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Staying Ahead of IBD Complications

Dr. Buch:

Welcome to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and joining me to talk about preventing complications in inflammatory bowel disease, or IBD for short, is Dr. Harish Gagneja. Dr. Gagneja is a board-certified gastroenterologist in Austin, Texas. Dr. Gagneja, thanks so much for being here today.

Dr. Gagneja:

Thanks for having me today. I really enjoy talking to you at ReachMD.

Dr. Buch:

Let's dive right in, Dr. Gagneja. How has treat to target changed what prevention means in IBD, and how hard should we push for endoscopic healing in a patient who feels well?

Dr. Gagneja:

IBD prevention has moved from preventing symptoms to preventing the consequences of inflammation. I do think treat to target has really changed the definition of success in inflammatory bowel disease. Patients can feel fantastic but still have significant mucosal inflammation.

So with that, what happens is the risk of hospitalization, risk for surgery, or even developing colorectal neoplasia over time is high. So for that reason, I do think that pushing for endoscopic healing is important. The goal is really deep control of inflammation, and endoscopic healing is one of our most important targets, I think.

Having said that, I would also say that shared decision-making is important in this context. I'm much more aggressive about achieving healing in a young patient who has years of disease ahead of them than an older patient with multiple comorbidities where the risk-benefit equation may be much different than a young patient. So to me then, the question is: Does my patient feel well, or is the disease truly under control? I go for the second one, and for that reason, I really think the treat to target is important.

Dr. Buch:

And how do you use calprotectin, C-reactive protein, and intestinal ultrasound to monitor patients between colonoscopies?

Dr. Gagneja:

We have moved away from invasive testing to non-invasive testing. So all the things you mentioned, which is fecal calprotectin, C-reactive protein, and intestinal ultrasound, are non-invasive modalities in between colonoscopy we use. Fecal calprotectin is really my favorite of these tools because it is relatively inexpensive, is very non-invasive, and gives us a very good sense of what's happening in the gut.

I like to use this as a trend rather than one number. So if somebody came to me, let's say they had a fecal calprotectin of 1200, and now after treatment that's come down to 130, 140, or 120, I know things are working. So that's very meaningful for me. If it is going from 150 to 200, 500, or 800, I really want to know now what's going on in the mucosa and what's going on with the inflammation.

So at that time, I may use a colonoscopy to figure that out so that I can optimize my patient's management. I like C-reactive protein, but C-reactive protein is secondary to calprotectin. About 20 percent of patients will not mount the response with C-reactive protein, and 80 percent will. If I have a baseline C-reactive protein that is elevated, then I will follow it. But otherwise, it's not one of my favorite testing. Calpro is my favorite.

Ultrasound is up and coming. It's really great. Potentially, I think it's a game changer in future. It's very non-invasive. But at this point,

the problem is that it is not available widely, and there is operator variability. There is variability in interpretations and all that. But it does give you information about bowel wall thickness, vascularity, and complications.

So in summary, I would say that I use fecal calpro and CRP. And at this time, ultrasound is not available to me, but I do think that this is a potentially a game changer.

Dr. Buch:

Colorectal cancer surveillance in IBD has changed a lot in the past decade. From your perspective, who needs surveillance? When should it start? And how do you set the interval?

Dr. Gagneja:

We have many guidelines regarding this, but in my opinion, it all depends on disease extent, how much colon is involved, duration of the disease, whether patient has a primary sclerosing cholangitis or family history of primary sclerosing cholangitis, whether they have multiple pseudopolyps in the colon, whether they have a prior dysplasia, how much inflammatory burden there is in the colon, and if there's a family history of colon cancer. So you look into all of these factors, and then you make the decision.

I think there is a misconception that every patient with IBD has the same colorectal cancer risk. They don't, as I explained earlier. So the major group I really focus on surveillance in is patients with colonic Crohn's disease or ulcerative colitis with meaningful colonic involvement. When I say meaningful, it means more than left side only involvement. If it's pancolitis or the transverse colon is involved, or somebody only has proctosigmoiditis, which means inflammation of the rectum and sigmoid, then their risk is not increased.

We also look at the disease interval after eight years risk complete. So we start at around eight years of a disease. And then more important part after that is the features I talked about earlier, and then you decide how soon or how late you're going to do the surveillance after that. For someone with extensive disease, significant inflammatory burden, previous dysplasia, strong family history, or PSC, I may do once a year. For somebody who's really under complete control with nothing going on, then I will do it probably three years. So that's how I think about it. But if somebody has PSC, which means primary sclerosing cholangitis, definitely once a year.

Now, how do we do it? It used to be that we randomly used to take biopsies every few centimeters, every ten centimeters, but now we're moving away from that. We do high-definition colonoscopy. We do careful inspection. The most important part is really a clean prep. A prep needs to be very clean for this. And then we also use a virtual chromoendoscopy, not using a dye anymore. So with that, we can really find subtle changes, and we can targeted biopsy that. So sometimes I do that if there is a significant disease that I do random plus targeted. So that's how I do the biopsy.

But I'll tell you something else, the important part. I always tell my patient, "The best surveillance, in my opinion, is to actually control the inflammation."

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 proactive IBD management.

So Dr. Gagneja, if we shift gears for a moment, how do you prevent and monitor for Crohn's recurrence after ileocecal resection?

Dr. Gagneja:

So that's also a good preventive strategy. I tell my patients that surgery treats the complications of Crohn's disease, but it does not cure Crohn's disease. That's the important part. Unfortunately, recurrence is very common, and if we simply operate and then forget about it, 60 or 70 percent patients will recur.

The biggest mistake I see is to wait until the patients start having symptoms such as anemia, abdominal pain, or diarrhea. By that point, recurrence has already taken. So preventive strategy also starts with a risk stratification. Think about it; start thinking about it this way. If somebody needed surgery, they probably had severe disease anyway to start with. So now, if somebody's smoking or has penetrating disease, prior resections, or other high-risk features, we'll be more aggressive with postoperative medical therapy. For those patients, I really start biologics right away, actually. But then, I also like early objective monitoring. I usually do a colonoscopy six to 12 months after surgery and look at the new terminal ileum. Usually, if I start seeing some aphthous ulcerations and something like that, then we go ahead and start the medication as well.

To me, the key is it should be managed proactively and not reactively. What I see in practice still today is the worst postoperative strategy that people use: "Oh, let's see how the patient does." By the time your patient's having symptoms, you really have lost the opportunity to prevent recurrence.

Dr. Buch:

We know that hospitalized IBD patients also have a markedly elevated VTE risk, but prophylaxis is often held because of rectal bleeding. What should inpatient teams do differently regarding this, if anything?

Dr. Gagneja:

This is one area where we need to change our thinking completely—180 degrees, I would say. Hospitalized patients with active IBD are at substantially increased risk for venous thromboembolism. And active bleeding really makes clinicians think, “Really? Do I really need to do anticoagulant prophylaxis?” Understandably so because they’re nervous. But I will tell you that hematochezia, blood in the stool, from active colitis is not automatically a contraindication to VTE prophylaxis, because the inflammation that’s causing the bleeding is also dramatically increasing their thrombotic risk.

So my approach is really if there’s small bleeding, I assess the severity of the bleeding and assess the overall bleeding risk, and if patient is not hemodynamically unstable and not having other major issues, there’s no contraindication to anticoagulation.

One thing that is very important in this that I think not even just gastroenterologist, but the entire patient team needs to know about, is I have seen in my practice—I was in fellowship, I cannot forget—I have seen a death from a saddle pulmonary embolism in a young patient who had severe ulcerative colitis because of a DVT. To me, this is so important.

Dr. Buch:

What’s the best way to make sure these prevention steps don’t get missed in a busy practice?

Dr. Gagneja:

As clinicians, we are so busy and doing so many things, and we really can’t rely on memory about everything, right? So prevention has to really become a part of our whole system. So this is where I think one place where electronic medical records really help. The checklist is very important. Every IBD visit should have at least few things which are automatic. One, is the disease objectively controlled? Are we monitoring the appropriate biomarkers? Is this patient up to date on vaccinations? Have we talked about smoking, bone health, nutrition? How is the colorectal cancer surveillance? Is it appropriate? What about mental health in these patients? Which I will admit is one part I lack in my practice. I don’t spend too much time on that, but I think we should.

So my thought process really is controlling the disease, improving the quality of life, and most importantly, preventing long-term complications. When I talk to my patients, I say, “You know what? My goal is to take care of your disease process. By doing that, I also want to improve the quality of life for you.” Also, I may not be verbalizing this, but I’m thinking “how to prevent long-term complications for you.” So that’s how I think it should be done in practice. Good IBD care isn’t just about putting out today’s fire; it’s about making sure the patient doesn’t have a bigger fire five, 10, or 15 years down the road.

Dr Buch:

That’s a great way to wrap up our conversation. I want to thank my guest, Dr. Harish Gagneja, for joining me to discuss how we can stay ahead of IBD complications. Dr. Gagneja, it was great having you on the program.

Dr. Gagneja:

Thank you so much for having me.

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.