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IBD Care Beyond Disease Control

Dr. Buch:

You're listening to *GI Insights* on ReachMD, and I'm Dr. Peter Buch. Today, we'll be learning about health maintenance in inflammatory bowel disease, also known as IBD, with Dr. Harish Gagneja. Dr. Gagneja is a board-certified gastroenterologist in Austin, Texas.

Dr. Gagneja, welcome to the program.

Dr. Gagneja:

Thanks for having me today. It's my pleasure to talk about preventive care and inflammatory bowel disease, which is very near and dear to me.

Dr. Buch:

To start us off, Dr. Gagneja, why are IBD patients so often under-vaccinated and under-screened, and who do you think should be responsible for their preventive care?

Dr. Gagneja:

Great question. We have gotten very good at treating IBD. We haven't been nearly as good at treating the patient with IBD, you know what I mean? Treating IBD is great, but we need to treat the patient with IBD. So I think as a gastroenterologist, we have to accept some responsibility for this vaccination process in this patient, because we are very focused on getting the inflammation under control, but sometimes the rest of the patient gets lost. The primary care doctor assumes that the gastroenterologist is handling vaccines because the patient is on immunosuppressive drugs, biologics, or small molecules, so they know what vaccinations to give. And then gastroenterologists assume that the primary care doctor is handling the cancer screening and bone health and everything else, and between these two, the patient falls through the cracks.

So I do think that gastroenterologists need to take the responsibility for vaccinations and talking about other things that we talked about earlier. But overall, preventive care really belongs to a whole team, not one person. So somebody needs to own the checklist, which we talk about with EMR checklists, and I think gastroenterologists should own that checklist.

Dr. Buch:

Before a patient starts a biologic or small molecule, what belongs on the pre-treatment checklist from hepatitis B and TB screening to vaccines?

Dr. Gagneja:

Good question. It all depends on which biologic or small molecule you are going to use. But as a general thing, before I start any small molecule or biologic, I really want to know three things. One is, does this patient have any infection? What infections are they susceptible to? Or do they have any kind of cancer or other preventive issue which I'm going to make more complicated by starting this medication? So start thinking about these. Then I figure out what else needs to be done. But generally speaking, we make sure there's no hepatitis B, no TB risk, hepatitis C, or HIV, and look at the vaccination status and make sure they have an influenza vaccine, COVID, and pneumococcal. Shingles is very important with some small molecules because of high risk for herpes zoster, and then it all depends on the patient's age and risk factor. I also look at varicella immunity very carefully because some of these vaccines are live vaccines, so I'm going to make sure that if we have to give any live vaccine, we give that before the start of the treatment. The best time to prevent an infection is to really before you suppress the immune system.

Dr. Buch:

And when it comes to cancer screening, how should we tailor it to a patient's medication history?

Dr. Gagneja:

Again, very important. A lot of these biologics and small molecules do have some increased risk in cancer. I think we have to be very careful not to frighten our patient by saying, "Oh my God, you're on a biologic, therefore you need a whole different cancer screening program." No. You still do the patient's age-appropriate cancer screening, which is colon, breast, cervical, prostate, and appropriate lung screening, and then layer the IBD medication risk on top of it, which is usually skin—most of the time skin—and I also make sure that their ophthalmology exam is up to date. HPV vaccinations and appropriate cervical cancer screening are also particularly important in these patients.

Dr. Buch:

For those just tuning in, you're listening to GI Insights on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Harish Gagneja about IBD care beyond disease control.

So Dr. Gagneja, when do you check bone density, and which nutritional deficiencies do you screen for?

Dr. Gagneja:

Bone health is one of those things that doesn't get much attention until someone fractures something or something happens. I do have a very low threshold for thinking about bone density in IBD, especially few patient characteristics. One is patients who have prolonged or repeated corticosteroid exposure. Luckily, we avoid that these days like a plague. For somebody who's very low body weight or somebody has malnutrition, I do pay a lot of attention to vitamin D and calcium. There's also some data suggesting an inverse relationship with vitamin D level in ulcerative colitis with maintenance and remission. So I really pay attention to that. We also look at the iron B12 and folate, especially if patient had an extensive small bowel disease or significant malabsorption; then I do have a lower threshold looking for other nutritional status as well.

One thing I will emphasize is that iron deficiency deserves very particular emphasis because patients can get accustomed to being tired and just assume that it's their IBD. It's important that these patients who have iron deficiency do get IV iron infusions and iron maintenance. Iron IV maintenance is very important.

So I always tell my patients and colleagues, "You know what? Absence of diarrhea doesn't mean that there is absence of malnutrition." Think about it. So that's why it's important to check for all these things.

Dr. Buch:

Depression and anxiety are also common in IBD and affect disease outcomes. How are you screening for them in practice, and what do you do with a positive screen?

Dr. Gagneja:

We know that the brain and the gut are communicating constantly. We have a brain-gut axis, right? And the patient who's struggling psychologically may also struggle with adherence to their medications, they may not tell you symptoms, and their overall disease outcome may be not as good if they're really having depression and anxiety. I'm the first one to admit that I really don't do a very good job at this. I really need to get better at this to do this.

There are few tools available. For depression, there's something called PHQ-9, or there are a few others. And if anxiety, there is a good one called GAD-7 for generalized anxiety disorder. So those tools should be used. If it's positive, then for that patient, you need to be asking more questions like, "How's your sleep? How's your work? How's your relationships? How's your appetite? How do you cope with this disease process?" And whether they're missing medications or whether they're feeling hopeless, all of that. Let's talk about it. Then at that point, I really don't feel comfortable taking care of the patient for these particular diagnoses. At that time, I do enlist primary care or a behavioral therapist or a psychotherapist or somebody who really is well-versed in these things so that these patients can be taken care of better than I can.

Dr. Buch:

Before we wrap up, do you have any final takeaways you'd like clinicians to remember from our conversation?

Dr. Gagneja:

I think we discussed a lot about, preventive health and inflammatory bowel disease. But for my final takeaways, I would say three things.

Number one, don't equate feeling well with having controlled IBD. We need to look for objective evidence of inflammation.

Number two, prevention needs to be built into IBD care, not just whenever we have extra time. It should be on the checklist. It should be

built in there, which includes vaccinations, cancer screenings, bone health, nutrition, mental health, and postoperative monitoring if somebody has surgery. That should become a part of routine workflow.

Third, which is very important to me, is that we really have to think beyond the next or this clinical visit. Question is, yes, the patient's feeling better this month, but what about in next five years, 10 years, or 20 years from now? So make sure to start thinking about how to prevent long-term complications. I would end this with a phrase: Treat the disease, protect the patient.

Dr. Buch:

With those final thoughts in mind, I want to thank my guest, Dr. Harish Gagneja, for sharing his insights on preventive care in IBD.

Dr. Gagneja, we appreciate you joining us today.

Dr. Gagneja:

Thank you so much. Thank you for having me. It was wonderful.

Dr. Buch:

For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in our series, visit *GI Insights* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.