohn's & Colitis Foundation & the American Gastroenterological Association. If you missed any part of this discussion, or to find others in this series, visit ReachMD.com/foundation, where you can be part of the knowledge.