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The Important Role of Preventive Screening in IBD: How, Who, and Does It Matter?

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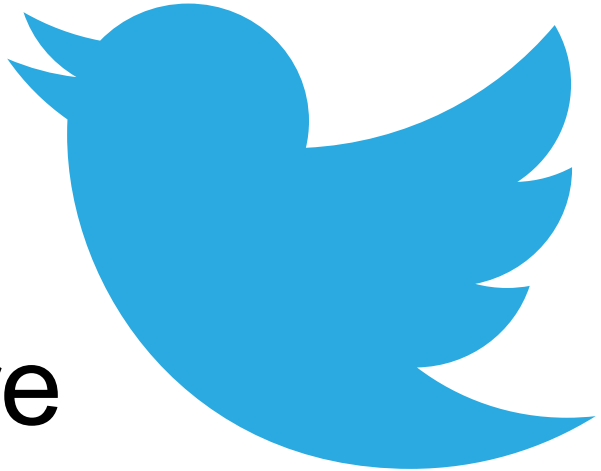

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Learning Objective 1

Integrate preventive screenings into practice to improve health outcomes in all patients with IBD.

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Learning Objective 2

Initiate interdisciplinary collaboration to provide optimal care for patients with IBD.

Case Study: Lynn

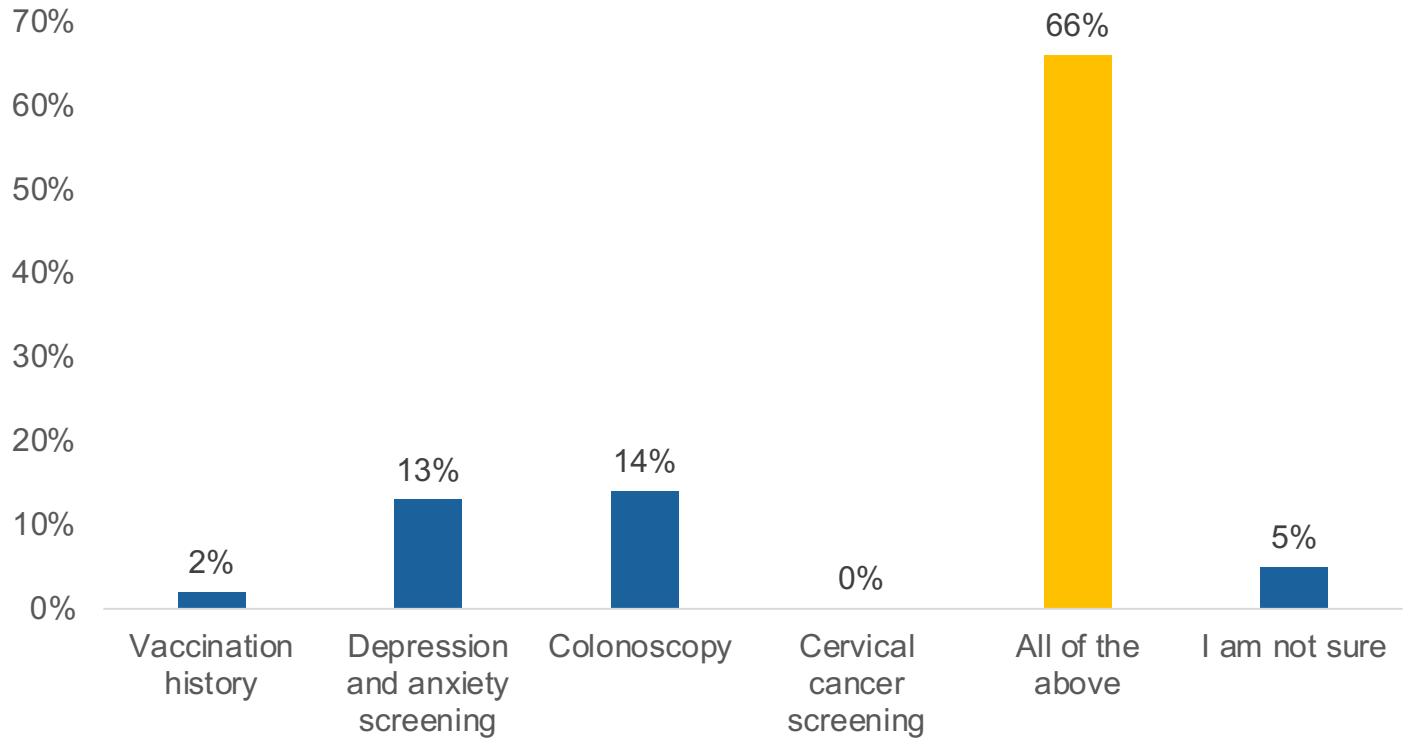
- 30-year-old African American female
- Newly diagnosed, moderate-to-severe ileocolonic Crohn's disease (CD)
- Prescribed 5 mg/kg infliximab, 15 mg methotrexate 6 months ago
- Her symptoms have improved but are not back to baseline
- Reports that the burden of her disease makes her sad as well as anxious about attending social gatherings
- States that she notices certain foods trigger her symptoms; she asks for information on special diets that will ease her symptoms

Audience Response

What kind of health care maintenance would you recommend in our patient, Lynn?

A. Vaccination history
B. Depression and anxiety screening
C. Colonoscopy
D. Cervical cancer screening
E. All of the above
F. I am not sure

What kind of health care maintenance would you recommend in our patient, Lynn?



Results recorded on November 8, 2021.

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Recommended Screenings for Patients with IBD

For all patients:

- Screening for latent tuberculosis (TB) at baseline
- Screening for smoking status at baseline; current smokers should be referred for smoking cessation therapy
- Screening for depression (PHQ9) and anxiety (GAD7) at baseline, and annually

For patients being treated with systemic immunosuppression*:

- Annual total body skin exams to screen for skin cancer
- Women should undergo cervical cancer screening by cytology annually (if cytology alone) or every 3 years (if HPV negative)

*Systemic immunosuppression refers to current treatment with prednisone (> 20 mg/day for more than 14 days), azathioprine (> 2.5 mg/kg/day), mercaptopurine (> 1.5 mg/kg/day), methotrexate (> 0.4 mg/kg/week), cyclosporine, tacrolimus, infliximab, adalimumab, golimumab, certolizumab, ustekinumab, or tofacitinib

HPV = human papillomavirus

Syal G, et al. *Inflamm Bowel Dis.* 2021;27(10):1552-1563.

Health Maintenance Video by Dr. Sara El Ouali

Recommended Screenings for Patients with IBD: Special Cases

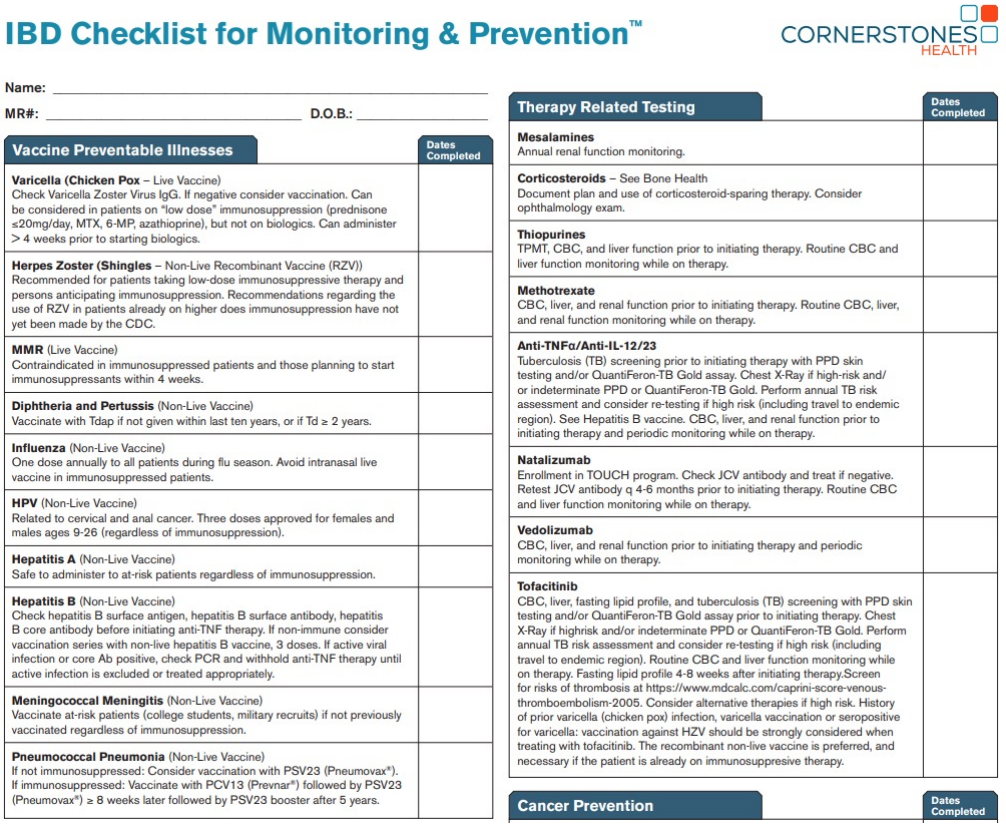
- All patients with extensive colitis (> 1/3 of the colon) for ≥ 8 years should undergo surveillance colonoscopy every 1-3 years, depending on cancer risk
- All patients should be screened for osteoporosis by central (hip & spine) DEXA if ANY risk factors for osteoporosis (i.e., low BMI, > 3 months cumulative steroid exposure, smoker, post-menopausal, hypogonadism) are present, and it should be repeated in 5 years

BMI = body mass index

Syal G, et al. *Inflamm Bowel Dis.* 2021;27(10):1552-1563.

Monitoring and Prevention Checklist

https://www.cornerstoneshealth.org/ibd-checklists/



IBD Checklist for Monitoring & Prevention™

CORNERSTONES HEALTH

Name: _____

MR#: _____ D.O.B.: _____

Vaccine Preventable Illnesses	Dates Completed
Varicella (Chicken Pox – Live Vaccine) Check Varicella Zoster Virus IgG. If negative consider vaccination. Can be considered in patients on "low dose" immunosuppression (prednisone ≤20mg/day, MTX, 6-MP, azathioprine), but not on biologics. Can administer > 4 weeks prior to starting biologics.	
Herpes Zoster (Shingles – Non-Live Recombinant Vaccine (RZV)) Recommended for patients taking low-dose immunosuppressive therapy and persons anticipating immunosuppression. Recommendations regarding the use of RZV in patients already on higher does immunosuppression have not yet been made by the CDC.	
MMR (Live Vaccine) Contraindicated in immunosuppressed patients and those planning to start immunosuppressants within 4 weeks.	
Diphtheria and Pertussis (Non-Live Vaccine) Vaccinate with Tdap if not given within last ten years, or if Td ≥ 2 years.	
Influenza (Non-Live Vaccine) One dose annually to all patients during flu season. Avoid intranasal live vaccine in immunosuppressed patients.	
HPV (Non-Live Vaccine) Related to cervical and anal cancer. Three doses approved for females and males ages 9-26 (regardless of immunosuppression).	
Hepatitis A (Non-Live Vaccine) Safe to administer to at-risk patients regardless of immunosuppression.	
Hepatitis B (Non-Live Vaccine) Check hepatitis B surface antigen, hepatitis B surface antibody, hepatitis B core antibody before initiating anti-TNF therapy. If non-immune consider vaccination series with non-live hepatitis B vaccine, 3 doses. If active viral infection or core Ab positive, check PCR and withhold anti-TNF therapy until active infection is excluded or treated appropriately.	
Meningococcal Meningitis (Non-Live Vaccine) Vaccinate at-risk patients (college students, military recruits) if not previously vaccinated regardless of immunosuppression.	
Pneumococcal Pneumonia (Non-Live Vaccine) If not immunosuppressed: Consider vaccination with PSV23 (Pneumovax®). If immunosuppressed: Vaccinate with PCV13 (Prevnar®) followed by PSV23 (Pneumovax®) ≥ 8 weeks later followed by PSV23 booster after 5 years.	

Therapy Related Testing	Dates Completed
Mesalamines Annual renal function monitoring.	
Corticosteroids – See Bone Health Document plan and use of corticosteroid-sparing therapy. Consider ophthalmology exam.	
Thiopurines TPMT, CBC, and liver function prior to initiating therapy. Routine CBC and liver function monitoring while on therapy.	
Methotrexate CBC, liver, and renal function prior to initiating therapy. Routine CBC, liver, and renal function monitoring while on therapy.	
Anti-TNFα/Anti-IL-12/23 Tuberculosis (TB) screening prior to initiating therapy with PPD skin testing and/or QuantiFeron-TB Gold assay. Chest X-Ray if high-risk and/or indeterminate PPD or QuantiFeron-TB Gold. Perform annual TB risk assessment and consider re-testing if high risk (including travel to endemic region). See Hepatitis B vaccine. CBC, liver, and renal function prior to initiating therapy and periodic monitoring while on therapy.	
Natalizumab Enrollment in TOUCH program. Check JCV antibody and treat if negative. Retest JCV antibody q 4-6 months prior to initiating therapy. Routine CBC and liver function monitoring while on therapy.	
Vedolizumab CBC, liver, and renal function prior to initiating therapy and periodic monitoring while on therapy.	
Tofacitinib CBC, liver, fasting lipid profile, and tuberculosis (TB) screening with PPD skin testing and/or QuantiFeron-TB Gold assay prior to initiating therapy. Chest X-Ray if highrisk and/or indeterminate PPD or QuantiFeron-TB Gold. Perform annual TB risk assessment and consider re-testing if high risk (including travel to endemic region). Routine CBC and liver function monitoring while on therapy. Fasting lipid profile 4-8 weeks after initiating therapy.Screen for risks of thrombosis at https://www.mdcalc.com/caprini-score-venous-thromboembolism-2005. Consider alternative therapies if high risk. History of prior varicella (chicken pox) infection, varicella vaccination or seropositive for varicella: vaccination against HZV should be strongly considered when treating with tofacitinib. The recombinant non-live vaccine is preferred, and necessary if the patient is already on immunosuppresive therapy.	

Cancer Prevention	Dates Completed

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Health Maintenance Checklist

https://www.crohnscolitisfoundation.org/science-and-professionals/education-resources/health-maintenance-checklists

Health Maintenance Summary

Vaccines and Infections

Influenza: All patients >6 months of age should receive annual inactivated influenza vaccine, irrespective of immunosuppression status.

MMR: IBD Patients not immune to MMR should receive a 2-dose series, at least 4 weeks apart. If immune status is uncertain, IgG antibody titer should be checked. MMR should not be given to patients currently on systemic immunosuppressive* therapy.

Pneumococcus: All patients >19 years age receiving systemic immunosuppression* should receive PCV13, followed by PPSV23 at least 8 weeks later, and a booster of PPSV23 5 years later.

Varicella: Seroprotection status should be checked with varicella zoster virus IgG antibodies in all patients without documented vaccination record or exposure. All patients who are not immune should receive a 2-dose series, 4–8 weeks apart, ≥4 weeks before immunosuppression, if therapy can be postponed.

Zoster: All patients receiving JAK inhibitor therapy should receive the recombinant adjuvanted zoster vaccine. Risk of zoster should be considered with combinations of other immunosuppressive* therapies.

TB: Screen for latent TB in all patients with IBD, at baseline. Perform clinical risk assessment for TB exposure annually in all patients with IBD.

Cancer Screening

Colorectal Cancer: All IBD patients with extensive colitis (>1/3 of the colon) for ≥ 8 years should undergo surveillance colonoscopy every 1–3 years, depending on cancer risk;

- IBD patients with a diagnosis of PSC should undergo colonoscopy, starting at the time of PSC diagnosis, and annually thereafter.
- IBD patients with features that are high-risk for developing colon cancer (i.e. prior history of adenomatous polyps, dysplasia, family history of colon cancer and extensive colitis) should have colonoscopies more frequently than every 3 years.

Cervical Cancer: All women with IBD who are being treated with systemic immunosuppression* should undergo cervical cancer by cytology annually (if cytology alone) or every 2 years (if HPV negative).

Skin Cancer: All IBD patients being treated with systemic immunosuppression* should have annual total body skin exams to screen for skin cancer.

Other Protection

Osteoporosis: Screen for osteoporosis by central (hip and spine) DXA scan in all patients with IBD if ANY risk factors for osteoporosis; low BMI, >3 months cumulative steroid exposure, smoker, post-menopausal, hypogonadism. Repeat in 5 years if initial screen is normal.

Depression/Anxiety: Screen all patients with IBD for depression (PHQ9) and anxiety (GAD7) at baseline, and annually. Refer for counseling/therapy when identified.

Smoking: Screen all patients with IBD for smoking status at baseline, and refer current smokers for smoking cessation therapy.

Audience Response

Which type of vaccination should our patient, Lynn, receive, considering she is on infliximab and methotrexate?

A. Pneumococcal pneumonia

B. Influenza

C. Hepatitis A

D. Hepatitis B

D. All of the above

F. I am not sure

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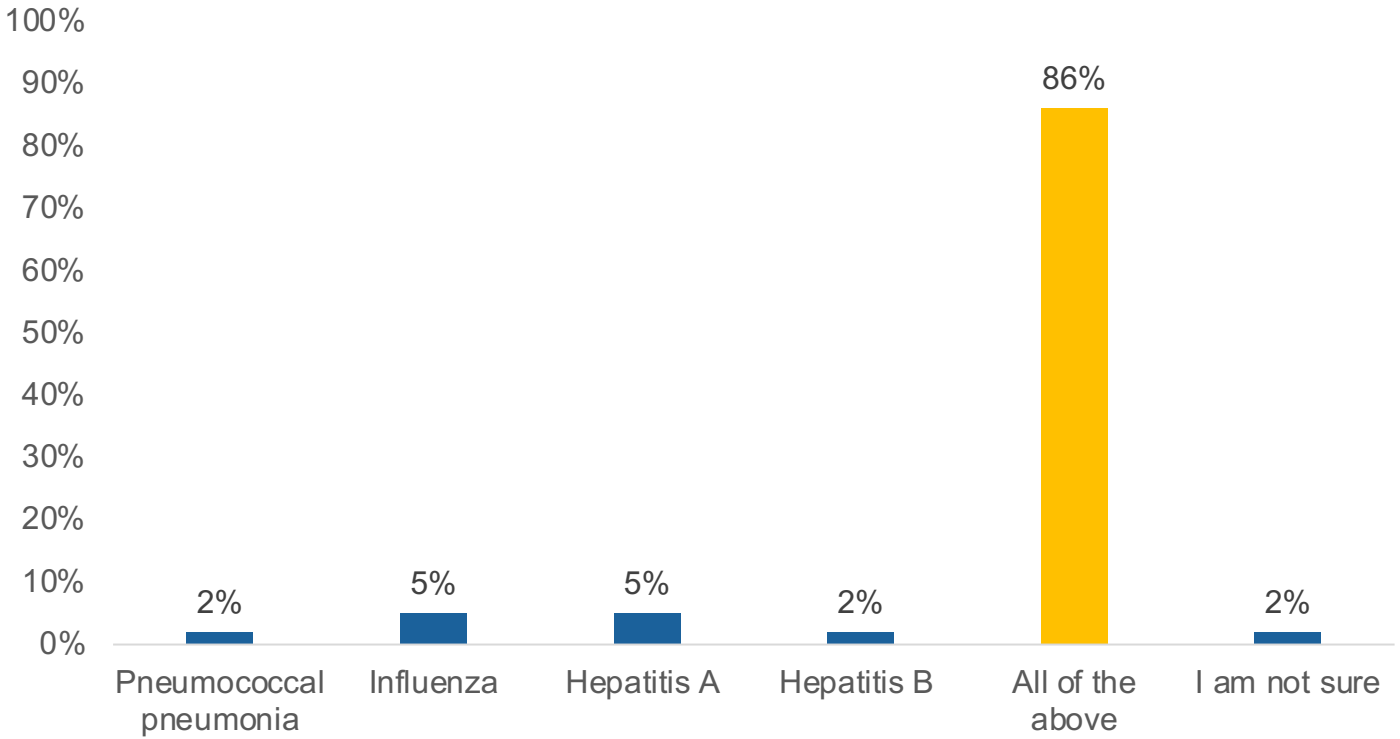
Which type of vaccination should our patient, Lynn, receive, considering she is on infliximab and methotrexate?



Results recorded on November 8, 2021.

Vaccinations for Patients with IBD

- Appropriate immunizations are an important component of preventive services for patients with IBD
- Immunosuppressive therapy puts patients at increased risk of developing vaccine-preventable illnesses
- Many gastroenterologists feel it is the role of the primary care provider (PCP) to administer vaccines, which leads to gaps in care
- Immunization status should be detailed during the first office visit, and required vaccines should be administered before immunosuppressive medication is started

Wasan SK, et. al. *Inflamm Bowel Dis*. 2014;20(2):246-250. Reich J, et al. *Gastroenterol Hepatol (N Y)*. 2016;12(9):540-546.

Interdisciplinary Approach for Managing IBD

- IBD care is managed by gastroenterologists and, when required, colorectal surgeons but ideally should be managed by an interdisciplinary team
- Several specialists involved in IBD patient care
- Increased risk of complications due to disease or treatment medications
- Responsibility for vaccinations and screenings must be assumed by a member of the care team

Syal G, et al. *Inflamm Bowel Dis.* 2021;27(10):1552-1563. Ghosh S. *Can J Gastroenterol*. 2013;27(4):198.

Members of the Interdisciplinary Team

- The team can include the following members:

Gastroenterologist	Dietitian
Surgeon	Psychologist
Nurse practitioner	Pharmacist
Social worker	PCP

- Can assist with the following screenings:

Dietitian – diet to minimize symptoms
Nurse practitioner – diet, smoking status, vaccinations, depression, and anxiety screening
Social worker – address social determinants of health
Psychologist – depression and anxiety screening
Pharmacist – vaccinations

Ghosh S. *Can J Gastroenterol*. 2013;27(4):198.

Patient Interaction Video by Dr. Sara El Ouali

How Gastroenterologists Can Improve Screening in Patients with IBD

- Holistic approach and better communication with PCPs as well as explicit clarification of roles regarding screenings and immunizations
- Strong therapeutic physician-patient relationships and shared decision-making are crucial to optimal outcomes
- Telehealth interventions may provide improved disease-related knowledge, communication between patients and providers, sense of reassurance, and appointment options
- Consider a medical home center of excellence for partial or complete care

Abegunde AT, et al. *World J Gastroenterol*. 2016;22(34):7625-7644. Davis SP, et. al. *Res Nurs Health*. 2021;44:155-172.
Fisher ES. *N Engl J Med*. 2008;359(12):1202-1205.

Guidelines to Guide Preventive Care

- ACG Guidelines

https://acgcasereports.gi.org/guidelines

Management of Benign Anorectal Disorders
October 2021
Arnold Wald, MD, MACG
READ

Prevention, Diagnosis, and Treatment of *Clostridioides difficile* Infections
May 2021
Colleen R. Kelly, MD, FACG
READ

Bleeding: Upper Gastrointestinal & Ulcer - Guideline
May 2021
Loren A. Laine, MD, FACG
READ

Liver: Idiosyncratic Drug-Induced Liver Injury - Guideline
May 2021
Naga P. Chalasani, MD, FACG
READ

Colorectal Cancer Screening - Guideline
March 2021
Aasma Shaukat, MD, MPH, FACG
READ

Irritable Bowel Syndrome (IBS) Therapy - Guideline
January 2021
Brian E. Lacy, MD, PhD, FACG
READ PODCAST

- ECCO Guidelines

https://www.ecco-ibd.eu/publications/ecco-guidelines-science/published-ecco-guidelines.html

ECCO GUIDELINES ON THERAPEUTICS IN CROHN'S DISEASE: MEDICAL TREATMENT (2019)

ECCO GUIDELINES ON THERAPEUTICS IN CROHN'S DISEASE: SURGICAL TREATMENT (2019)

These are the first ECCO Guidelines to adopt the GRADE approach [Grading of Recommendations Assessment, Development, and Evaluation] in order to provide transparent, high-quality, evidence-based recommendations on medical treatment in CD. The surgical treatment manuscript utilised the traditional Oxford Levels of Evidence in order to address surgical management, including preoperative aspects and drug management before surgery.

ACG = American College of Gastroenterology; ECCO = European Crohn's and Colitis Organisation

Importance of Preventive Screenings

- Medications to treat IBD, in addition to the disease itself, can place patients at increased risk of developing complications such as osteoporosis, and malignancies
- Opportunistic infections are more common in patients with IBD; associated with immunosuppressive agent therapy
- Opportunistic infections encompass:
  - bacterial infections (e.g., *C. difficile*, pneumococcal)
  - fungal infections (e.g., histoplasmosis, *Candida*), and
  - viral infections (e.g., influenza, HPV)
- Preventive screenings reduce treatment- and disease-related complications

Zaahid M, et al. *Inflamm Bowel Dis.* 2020;26(2):291-300. Yu N, et al. *Inflamm Bowel Dis.* 2021; izab247. https://doi.org/10.1093/ibd/izab247.

How to Improve Use of Preventive Screenings

- Interventions to improve uptake of preventive screenings include:

Education to gastroenterologists and patients

Posters in exam rooms

Patient questionnaires

Yu N, et al. *Inflamm Bowel Dis.* 2021; izab247. https://doi.org/10.1093/ibd/izab247.

Ways to Improve Quality of Care

- Care standardization
- Collaboration (via health technology platforms)
- Practice guidelines
- System and provider alignment
- Quality metrics

Egberg MD, et al. *Inflamm Bowel Dis*. 2018;24(8):1660-1669.

SMART Goals

Specific, Measurable, Attainable, Relevant, Timely

- Recognize the need for preventive screenings for patients with IBD
- Adhere to guidelines for appropriate screenings and immunizations
- Collaborate with an interdisciplinary team to provide optimal patient care
- Integrate recommended preventive screenings into practice using guidelines and checklists
- Regularly discuss the importance of preventive screenings with patients with IBD

Join us for the remaining program in this series:

The Medical Neighborhood and IBD: Steps to Improve Care for All Patients

November 16, 2021

6:30 PM ET – 7:15 PM ET

All activities are available on the CMEO website and can be found in the GI hub:

https://www.cmeoutfitters.com/gastrohub/

To Ask a Question

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AFTER THE SHOW

Questions & Answers

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Visit the

Gastroenterology Hub

Free resources and education to educate health care providers and patients on IBD

https://www.cmeoutfitters.com/gastrohub/

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AFTER THE SHOW

Questions & Answers
Recorded on November 8, 2021