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Evaluating the Evolution of Inflammatory Bowel Disease Management

Dr. Buch:
The evaluation and treatment of inflammatory bowel disease has dramatically changed in the last several years. These changes have improved the quality of life for many patients. Yet there are still many questions that need to be answered.

Welcome to *GI Insights* on ReachMD. I'm Dr. Peter Buch. Joining us today to help answer some of these questions is Dr. Jeffrey Basile, a gastroenterologist from Charleston GI, whose passion is the treatment of IBD. Dr. Basile, I'm delighted to have you join us here today.

Dr. Basile:
Thanks so much for having me, Peter.

Dr. Buch:
It's my delight. So let's get right into it. Should we be using 5-ASAs for the treatment of Crohn's disease?

Dr. Basile:
It's a great question. 5-ASAs, or mesalamine, they have been in existence for a long time, and they've been used for both Crohn's and ulcerative colitis for many years. We know that they have good benefit in patients who have mild to moderate ulcerative colitis. In terms of their use in Crohn's disease, I use them in a few instances. I use them in patients who have very mild Crohn's colitis, in the same way that they work for patients who have ulcerative colitis, I do think that they still have a role in very mild Crohn's colitis. There are some patients that will scope who are actually asymptomatic, and they'll have a little bit of inflammation with some skip lesions, and the pathologist verifies that there's some chronicity. And these patients are asymptomatic, and so putting them on something much stronger like an immunomodulator or a biologic therapy might not be necessary. And so those patients who have Crohn's colitis with mild disease or who are asymptomatic can benefit from using mesalamine.

In terms of Crohn's ileitis, the data shows that mesalamine-based products really don't give much bang for the buck. They are not as effective as some of the stronger medicines like biologics or immunomodulators. And so, when I do a colonoscopy, if I have a new diagnosis of Crohn's, ileitis, I'm hesitant to use these. I find that the inflammation doesn't go away. The next time I scope them, symptoms don't go away. And so I tend to use other medications for Crohn's ileitis. There are some caveats and that would be in someone who is very hesitant to go on other medication, who would like to be on something who has very mild ileitis. And so those patients who do not want to go on immunosuppression, biologics, and immunomodulators, those are specific patient population that I would consider using something like Pentasa or Asacol, a mesalamine-based product.

Dr. Buch:
But ultimately you wouldn't be too optimistic about the success for ileitis?

Dr. Basile:
Exactly, I don't think it works very well. And in the patients who have mild ileitis, I think it is very important that we make sure that their ileitis is actually Crohn’s ileitis. There are other things that cause ileitis, and I certainly have seen patients who come to me who had been seen elsewhere and they were diagnosed with Crohn's ileitis and you review the pathology and it actually showed only acute or focal ileitis and no chronic changes. And that could be due to NSAIDs. That can be due to self-limiting infections or trauma and prolapse and other entities that have nothing to do with inflammatory bowel disease. So I think it's very important that we get the diagnosis correct. But if they have Crohn's ileitis, I tend not to use mesalamine unless the patient really does not want anything else.

Dr. Buch:
Thank you. So let's move on to the next one. When are antibiotics useful in the treatment of Crohn's disease?

Dr. Basile:
Antibiotics are useful in a few different scenarios in patients who have Crohn's disease. Certainly a patient who has fistulizing Crohn's disease and develops a perirectal abscess, I will start them on antibiotics, such as Cipro and Flagyl and send them for evaluation to a colorectal surgeon. Patients who have an intraabdominal abscess I certainly will give antibiotics to treat that abscess. And then in patients who have an ileal resection there's a clear consideration for three months of use of metronidazole or Flagyl. And this has been shown to help improve post-surgical outcomes after an ileal resection and patients with ileal Crohn's disease and may help reduce recurrence. And so those are a few instances that I use antibiotics in Crohn's disease. Certainly, there are other instances such as patients who have Crohn's disease who develop C. diff colitis, I'll use them in patients who have inflammatory bowel disease who are at increased risk for C. diff colitis. And so I will use it in those instances. And then a lot of patients who have inflammatory bowel disease, whether it's Crohn's or ulcerative colitis, they have GI symptoms and we scope them and everything's normal, and they're actually in remission. So they may be on therapy. They're in complete remission, but they still have gas, bloating, and diarrhea. And so it is very common for patients who have inflammatory bowel disease to also have overlapping IBS. And so those patients, I may use antibiotics, especially Rifaximin and treat them for bacterial overgrowth. Those patients are at increased risk for bacterial overgrowth, because a lot of these patients have had surgery and don't have an IC valve which can cause them to have an increased risk of SIBO. And a lot of these patients have overlapping IBSD. So not every time a patient has inflammatory bowel disease complains of diarrhea, gas, and bloating, it's not always related to inflammation. Sometimes they're in remission, and we need to treat them with antibiotics for other reasons.

Dr. Buch:
And SIBO being a small intestinal bacterial overgrowth, for those members of the audience who didn't know that terminology.

For those of you just joining us, this is *GI Insights* on ReachMD. I'm Dr. Peter Buch. And joining me today is Dr. Jeffrey Basile who is discussing inflammatory bowel disease.

Dr. Basile, there is often confusion about who's in charge of vaccinations, gastroenterologist or primary care providers. This is extremely important for our IBD patients. Would you review the appropriate vaccinations for IBD patients and why they need to be administered early?

Dr. Basile:
So it's very important as a gastroenterologist, especially a gastroenterologist who is specializing in inflammatory bowel disease, to be involved in all aspects of care. Patients look at you as their primary care physician. They might actually see you more than they see their primary care physician, because you're managing a lot of their main issues, which stem from their inflammatory bowel disease. So it's important that not only we deal with their vaccinations, but that also we make sure that they're up to date on DEXa scans, that they're not smoking and that we've checked their smoking status, that their Hepatitis B and C and PPD have been checked, especially if they're on biologic therapy, and that we check for depression. So it's very important that we do basic screening. But especially with vaccinations, these patients are at increased risk for infections because they're on immunosuppression. And so, it's very important that we're involved that we make sure that they're up to date with their vaccinations and either we administered ourselves or we write them a script to get them vaccinated.

In terms of vaccinations, it's very important that all patients who have IBD have had a yearly flu vaccine. The pneumonia vaccine is also very important. It's important right now with Coronavirus that we emphasize the need for getting vaccinated once that's available for our IBD patients. And so I'm continually looking at when they're going to be able to get the vaccine if they haven't already qualified. And then it's important that we make sure that they're vaccinated for herpes zoster. Herpes zoster is very common with certain medications, including tofacitinib. It's more common with Xeljanz. And so it's very important that all of our IBD patients who are immunosuppressed, get vaccinated and that they do not get the live vaccine, but get the inactive vaccine, which is the Shingrix. The Zostavax is live, and should not be given to anyone on immunosuppression. But the Shingrix vaccine is very safe. And they should get both doses of this either before you start them on immunosuppression or if you inherit a patient who is already on immunosuppression, that they get this at some point in the near future. There are other vaccines that they should have had as a child. And so you would want to make sure that they're up to date on these as well, but they should not get any live vaccines.

Dr. Buch:
Can we just re-emphasize for our audience, something that you just talked about? Is getting the COVID immunization in IBD patients and the recommendation behind that and is it safe?

Dr. Basile:
The vaccine is safe. There's no question that it is safe. It is very effective, and is something that all of my patients who have inflammatory bowel disease should get. And actually all of my patients in general should make sure that they strongly consider getting

the vaccine. But patients who have IBD are at increased risk for infections, and that includes COVID-19. And so those patients really should get the vaccine as soon as they are able to get the vaccine. It is safe, it is effective, and it's something that they should get.

Dr. Buch:
And I fully agree.

Moving on to ulcerative colitis, under what circumstances do we say the medicines are ineffective, and it's time for surgery?

Dr. Basile:
In general, we always want to avoid surgery if possible. But there are some instances where surgery is necessary in ulcerative colitis. And surgery can actually be curative in ulcerative colitis. And that would be through an ileal pouch anal anastomosis surgery, and so that's a total colectomy. And patients who need this are - There are a few clear indications, and one would be a patient who has refractory bleeding. So a patient who is bleeding so badly that they're requiring blood products and we can't keep up with transfusions, and they're having chronic severe anemia, and are getting not only I.V. iron infusions regularly, but are also getting transfusions regularly, that can be an indication. That's not very common with some of the good medicine we have now, but that still is an indication. Anyone who has dysplasia or flat dysplasia. And so if we do a colonoscopy, we see inflammation, we do our random biopsies, and some of those biopsies show some dysplasia. It's a discussion that needs to be had. We used to say all those patients had to go straight to surgery. But it's definitely a very strong consideration for surgery. And it would be a discussion you need to have with your gastroenterologist. But a lot of those patients do end up getting surgery, who have flat dysplasia or who have malignancy in the setting of IBD.

And then patients who do not want medication. That's unusual. I try to promote that these medicines and patients who need them are safe and effective. They all have some side effects, but we think that the benefit outweighs any risk with those medicines. And so there are rarely a patient who refuses medication who has bad disease, and that would be someone who would need to be considered.

And then someone who of course is refractory to all medication. We've tried biologics, we've tried combination therapy with immunomodulators. We've gone through multiple biologics and they still have not responded. They have refractory symptoms, refractory disease. That would be a clear indication to at least see a surgeon and discuss surgical options.

Dr. Buch:
Thank you. How are you approaching the use of steroids for IBD in this COVID-19 era?

Dr. Basile:
So in general, I try to avoid steroids in patients who have inflammatory bowel disease. They have a lot of side effects. You can get diabetes from chronic steroid use. You can get osteopenia and osteoporosis, cataracts, and they can cause steroid mania, and some other side effects. And so I always try to avoid steroids in general. If I need to use steroids, I like to use topical steroids. So I would much rather use Uceris, or budesonide, depending on where the disease is, and either extended release or immediate release. And these are a little bit safer. And so if I need to treat someone for a flare or from bridging them to a different therapy, I prefer these sorts of medicines over prednisone. There is a rare case where you'll need to use prednisone because someone is in such a flare, and it's the only thing they're responding to.

But the data has shown that TNF alpha inhibitors and biologics, we don't think they really increase the risk right now of the severity of the COVID infection. So patients who have had infections who are on biologic therapy, they're not seeing necessarily worse outcomes, which is actually good news and which is why we're keeping patients on biologic therapy during this Coronavirus pandemic. But there is data that shows that patients who are on steroids do have a worse outcome. And so, in general, especially during the Coronavirus pandemic, I'm trying to avoid steroid use unless absolutely necessary.

Dr. Buch:
Finally, before we conclude, is there any message you would like to share with our audience?

Dr. Basile:
In inflammatory bowel disease, there are a lot of nuances to treatment, to getting diagnosed, and so it's very important that you see a specialist regarding inflammatory bowel disease, that you research your treatment plan, and that you feel comfortable with the treatment that you're on. And it's important that you follow up closely. And the patients who follow up closely with their gastroenterologist who have IBD tend to do much better. And so I think there are a lot of nuances. We've discussed some of these today in terms of the different medications, and that is part of the art of medicine. So I think it's very important that you see a specialist and that you take their advice and kind of think about the various options. The good news is we have good medication, more medicines are coming out, and the treatment of IBD is very promising in the future.

Dr. Buch:
That's all the time we have for today. I want to thank Dr. Basile for helping us sort through these questions. Dr. Basile, thanks so very much for your insights.

Dr. Basile:
Thank you for having me. I really appreciate it.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this episode and others from our series visit ReachMD.com/GIInsights where you can Be Part of the Knowledge. Looking forward to joining you soon.