Transcript Details
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Looking Out for the Key Signs & Symptoms of IBD

Announcer:
Welcome to Crohn's & Colitis Perspectives on ReachMD, produced in collaboration with the Crohn's & Colitis Foundation.

Dr. Caudle:
A fast and accurate diagnosis is the first crucial step in getting patients to therapy faster. And when it comes to debilitating life-altering conditions like inflammatory bowel disease, the first step is even more critical. But because inflammatory bowel disease can affect so many different parts of the digestive tract, it can be difficult to diagnose. So what are the key signs and symptoms that we should be on the lookout for? Coming to you from the ReachMD studios in Fort Washington, Pennsylvania, this is Crohn's and Colitis Foundation Perspectives. I'm your host Dr. Jennifer Caudle, and joining me is Dr. Neil Nandi, an Associate Professor of Medicine, Academic Gastroenterologist, and Director of the Center for Inflammatory Bowel Disease at Drexel Medicine in Philadelphia. Dr. Nandi, thank you so much for being here today.

Dr. Nandi:
Thank you for having me.

Dr. Caudle:
Absolutely. So let's talk about patient demographics. Is IBD more common in certain age ranges or genders, or even races?

Dr. Nandi:
Yes. So particularly Crohn's disease has a predilection for the second and fourth decades of life. And there's a smaller peak between the age 50 to 60 range. Truth be told, it can affect almost any age from infancy on up, but it's usually in the younger age population. So second to fourth decades is the highest peak onset. It turns out that Crohn's is more prevalent in westernized nations. That's a lot of theories there, but we are seeing is that countries like Canada, Europe, North America have much higher rates of inflammatory bowel disease, than developing nations like Africa, India, or Asia. That said, if you go to towns or cities in developing nations, Bombay okay, New Delhi, you are now starting to see where they have more westernized diet and westernized lifestyle, increasing incidence of IBD there. So there's something about the Western diet, the Western type of living that seems to be increasing the prevalence. Ashkenazi Jews have a three to four times increased risk compared to non Jewish people to develop a Crohn's disease. And we believe that for that specific group, it seems to be more genetically influenced than others. by and large, African-Americans and Asians seem to be lower risk but clinically around the country, especially here in the United States, we're even seeing those populations of African-Americans and Asians to start seeing increasing IBD, as well.

Dr. Caudle:
Interesting. You know, I work in a primary care setting. I'm a family doctor and I often see patients presenting with GI issues. So from your vantage point as a gastroenterologist, Dr. Nandi, um, you know what signs or symptoms should I be looking for in my patients when it comes to IBD?

Dr. Nandi:
So I'm glad you asked because I really believe that the diagnosis of Crohn's really lies pretty much most in clinical history taking, just like most of us do, right. So in terms of the history, we're always looking for not just the abdominal pain and diarrhea, but when they're having abdominal pain and diarrhea. And Crohn's and ulcerative colitis are pathological illnesses that don't take a break; they work 24/7. So even through the night, patients can wake up from the dead of sleep with pangs of abdominal pain, urgent, diarrhea, and incontinence even. And that should be an alarm, sign to the clinician that something is wrong and this is unlikely to be something like irritable bowel syndrome. So the presence of nocturnal awakening, is an alarm sign to us. Also we're looking for extra intestinal

manifestations of inflammatory bowel disease. We know that about 25% of patients will experience one extraintestinal manifestation before their formal diagnosis. And if you have had IBD long enough, that about half of patients will at least one extraintestinal manifestation over their lifetime. Now when I mean extraintestinal manifestation, I'm talking about the immune system attacking another organ system such as the eyes; getting episcleritis, uveitis, painful vision, oral aphthous ulcers that don't have to be painful, but these can be whitish ulcers on gums, the lips, the cheek. You can also have, joint aches, arthralgia. Rheumatologists collectively call these spondyloarthropathies; that's a mouthful. But typically they're of the axial skeleton, so the spinal cord or the lower sacrum, such as ankylosing spondylitis. And that commonly has nocturnal awakening with arthralgic pain. And lastly, there's also cutaneous manifestations such as erythema nodosum, which are painful purplish-reddish nodules on the shins, in textbooks, but in the real world they don't have to be very discolored; they don't have to be very obvious nodules, but painful bumps on the shins typically. Those four in particular, eyes oral aphthous ulcers, joints and erythema nodosum typically parallel disease activity. What does that mean? It means that they can actually herald intestinal disease activity before a patient flares or while they're flaring. So they're basically markers of disease. There are other extraintestinal manifestations that I haven't addressed, yet but we can get, into that in a little bit more detail. Other things that we're looking for, when we're making a diagnosis are the the extraintestinal complications of a Crohn's disease patient such as stricture, the patient may have nausea, vomiting, abdominal distention signaling a small bowel obstruction. Or they may have a fistula, connection from the intestine to the skin, or to the bladder where they get frequent urinary tract infections; that's common to see. Or perianal fistulizing disease, where the patient has some difficulty sitting on their tuchus, uh, but in reality it's because they have a little abscess brooding from a perianal, fistula, that's developing. So, those are things that we have to pay attention to on clinical history. Of course labs and stool studies, right? So, often times, we're checking labs and looking for iron deficiency anemia, elevated markers of inflammation such as a sedimentation rate or CRP. Typically CRP, tends to trend a little bit better to active IBD. We're also looking in the stool markers of inflammation such as fecal calprotectin. Fecal calprotectin is a marker that's found in neutrophils attacking the gut, so they get pooped out and we can detect it in the stool. If the calprotectin is elevated, uh, then it, uh, suggests that there's some type of inflammation going on in the gut. So history is most paramount in making the diagnosis of IBD looking at the labs and stool samples to help further confirm or characterize the level of inflammation is also very important. And then of course, you know, when you have that suspicion, you know, making the referral to the right type of GI specialist or IBD specialist.

Dr. Caudle:
Excellent. And you gave us a lot of really important symptoms to look out for, the nocturnal symptoms. You talked about the GI symptoms. You even talked about the systemic symptoms that we often see, in inflammatory bowel disease. Have any of these symptoms changed over the last few years? So, for instance, are you seeing a shift in how patients initially present?

Dr. Nandi:
I'm seeing that patients are being referred earlier. I don't think that we are seeing an increased prevalence of inflammatory bowel disease. And we verify this statistically. We used to think that there was only about 1.5 million Americans with inflammatory bowel disease. That study was redone a few years ago and confirmed by multiple bodies, and now we have over 3 million people. And it's because patients can have clinically silent or underdiagnosed IBD, but we're finding that clinicians in the community are picking up on early iron deficiency anemia that can't be explained. We're paying attention to extraintestinal manifestations, or being confident that the patient's symptoms may not be explained, but it doesn't really fit quite IBS, with them making the referral early. So I don't think that symptoms have really changed, but we are seeing people refer earlier so we can make the diagnosis of IBD sooner.

Dr. Caudle:
Well that actually sounds like a really good thing. I'm happy to hear that. You know, and now that we've covered a lot of the common symptoms of IBD, let's talk about how primary care clinicians and gastroenterologists can work together with their IBD patients. So what advice would you give to us primary care clinicians as to what the first step should be if we suspect a patient might have IBD?

Dr. Nandi:
So one is giving some basic education to the patient about why you're reaching out to the GI doctor. I think prepping the patient psychologically is really important because oftentimes a lot of fear, and patients can get lost from primary care diagnosis to the specialist's office. We see that all the time – that's a dangerous period, that's a lost missed opportunity. So providing reassurance - that's a very important part. Then, you know, do what primary care doctors do best, honestly; primary care doctors are the best communicators, and I hope my specialists out there don't hate me too much, but I feel that specialists don't communicate enough back to their primary care doctors. But it's that communication that's key so I think communicating with the multidisciplinary team verbally is invaluable rather than just sending records alone. That's probably the first and foremost thing. The other thing is once the patient gets to the GI doctor's office and we make the diagnosis and we made initiated treatment oftentimes other important facets of care are missed. And Dr. Caudle, that's exactly what primary care and family medicine excel at, which is preventive care. I think you'd agree, right? When we put our patients on biologics, they're at risk for infections. Would you agree?

Dr. Caudle:
Absolutely. Absolutely.

Dr. Nandi:
And now in 2019 we see more than ever that we need to be optimizing our vaccines on our patients. So those patients need non-live vaccines for influenza, pneumonia some patients may need vaccinations for varicella-zoster and other things. The also we need primary care to help us do bone scans because the untold side effects of steroids causing osteoporosis. I'm sure you see that all the time.

Dr. Caudle:
Right.

Dr. Nandi:
And then of course all the other things that GIs don't know how to do. GIs don't know how to do Pap smears. GIs don't know how to do breast exams.

Dr. Caudle:
Right.

Dr. Nandi:
We know how to do a prostate exam, for whatever that's worth, right. We also don't know how to do good skin exams. So we need the help of primary care and dermatologists because some of our medications may increase the risk of melanoma or non-melanomatous skin cancers. And then another thing that I think that's really important, we take it from - some of us take it for granted is smoking cessation. Even in 2019, you know, we still see people lighting up; young people, old people. And we know that tobacco actually makes Crohn's worse. We can give you the best biologic in the world, and tobacco will undo its effect. So those are things that, you know, each of us trained to be good at certain things and each of us have our certain talents. And primary care is critical for these specific types of preventative healthcare measures to be taken. They're the best at doing it and I think that there needs to be better communication from the subspecialists to our primary care brother.

Dr. Caudle:
Well, let me just say as a family doctor I would like to thank you for those comments and and I'd like to thank you on behalf of all my primary care colleagues, so I definitely appreciate you saying that. And it certainly is, as a primary care physician, your prevention is one of the banes of our existence, right? It's one of the reasons why we do what we do. And it's wonderful that you feel that communication from your primary care specialists has been good. You mention a lot of things I think of a really important for us helping our patients because that's what they really are. It's all of our patients, right? Our IBD patient is your patient, my patient, everyone's patient. Are there any other ongoing management recommendations that you may have for us physicians? You know, do you have any other tips for success on how we can make this a really successful collaboration?

Dr. Nandi:
I think communication being key, but I think the thing I want to impress the most, and this is where we the GIs really need the help. Which is making that early diagnosis, that early referral because when we introduce all these beautiful new treatments that we have too late, they really don't prevent surgery. But if we introduce the treatments early induction, that's what we make the difference, that's where we improve the patients lives, where we continue for them to be a productive member of school, work, society, as a husband, wife, father, where they don't have to go to surgery. But all that is disrupted when we introduced the treatments too late. So I think the beautiful thing is, is that primary care really has and always has had the wonderful opportunity to make the diagnosis early and make that referral early to the doc. And getting in to see and IBD specialist or GI specialist is expedited when we speak to each other over the phone.

Dr. Caudle:
Excellent. I couldn't agree more with that. Ufortunately now we're actually almost out of time for today, but before we go, Dr. Nandi, do you have any final thoughts to share with their audience?

Dr. Nandi:
No, I think that inflammatory bowel disease treatment has come a long way. The key is making the early diagnosis communication between all subspecialists involved in the care and in doing so we can really have a good chance of improving the quality of our patient's lives.

Dr. Caudle:
Well those are all great concepts to take with us. And with that, I'd like to thank my guest, Dr. Neil Nandi, for joining me to discuss the signs and symptoms of inflammatory bowel disease. Dr. Nandi, it was great having you on the program.

Announcer:
This program was brought to you in collaboration with the Crohn's & Colitis Foundation. 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.