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Preventive Care Essentials for Patients with IBD: Reviewing ACG Guideline Updates

Dr. Buch:
This is *GI Insights* on ReachMD. I'm Dr. Peter Buch. And today I'm joined by Dr. Francis Farraye to discuss a 2025 update to the American College of Gastroenterology's Clinical Guideline on Preventive Care in Inflammatory Bowel Disease, or IBD. Dr. Farraye is the lead author of this guideline as well as a Professor of Medicine and Director of the Inflammatory Bowel Disease Center at the Mayo Clinic in Jacksonville, Florida.

Dr. Farraye, welcome back to the program. Your insights always make us better practitioners.

Dr. Farraye:
Thank you so much for having me, Dr. Buch.

Dr. Buch:
To start us off, Dr. Farraye, could you give us a brief overview of what's new in this updated clinical guideline?

Dr. Farraye:
Our original guideline was published in 2017, and there have been significant changes from the ACIP in terms of recommendations. So in this guideline, we talk about new ages for recommendation of the shingles vaccine. It used to be everyone should receive it 50 and older, and that continues, but in addition, immunocompromised patients aged 19 and older are all eligible to receive the shingles vaccine. And in fact, anyone who's at risk for becoming immunocompromised is eligible, so that includes the majority of our patients with ulcerative colitis and Crohn's disease.

There are new recommendations for pneumococcal vaccines. Basically, anyone over the age of 50 is now recommended for pneumococcal vaccines, and again, those individuals who are between the ages of 19 and 49 are also eligible. And perhaps later on we'll talk a little bit about the new recommendations using PCV20 or PCV21.

Back in 2017, we were not talking about RSV infection. We've actually published some data from our group showing that RSV infections are more common in patients with inflammatory bowel disease. We now have several excellent RSV vaccines, and the recommendations from the ACIP are for all individuals over 75 to receive that vaccine. And again, patients between the ages of 50 and 64 who have risk factors for significant illness, if they acquired RSV, would be eligible, and that would include our patients with IBD.

And the last one I want to briefly mention is the safety of giving rotavirus vaccine to infants whose mothers are on advanced therapy, such as anti-TNF. There was some concern that you could not give that live vaccine to those infants, but now we know that it is indeed safe. So lots has happened since 2017.

Dr. Buch:
Now, how do simple office measures, like checklists, improve vaccination rates in patients with IBD, and where can clinicians find them?

Dr. Farraye:
So I think we all realize that taking care of patients is complex, and there's lots of balls in the air that we have to keep. Aand it's easy to identify checklists that list, for example, all the vaccines; what ages should they be administered to? Are they safe to give in someone who's on, for example, immunocompromising medicines? So those I think clearly are going to make the gastroenterologist, the primary care doctor, the rheumatologist easier to keep them at hand's length.

And these are available from the Crohn's and Colitis Foundation. And then there's another group called Cornerstones, and both of those groups published the recommended guideline as a checklist, and they're available for free downloads from their respective websites.

Dr. Buch:
Thank you. So you noted in the guidelines that adults with IBD should receive age-appropriate vaccinations before initiation of immune-modifying therapy. What do you recommend when a patient is already on an immunosuppressant?

Dr. Farraye:
So this is a common issue in that you see a patient with ulcerative colitis or Crohn's disease, they seem to be doing well, and then six or 12 months later they flare and they need to go on prednisone, and they're not up-to-date with their vaccine-preventable immunizations. So the bottom line is, when we see patients with newly diagnosed ulcerative colitis or Crohn's disease, or when we're seeing them for their routine follow-up, we use the checklist. We check their hepatitis serology. We ask about previous vaccinations against pneumococcal pneumonia. And in those situations, we administer the vaccines before they're immunocompromised.

Now, the reality is sometimes you will see patients who are already on therapies that will blunt the immune response to vaccines, but there's good data to suggest that even in those patients who are on these drugs and may have a blunted response, they can still have an immune response that offers some protection. So the best time to vaccinate would be during a routine check when they're well, soon after they're diagnosed, but if they are on immunosuppressive medicines, we should not withhold vaccines other than live vaccines. Obviously, we can't give live vaccines to those individuals who are on immune-modifying therapy.

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. Francis Farraye about the American College of Gastroenterology's 2025 Clinical Guideline Update on Preventative Care in Inflammatory Bowel Disease.

Now, Dr. Farraye, if we shift over to pneumococcal vaccines, what are the updated recommendations for patients who are either pneumococcal vaccine naive or have an incomplete vaccine history?

Dr. Farraye:
Well, things have come a long way from the days of using PCV13 and PPSV23, and in the last several years, the ACIP has recommended a simplified regimen to protect patients against pneumococcal pneumonia. And this would be, again, as I mentioned earlier, all individuals over the age of 50 and those individuals who are on immune-compromising medications—again, many of the medications that we use to treat patients with inflammatory bowel disease. So now the recommendations in someone who's never received pneumococcal vaccine is to receive the vaccine PCV20 or PCV21, and that was a single dose.

Now, if someone has had previous vaccination, it gets a little bit more complex. For example, if they've had PPSV23, they should receive the PCV20 or PCV21 a year after the pneumococcal vaccine. But the reality is, if you don't know, just give them a single dose of PCV20 or PCV21. In our guideline that can be downloaded, we have a nice figure that walks through all the various scenarios for you.

Dr. Buch:
And what about varicella? Should we be doing serologic testing in patients previously immunized?

Dr. Farraye:
So there's an issue there in that the testing for varicella antibodies is not particularly sensitive. So the CDC recommends that if someone tells you that they had chickenpox or they tell you that they completed the appropriate vaccination series for varicella or chicken pox, we would not check the serology because that creates a situation where the serology may be negative, but they truly were exposed. And because the varicella vaccine is a live vaccine, we would then have to hold or defer treatment for their inflammatory bowel disease because, again, we can't give a live vaccine to those individuals who are on immunosuppressive medications.

Dr. Buch:
So when it comes to household members of immunocompromised patients, can they safely receive live vaccines?

Dr. Farraye:
So we do recommend that family members of immunocompromised patients be up-to-date on all their vaccines. We don't want grandma, brother, or sister to basically get influenza and then come and visit the immunocompromised family member and potentially introduce an infection. This is called the cocoon strategy. Again, you want to basically cocoon the immunocompromised individuals and not expose them to various infections.

So the bottom line is, if you're a household member of an immunocompromised patient, you should absolutely receive all the inactive vaccines, but there are situations where you might need to receive a live vaccine. But the reality is that the likelihood of causing infection in a family member who's immunocompromised if you receive a live vaccine is extraordinarily low.

The ones that you do need to know about is if, for example, you give the rotavirus vaccine to an infant and mom is

immunocompromised, mom needs to be very careful about changing diapers and hand hygiene. The other live vaccine that we do worry about is the live influenza vaccine. That's the intranasal vaccine. And it is recommended that we not have a family member use the live intranasal vaccine if they're present with an immunocompromised patient but rather use the inactive standard influenza vaccine.

Dr. Buch:
And moving on to guidelines about melanoma and other skin cancers, what should we know about this in IBD?

Dr. Farraye:
It may not be generally known that patients with Crohn's disease, independent of any treatment that they receive, have an increased risk of melanoma. Furthermore, some of the medicines that we use—for example, the thiopurines and JAK inhibitors, such as upadacitinib or tofacitinib—increase the risk of non-melanoma skin cancer. So in the guideline, we recommend that every patient with inflammatory bowel disease see a dermatologist. The dermatologist will then look at their history of sunburn, the medications they're on, and how long they have had inflammatory bowel disease, and then I defer to the dermatologist and the patient to decide the frequency of follow-up visits.

Dr. Buch:
In the last few moments of our conversation, Dr. Farraye, do you have any additional thoughts you'd like to share with our listeners?

Dr. Farraye:
So the authors felt strongly that in 2025, as well as in 2017, when the first version came out, that gastroenterology clinicians, the physicians, the nurse practitioners, and the PAs on the team need to take more ownership of preventive care for their patients with IBD. You have to realize that a 25-year-old who has no other medical problems typically only sees their gastroenterologist and may not see their primary care doctor. We're prescribing drugs that affect their immune system. Their disease may lead to an increased risk of osteoporosis because they're taking steroids.

So because we're so intimately involved in the management of these patients, we really feel strongly that gastroenterology team of clinicians take more ownership, make the appropriate recommendations for vaccines, and then obviously refer back to the primary care doctor or subspecialist as needed to keep those patients well and safe.

Dr. Buch:
As those insights bring us to the end of our program, I want to thank my guest, Dr. Francis Farraye, for joining me today to discuss the ACG's latest recommendation on preventive care in patients with IBD.

Dr. Farraye, thanks for this very practical and informative update.

Dr. Farraye:
Thanks again for having me.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit *GI Insights* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening, and looking forward to learning with you again very soon.