

Shedding Light on Bowel Urgency

Presenting the Latest Data
and Initiating Conversations
in Crohn's Disease Management





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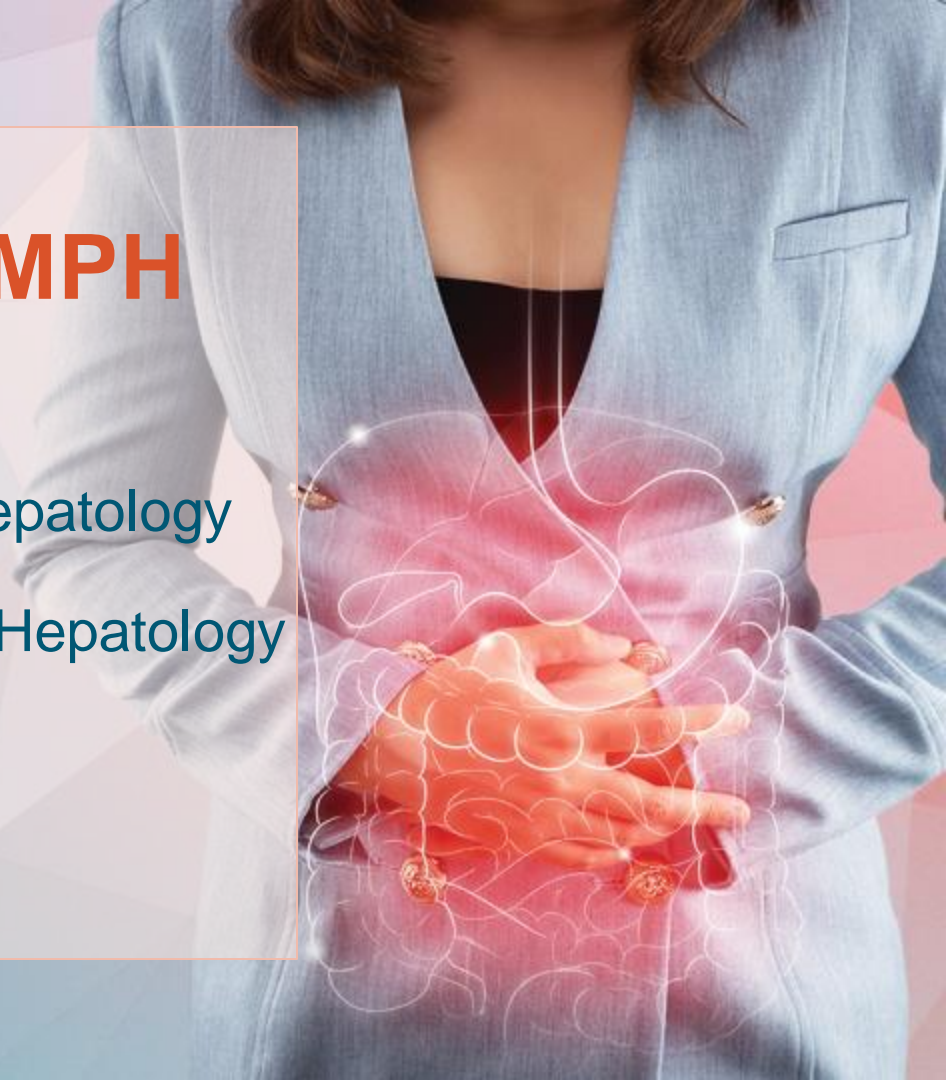
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Recognize the frequency of bowel urgency in patients with Crohn's disease (CD) and the impact on patient quality of life (QoL).

**LEARNING
OBJECTIVE**

1



Incorporate assessments for bowel urgency as part of thorough symptom evaluation for patients with CD.

**LEARNING
OBJECTIVE**

2



Engage patients in open communication about their bowel urgency as part of shared decision-making in order to improve clinical outcomes.

**LEARNING
OBJECTIVE**

3



Audience Response



How often do you incorporate bowel urgency assessments into your evaluation of patients with Crohn's disease (CD)?

- A. Always
- B. Usually
- C. Seldom
- D. Never

A person wearing a white lab coat is shown from the chest down to the waist. Overlaid on their torso is a glowing, semi-transparent anatomical diagram of the human digestive system, including the esophagus, stomach, small intestine, and large intestine. The diagram is rendered in a light blue and white color scheme, with some areas appearing to glow. The background is a solid light blue color.

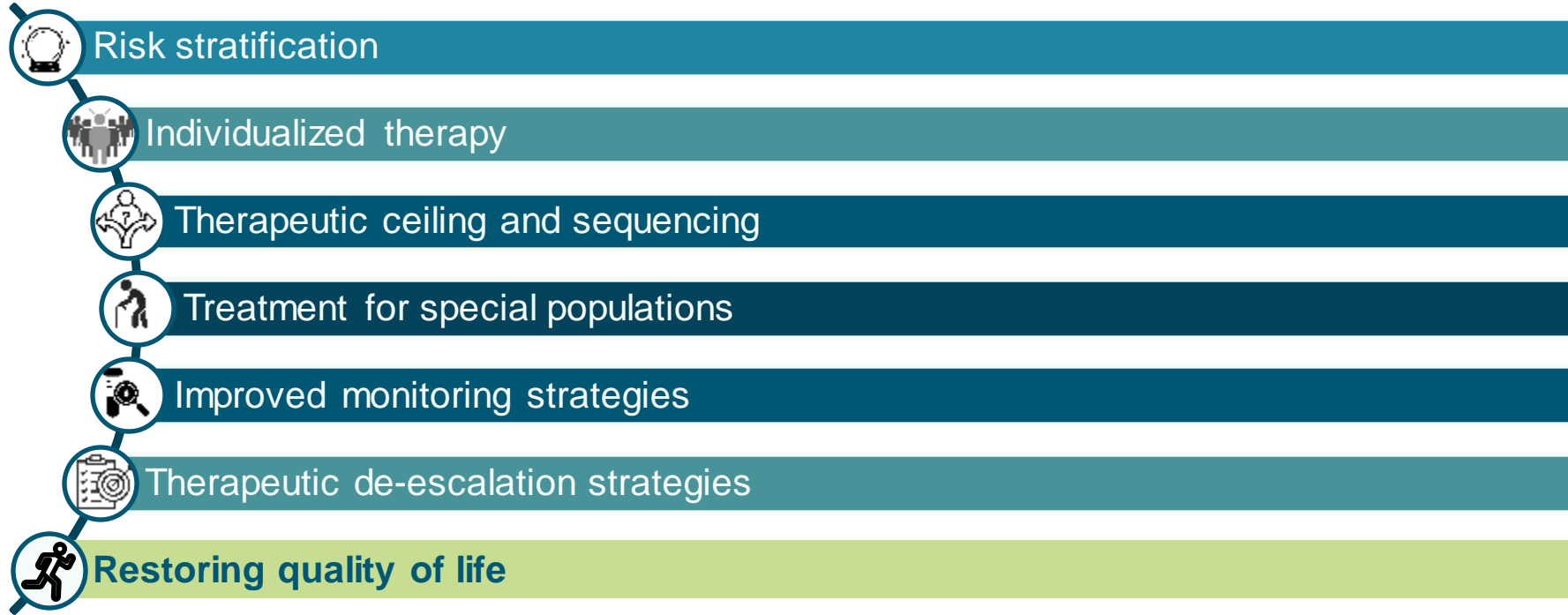
Symptom Impact in CD

Millie D. Long, MD, MPH

A person wearing a white lab coat is shown from the chest down to the waist. Overlaid on their torso is a faint, semi-transparent anatomical diagram of the human digestive system, including the esophagus, stomach, small intestine, and large intestine. The background is a light blue color with a subtle geometric pattern of overlapping triangles.

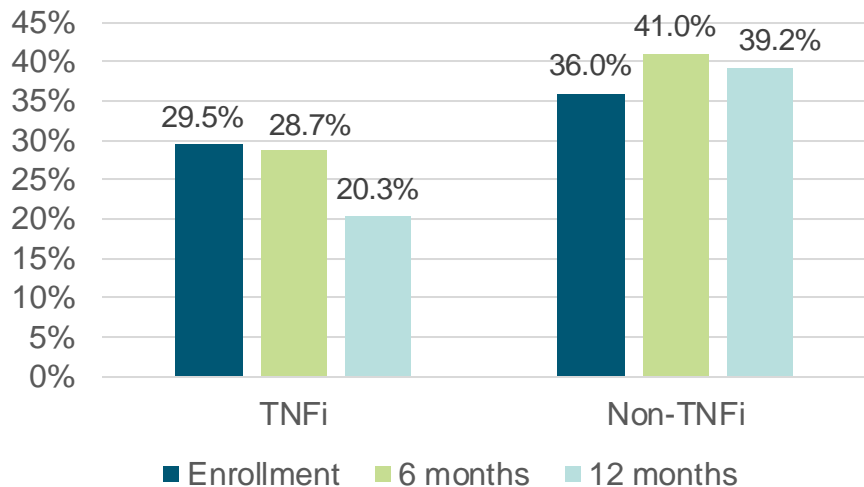
**The impact of
bowel urgency:
Cristina C.**

Unmet Needs in Crohn's Disease



Patients with CD Experience Persistent Bowel Urgency Despite Use of Advanced Therapies

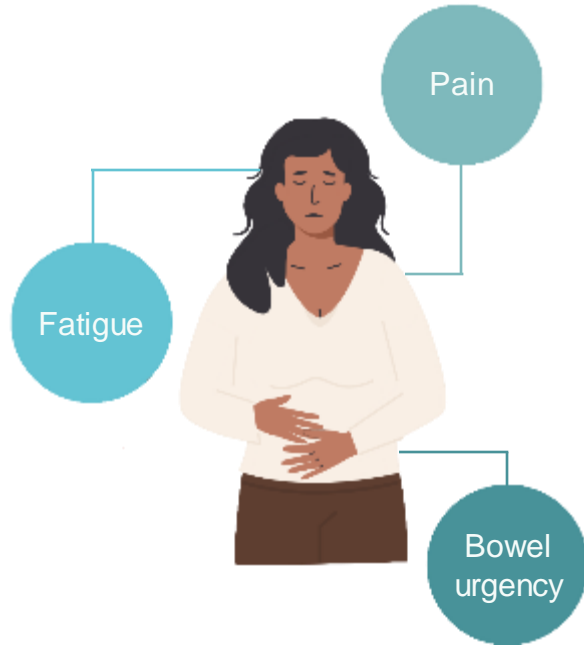
Proportion of Patients with CD Reporting Bowel Urgency by Advanced Therapy Cohort



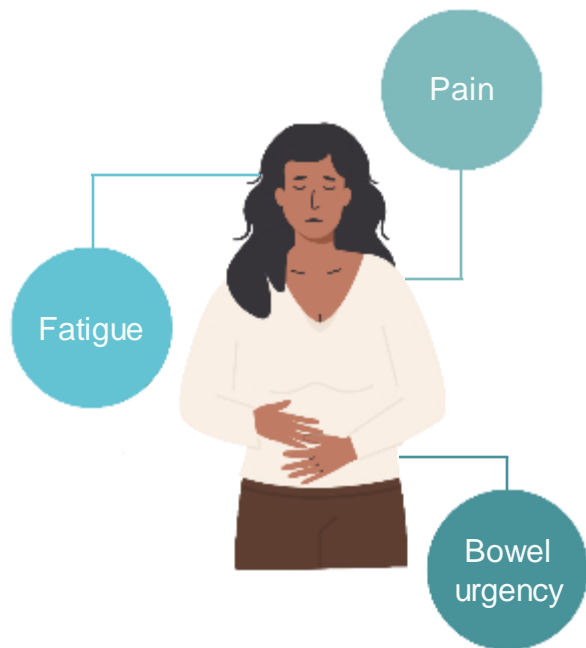
Worsening of Bowel Urgency Symptoms

	TNFi N = 332	Non-TNFi N = 200
Enrollment to 6 months	21.3%	19.9%
Enrollment to 12 months	21.7%	19.4%

Symptoms Most Impacting QoL in CD



Symptoms Most Impacting QoL in CD

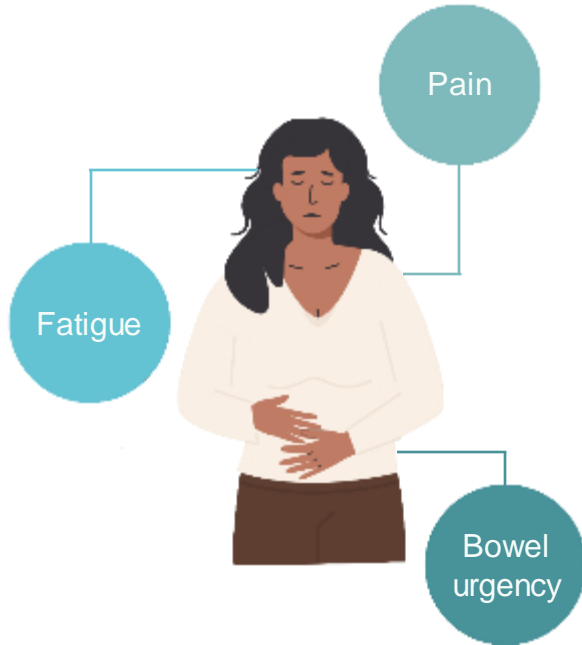


Multiple aggravators

Relentless and unpredictable symptoms

Far-reaching negative impact

Symptoms Most Impacting QoL in CD



Multiple aggravators

Requires constant planning and adaptation

Relentless and unpredictable symptoms

Creates uncertainty/anxiety

Far-reaching negative impact

Mental health

Relationship closeness and intimacy

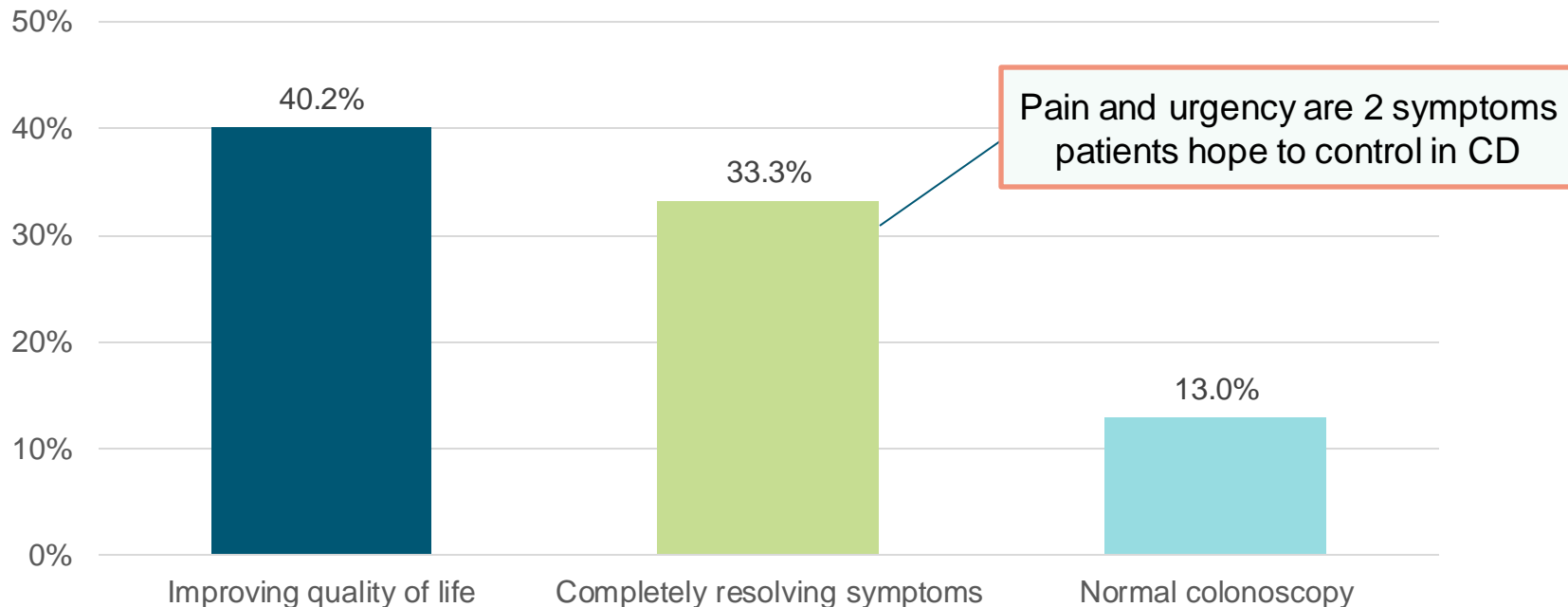
Work or school performance

Social isolation and stigma

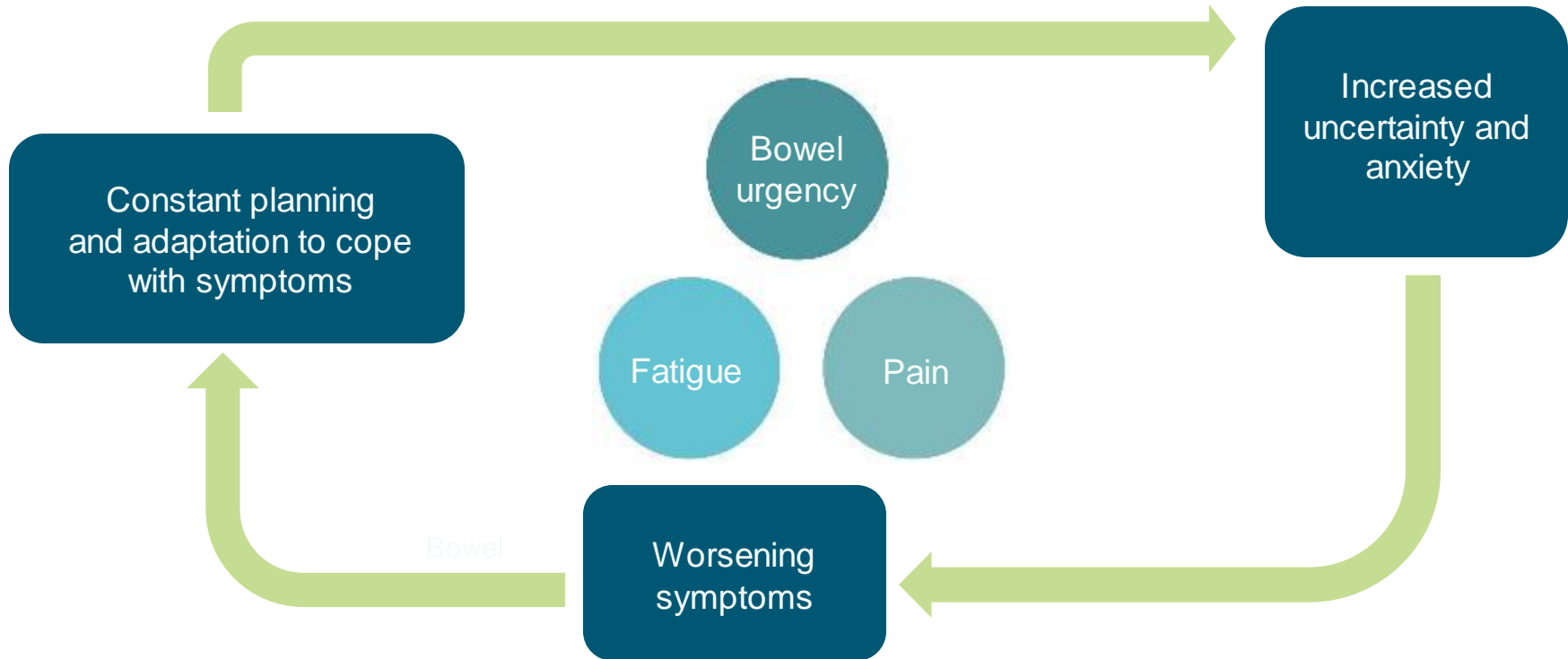
Patients with IBD Most Want Pain and Urgency to Improve with Treatment



Most Important Treatment Targets for Patients



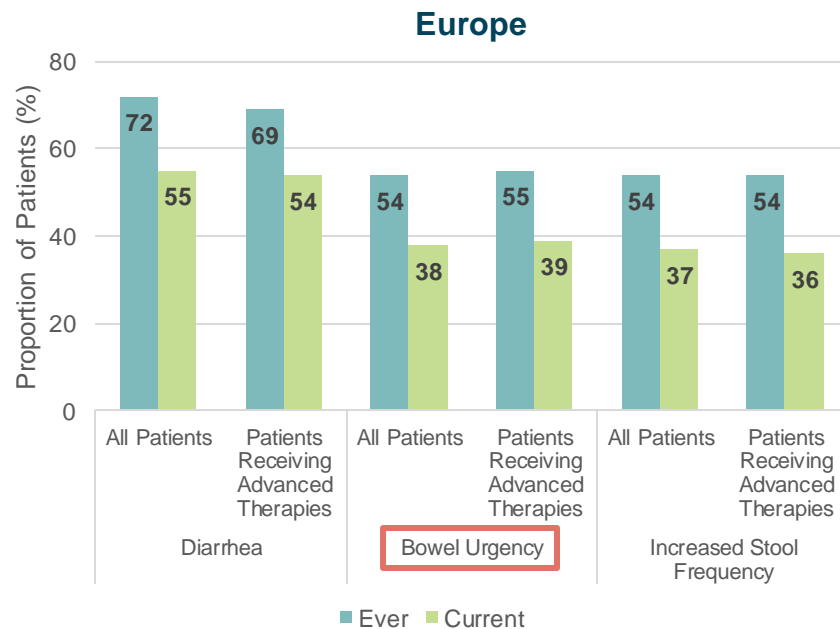
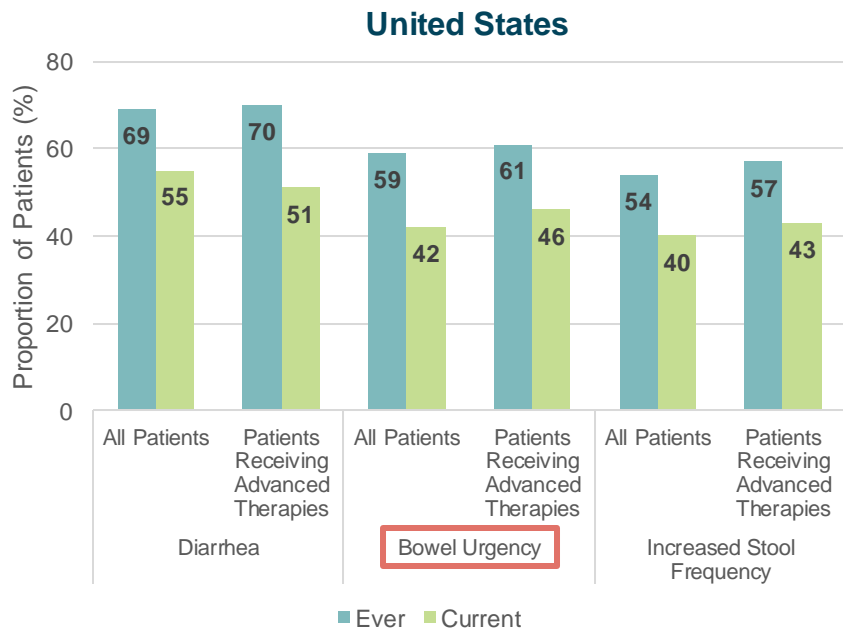
The Cycle of Adaptation to a “New Normal”



CONFIDE Survey Results



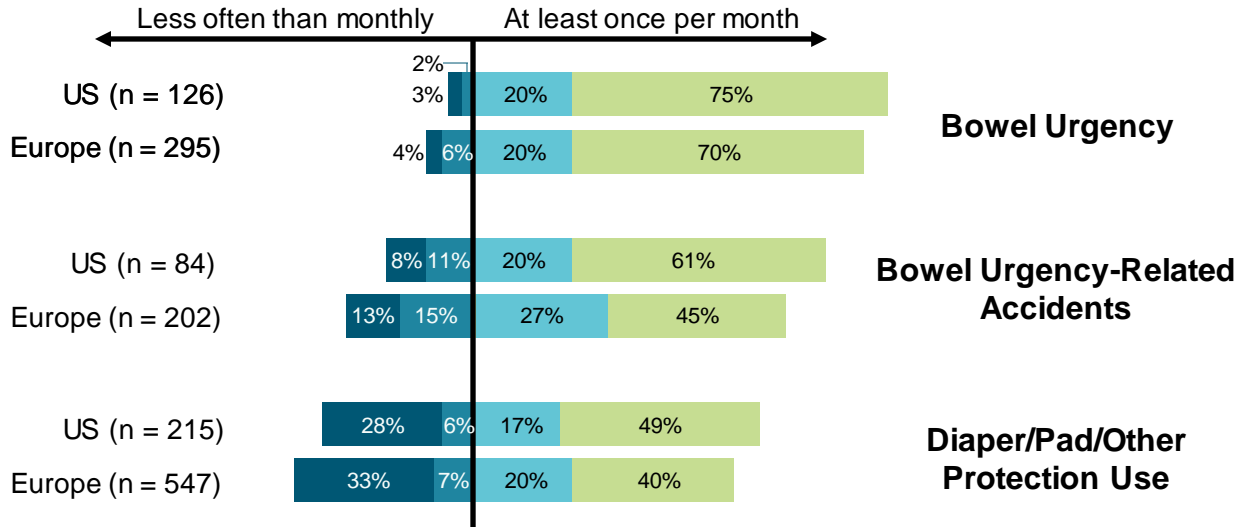
Bowel urgency was among the top three most frequently reported CD symptoms



CONFIDE Survey Results



Patients with CD



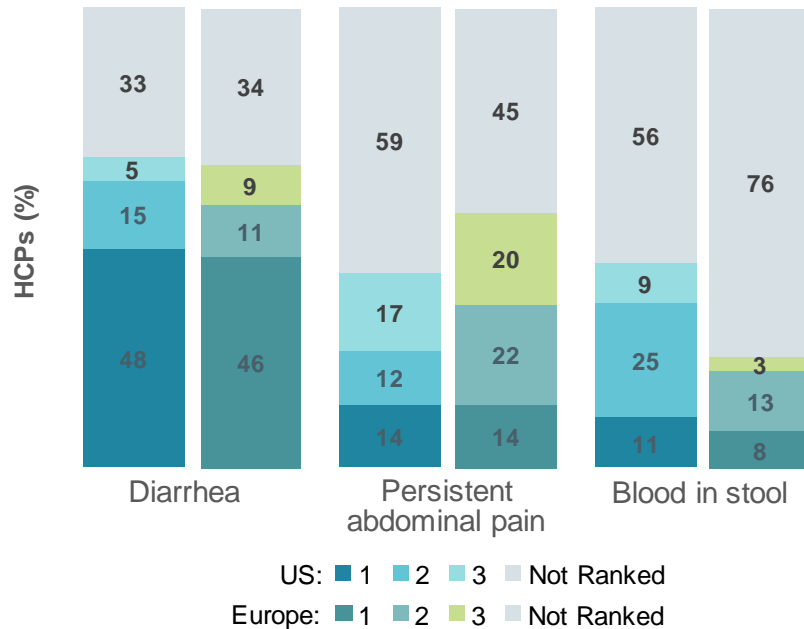
Bowel urgency is just as much of an issue in CD as it is in UC

CONFIDE Survey Results

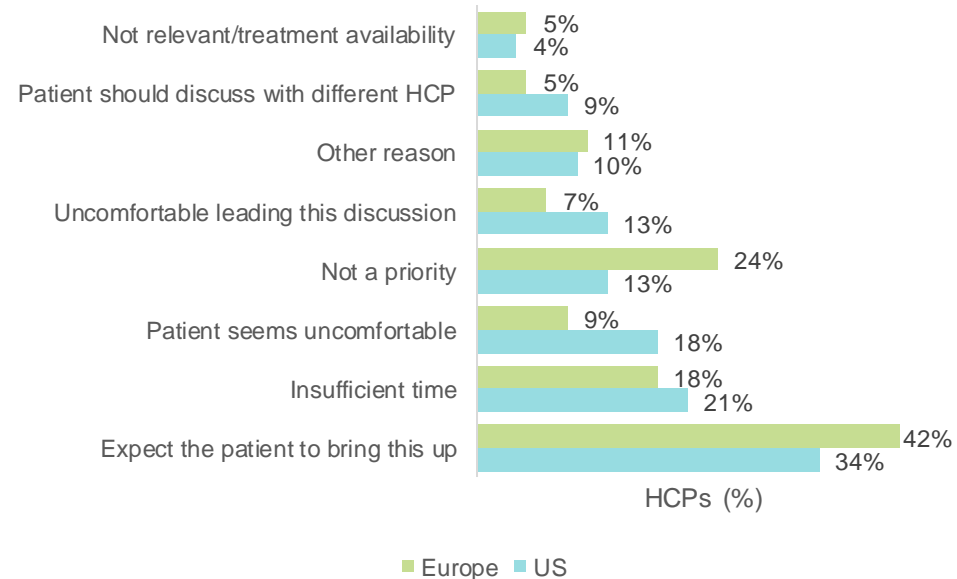
81% of US and 85% of European HCPs **did not rank bowel urgency** among the symptoms most reported by patients

HCPs **do not proactively discuss bowel urgency and bowel urgency-related accidents** with patients

Ranking of HCP-perceived top three CD symptoms reported by patients



HCP-reported reasons for not proactively discussing bowel urgency



HCPs = health care professionals.



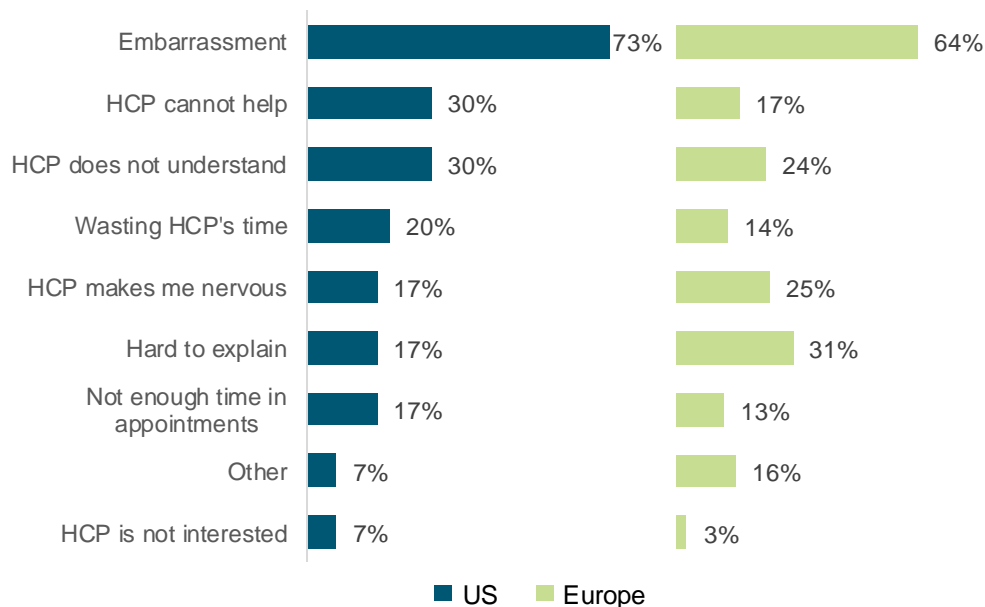
CONFIDE Survey Results



▶ **Embarrassment was the most common reason** for patient discomfort in discussing bowel urgency and bowel urgency-related accidents with HCPs

▶ Only **40% of US** and **27% of European patients** were completely comfortable discussing bowel urgency with their HCPs

Patient-reported reasons for not feeling comfortable discussing bowel urgency

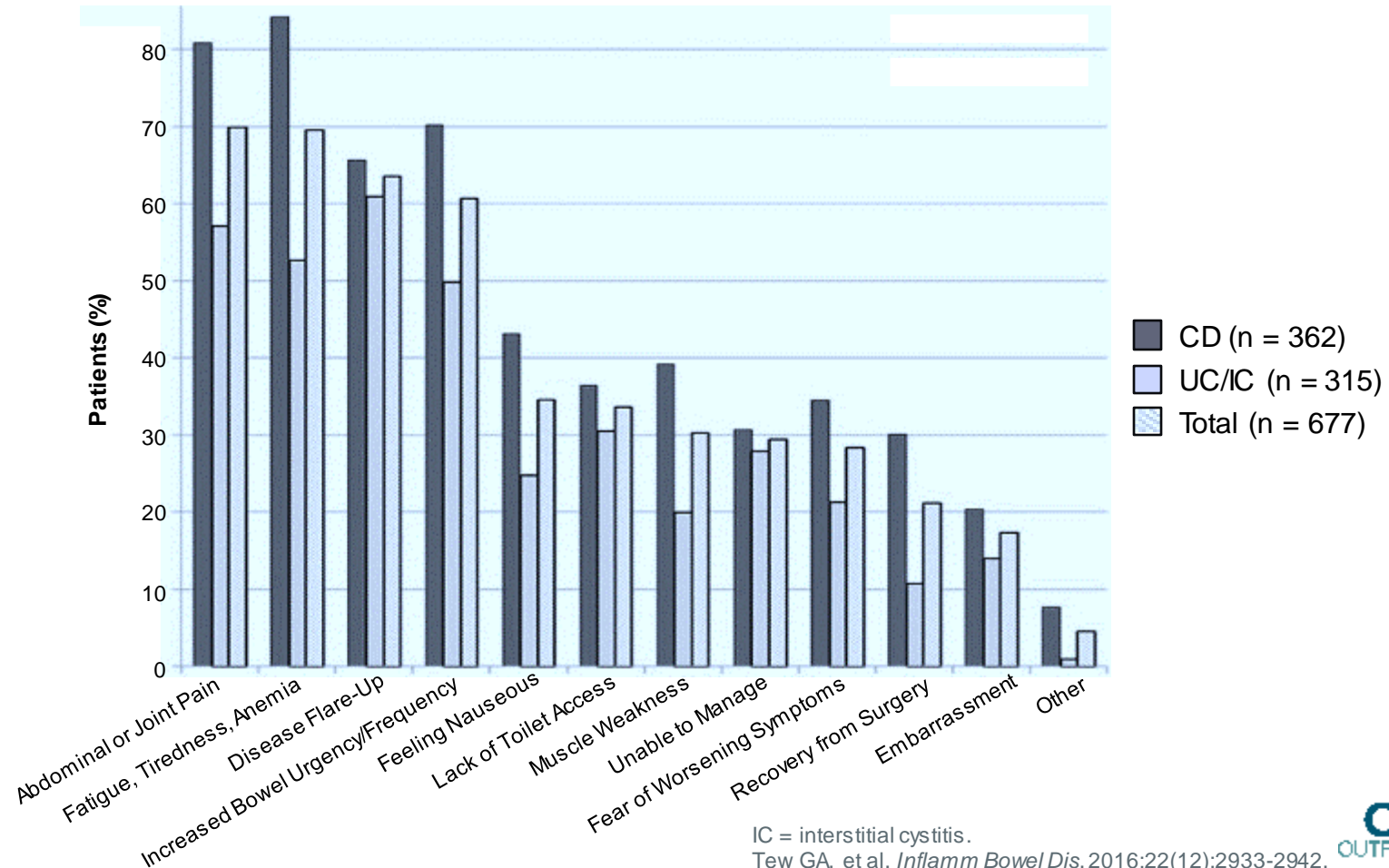


Impact of IBD on Daily Activity



- ▶ 79% of patients limited physical activity
- ▶ 34% of patients reported avoiding running or jogging
- ▶ Reasons for limited activity
 - ▶ 70% fatigue/tiredness
 - ▶ 69% disease flare-ups
 - ▶ 61% increased toilet urgency

Reasons for Avoiding Activity in IBD

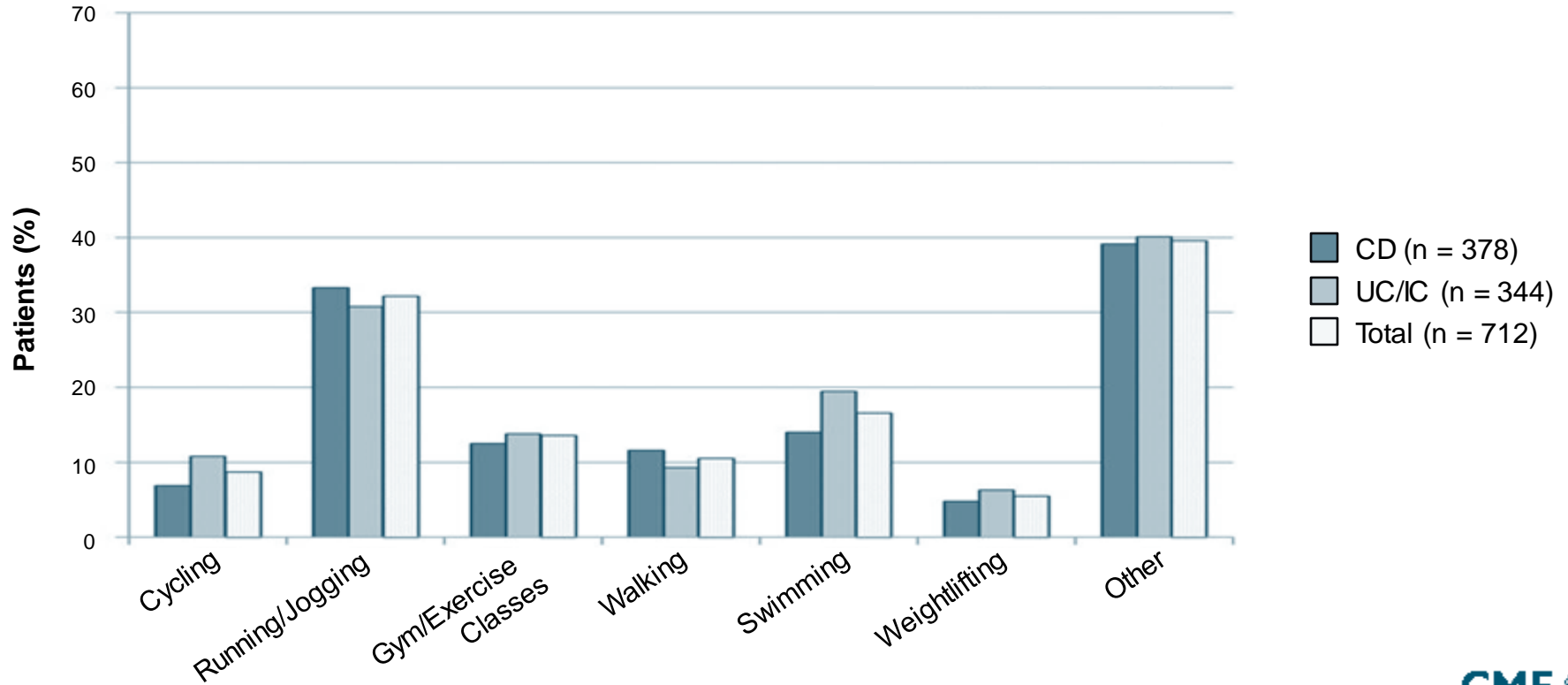


IC = interstitial cystitis.

Tew GA, et al. *Inflamm Bowel Dis.* 2016;22(12):2933-2942.

Activity Adaptation in IBD

Activities Avoided



IBD and Sexual Health



- ▶ Sexual functioning, satisfaction, and drive can be negatively impacted by IBD and can impact QoL



Survey of 426 gastroenterologists

70% never or rarely ask patients about sexual dysfunction

75% did not change treatment if a patient reported sexual dysfunction

Gastroenterology survey reported barriers to addressing sexual dysfunction during appointments

Lack of knowledge
(80%)

Lack of experience
(58%)

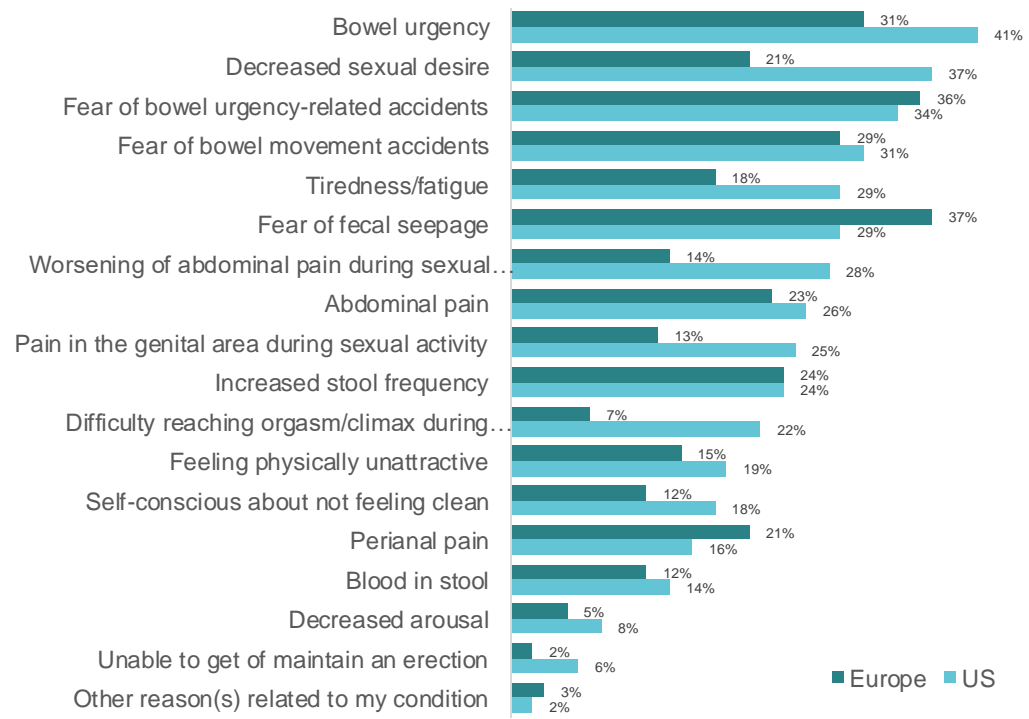
Lack of time
(44%)

Embarrassment
(30%)

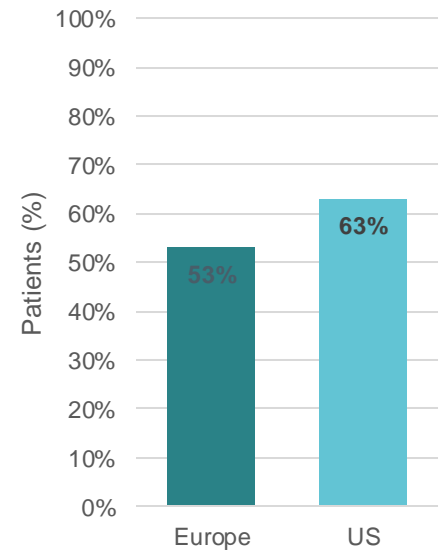
Impact of Bowel Urgency on Sexual Activity



Patient-provided reasons for avoiding or decreasing sexual activity



Patients who avoided or decreased sexual activity in the last 3 months



MUSIC Study: Significant Proportion of Patients with CD Reported Bowel Urgency



Characteristic	Bowel Urgency (UNRS 2-10)* n = 883	No or Minimal Bowel Urgency (UNRS 0-1)* n = 650	P Value**
Age (years), mean (SD)	54.1 (15.5)	53.4 (16.1)	.320
Female gender, n (%)	632 (73)	452 (70)	.290
Education (> high school), n (%)	789 (89)	601 (92)	.039
Caucasian (White), n (%)	789 (89)	592 (91)	-
Current smoking (yes), n (%)	29 (3)	11 (2)	.053
Body mass index, mean (SD)	26.8 (6.3)	25.3 (4.9)	< .001
Disease duration (years), mean (SD)	25.7 (14.1)	23.7 (13.7)	.003
Ever GI surgery (yes), n (%)	540 (61)	311 (48)	< .001
Ever GI hospitalization (yes), n (%)	649 (73)	417 (64)	< .001
Number hospitalizations, mean (SD)	3.9 (2.6)	3.1 (2.3)	< .001
Remission (yes), n (%)	544 (62)	599 (92)	< .001

58% of patients reported bowel urgency

Bowel urgency was higher among patients with active disease as compared to those in remission (87% vs 48%, $p < .001$)

*Urgency was measured using 11-point UNRS: 0-1 = no minimal bowel urgency, 2-10 = bowel urgency.

**Chi-square test was used to compare no or minimal bowel urgency vs bowel urgency for each of the categorical variables and t-test was used for continuous variables.

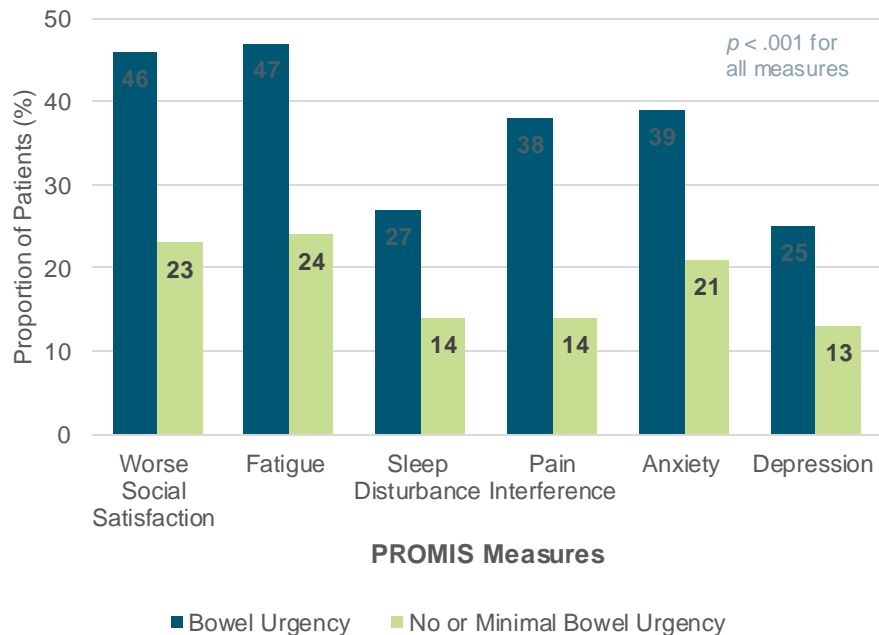
GI = gastrointestinal; SD = standard deviation.

Long MD, et al. Prevalence of bowel urgency and its association with quality of life in a real-world Crohn's disease population: results from the Measuring Urgency Symptoms in Inflammatory Bowel Disease Collaboration (MUSIC) study. Poster presented at American College of Gastroenterology [ACG]; 2023.

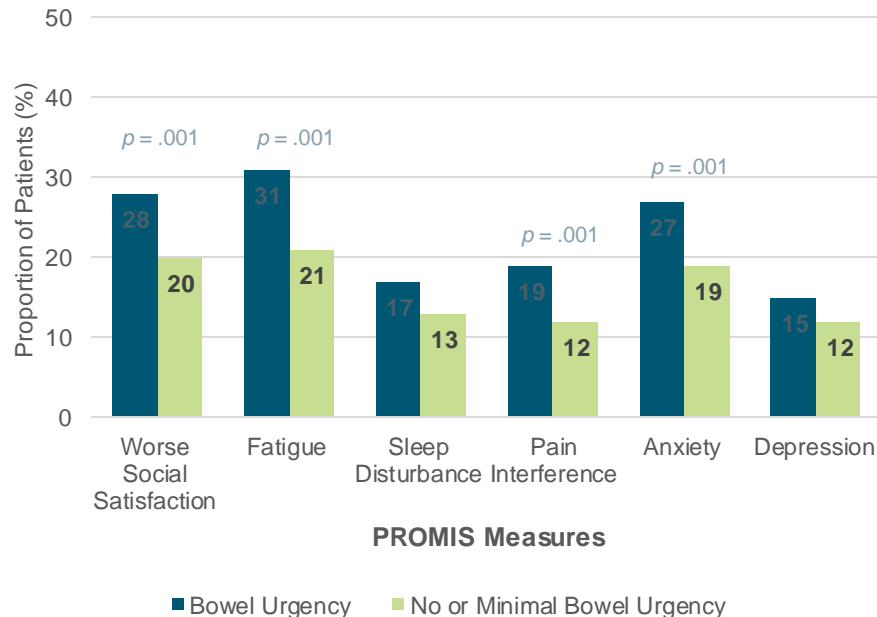
MUSIC Study: Bowel Urgency Negatively Impacted Quality of Life in CD



Patients with bowel urgency had significantly worse quality of life



Of those **in remission**, bowel urgency was significantly associated with anxiety, pain, fatigue, and worse social satisfaction



Summary: Impact of Bowel Urgency



- ▶ Urgency is prevalent in Crohn's disease
- ▶ Embarrassment is a common reason patients avoid bringing it up
- ▶ Almost half of patients report using pads, liners, or diapers at least once a week due to bowel urgency
- ▶ Patients frequently avoid physical and social activities due to bowel urgency
- ▶ Urgency is the most commonly reported reason for decreasing sexual activity

A person wearing a white lab coat is shown from the chest down to the waist. Overlaid on their torso is a glowing, semi-transparent anatomical diagram of the human digestive system, including the esophagus, stomach, small intestine, and large intestine. The background is a light blue color with a faint geometric pattern of overlapping triangles.

Assessments for Bowel Urgency

Marla Dubinsky, MD

Audience Response



Which of the following assessments captures bowel urgency impact in patients with CD?

- A. CDAI
- B. HBI
- C. UNRS
- D. IBDQ
- E. I don't know

Defining Bowel Urgency



Definition Use in Study	N
Inability to defer defecation for more than 15 minutes	4
No definition	20
Not making it to the toilet in time	1
Immediate need to defecate	1
Hurry to/immediately go to the bathroom/unable to make it in time	1
Simple Clinical Colitis Activity Index (SCCAI) definition	2
Having to rush to the toilet to avoid an accident	1
Sudden and severe urge to defecate	1
Inability to defer defecation for more than 5 minutes after the first call to stool	2
Having to urgently visit the toilet to pass stool	1
Urgency to go to the bathroom	1
An irresistible and urgent desire to defecate	1

Barriers to Identifying Bowel Urgency in Patients with CD



Does normal stool frequency mean no bowel urgency?



55% of patients report urgency symptoms with no change in stool frequency



Commonly Used CD Disease Activity Indices

- ▶ Clinical Disease Activity Index (CDAI)
- ▶ Harvey-Bradshaw Index (HBI)
- ▶ Inflammatory Bowel Disease Questionnaire (IBDQ)
- ▶ Patient reported outcome-2 (PRO-2)

Commonly Used CD Disease Activity Indices



- ▶ Clinical Disease Activity Index (CDAI)
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- ▶ Patient reported outcome-2 (PRO-2)

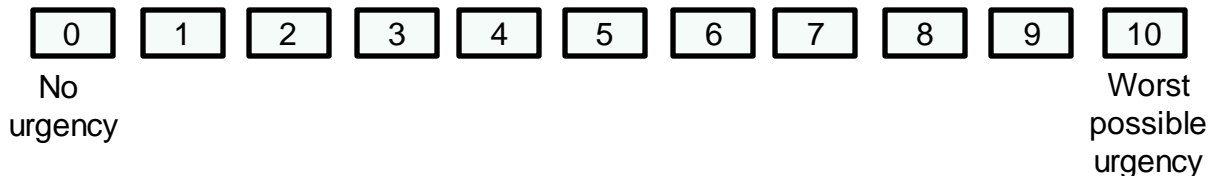
None of the commonly used scales capture bowel urgency severity

The Urgency Numeric Rating Scale (UNRS)



Patients with CD have indicated that it is important to have a bowel urgency scale that distinguishes between different levels of severity instead of just a yes or no

How severe was your urgency (sudden or immediate need) to have a bowel movement in the past 24 hours?



- ▶ Patients report the severity of their bowel urgency symptoms over the past 24 hours
- ▶ Weekly average scores are calculated as mean score over a 7-day period
- ▶ Higher scores indicate worse urgency severity (e.g., immediacy of need to have a bowel movement)

The UNRS was used in the mirikizumab phase III studies to assess bowel urgency whereas the upadacitinib phase III studies used a yes/no binary scale

Second N-ECCO Consensus Statements in Caring for Patients With IBD



“A major life impact is the **need to be near a toilet. Urgency** can be severe, with some patients reporting less than 30 seconds between calls to stool and actual defecations. Fear of losing bowel control is so great that some patients always worry about where the nearest toilet is.”

“Recent evidence suggests that, at some point of the disease course, between 31% and 74% of people with IBD experience fecal incontinence, not necessarily related to disease activity.”

“Despite it being a major concern, incontinence is rarely reported to or addressed by clinicians.”

FDA Guidance for Developing New Drugs in CD



“We encourage sponsors to explore the effect of an investigational drug on additional symptoms of CD identified by subjects as important but that are not captured within the CDAI (e.g., **urgency**) using fit-for-purpose patient-reported outcome (PRO) instruments.”

Assessment of Bowel Urgency: Patient-Reported Outcomes



FDA and EMA have recommended that clinical parameters, endoscopic findings, and patient-reported symptoms be **separately quantified** and reported in IBD trials



PRO tools developed per FDA guidance that include measures of urgency:

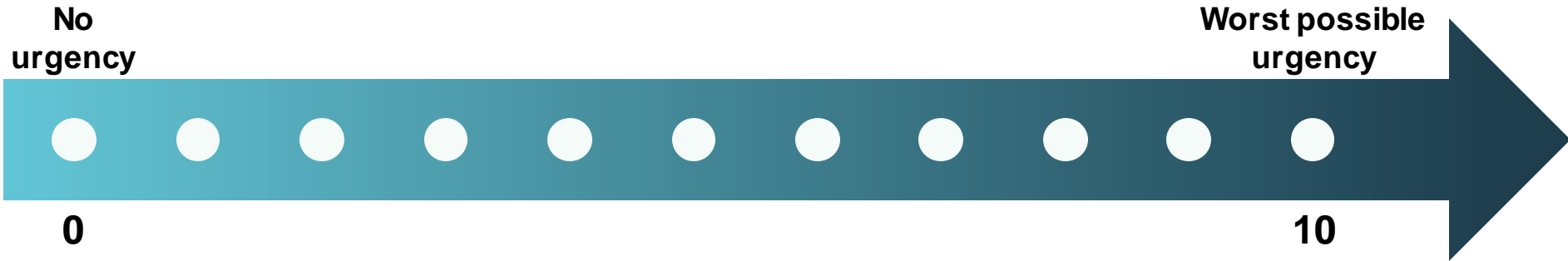
- ▶ Symptoms and Impacts Questionnaire for CD (SIQ-CD)
- ▶ Crohn's Disease Patient-Reported Outcomes Signs and Symptoms (CD-PRO/SS) Diary
- ▶ UNRS

Note: Apart from the UNRS, the other PROs listed include multiple items and measure symptoms assessed by traditionally used scales (e.g., SES-CD, CDEIS) and therefore may be duplicative

Recent Innovations: Urgency Score for Adults with CD



How severe was your urgency (sudden or immediate need) to have a bowel movement in the past 24 hours?



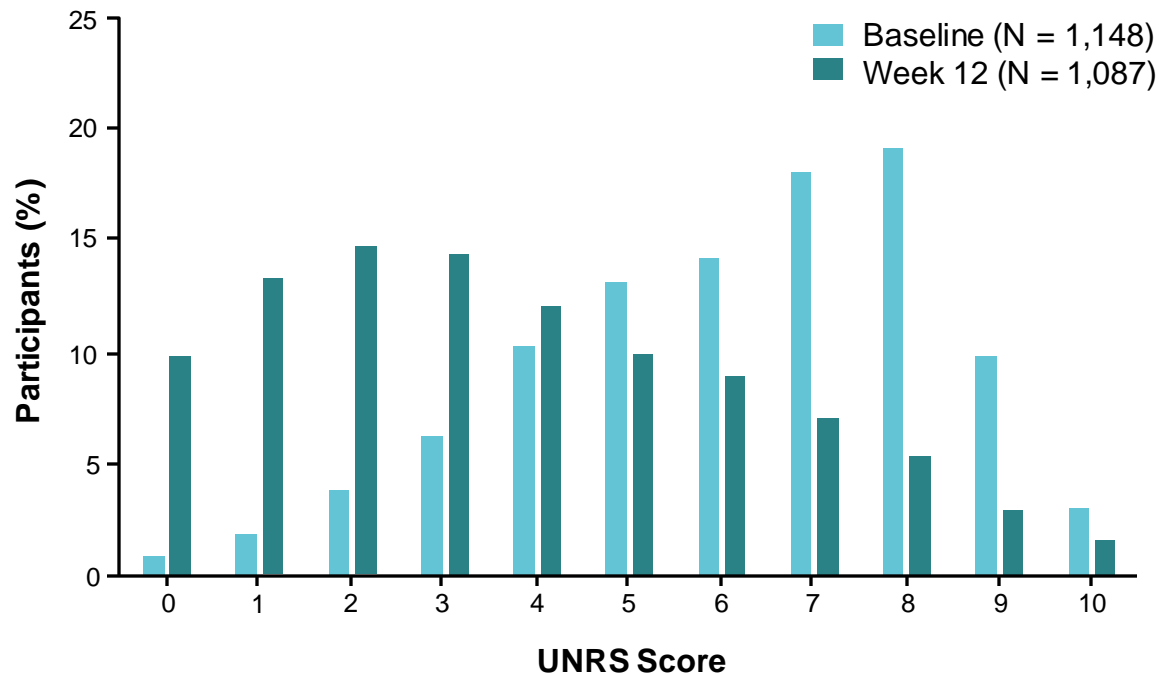
Urgency Score

- ▶ Bowel urgency is a distinct symptom of CD
- ▶ Urgency score is correlated highly with patient global rating of severity scores

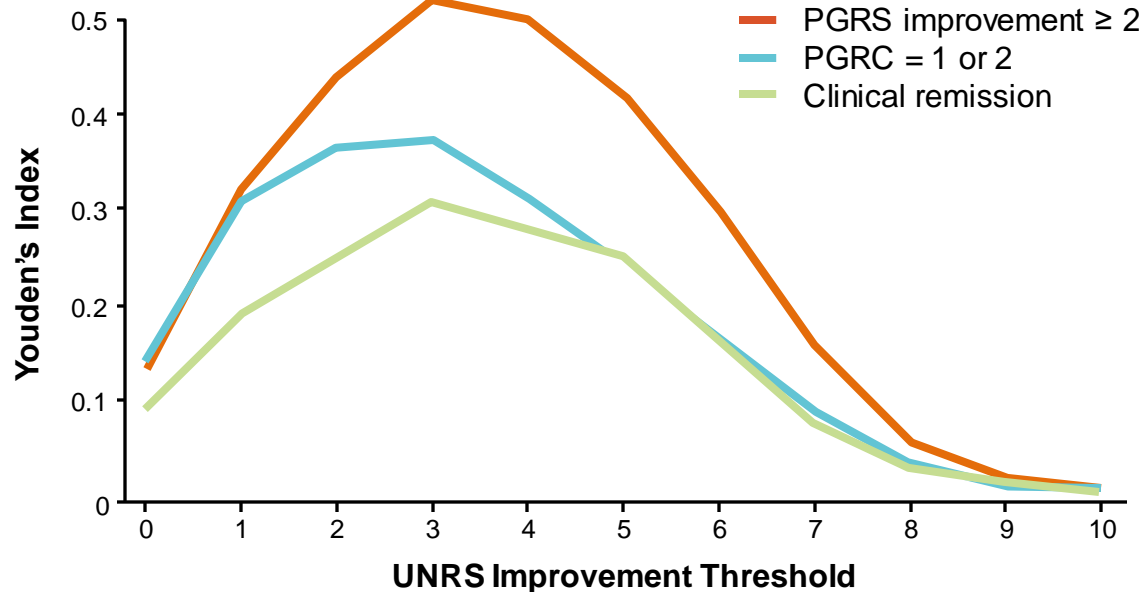
Psychometric Evaluation of UNRS: UNRS Score Distributions



- ▶ Participants registered full range of weekly average UNRS scores (0 to 10) at baseline and at Week 12
- ▶ Mean UNRS score was higher (worse) at baseline than at Week 12 (6.2 vs 3.7)
- ▶ Weekly averages were appropriate to summarize daily UNRS scores



Psychometric Evaluation of UNRS: Patient Improvement from Baseline



≥ 3 -point improvement on UNRS yields best balance between **sensitivity and specificity** of any UNRS threshold at identifying large improvement in overall symptom severity

Youden's Index from an anchor-based analysis of improvement in UNRS from baseline to week 12

Clinical remission was defined as Mayo stool frequency subscore of 0, or 1 with a ≥ 1 -point decrease from baseline; a Mayo rectal bleeding subscore of 0; and a Mayo endoscopic subscore of 0 or 1 (excluding friability)

Why Bowel Urgency Matters: Summary



Bowel urgency is one of the most important symptoms for patients and has a significant impact on patient quality of life and psychosocial function.



HCPs are not always routinely assessing bowel urgency in clinical practice, and there is a communication gap between HCPs and their patients.



Bowel urgency is being increasingly recognized in guideline recommendations and consensus statements as a key component of CD.




The UNRS moves beyond yes/no data and assesses severity over time; it has utility in both clinical trials and clinical practice.

A person wearing a white lab coat is shown from the chest down to the waist. Their hands are clasped in front of them. Overlaid on the person's torso is a glowing, semi-transparent anatomical diagram of the human body, showing internal organs and a network of white lines. The background is a light blue color with a faint geometric pattern of overlapping triangles.

Treatment Planning

Angelina E. Collins, MSN, ANP-BC



**Treatment
planning in
bowel urgency:
Cristina C.**

Patient Case: Victoria M., 29 y/o woman



- ▶ **HPI:** 29-year-old woman diagnosed with colonic Crohn's disease with perianal phenotype CD 3 years ago
- ▶ **Current treatment:** Infliximab 5 mg/kg every 8 weeks

Patient Statements

"I worry about having access to a bathroom at work and have cut back my hours."

"I have stopped going out with friends and family if I am unsure of the bathroom situation."

"I haven't been able to make it to the bathroom in time twice this month and have started carrying extra clothes."

Patient Case: Vittoria M. (continued)



Urgency-Related Symptoms

“I worry about having access to a bathroom at work and have cut back my hours.”

“I have stopped going out with friends and family if I am unsure of the bathroom situation.”

“I haven’t been able to make it to the bathroom in time twice this month and have started carrying extra clothes.”

Patient Treatment Goals

Identify the ideal number of hours/shift length and develop a work bathroom plan.

Identify “rescue interventions” to support social and family activities.

Identify potential bowel urgency triggers. Trial interventions to improve overall bowel control.

Discussion: What would you do next for Victoria?



Faculty Discussion

Next Steps: Victoria M.

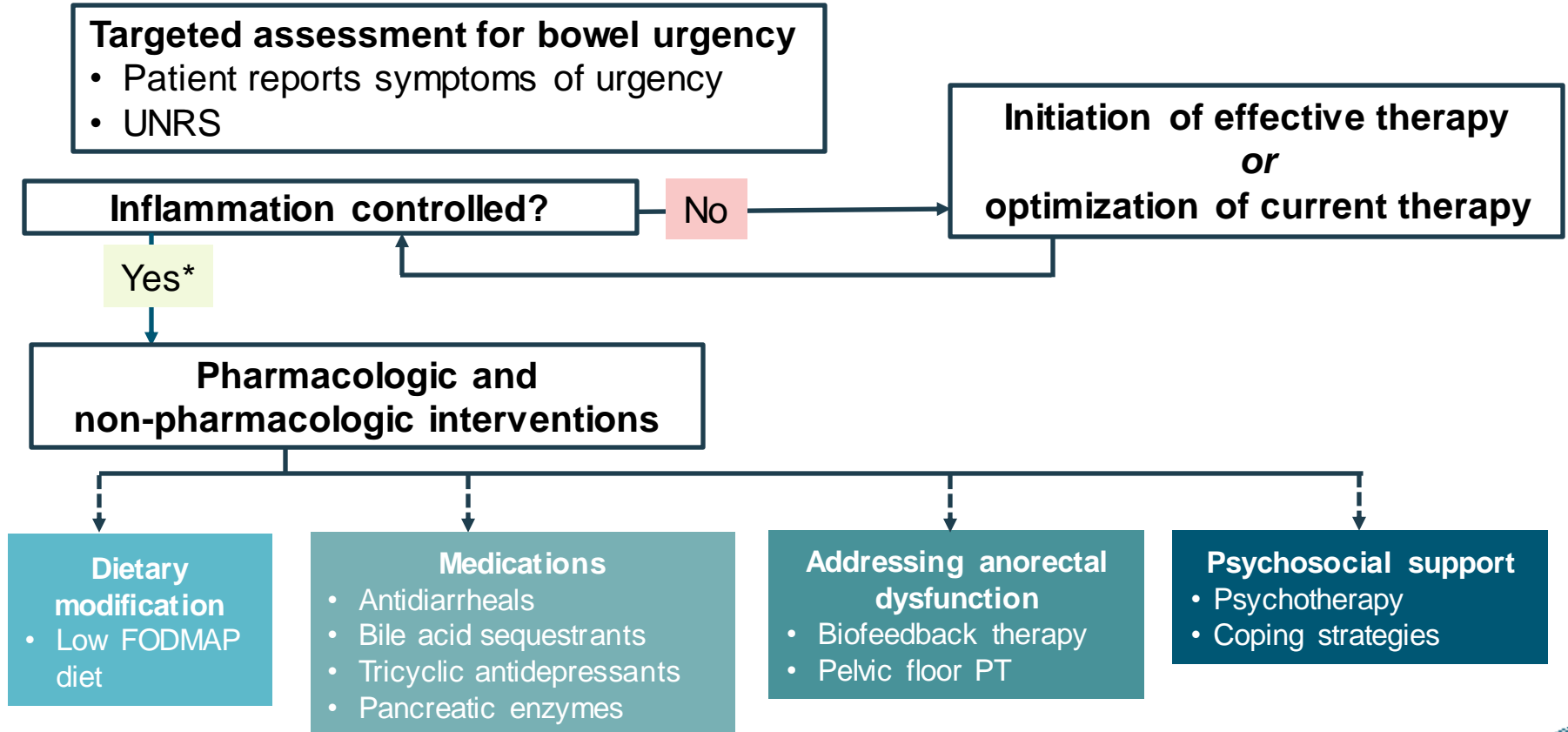


Lab (normal range)	Patient Values
Infliximab trough (goal ≥ 5 $\mu\text{g/mL}$)	6 $\mu\text{g/mL}$
CRP (< 5 mg/L)	12 mg/L
Fecal calprotectin (50-200 $\mu\text{g/mg}$)	310 $\mu\text{g/g}$
Stool culture, enteric pathogens	Negative
Clostridioides difficile	Negative
Ova and parasite negative	None seen

Colonoscopy: Mild Crohn's disease



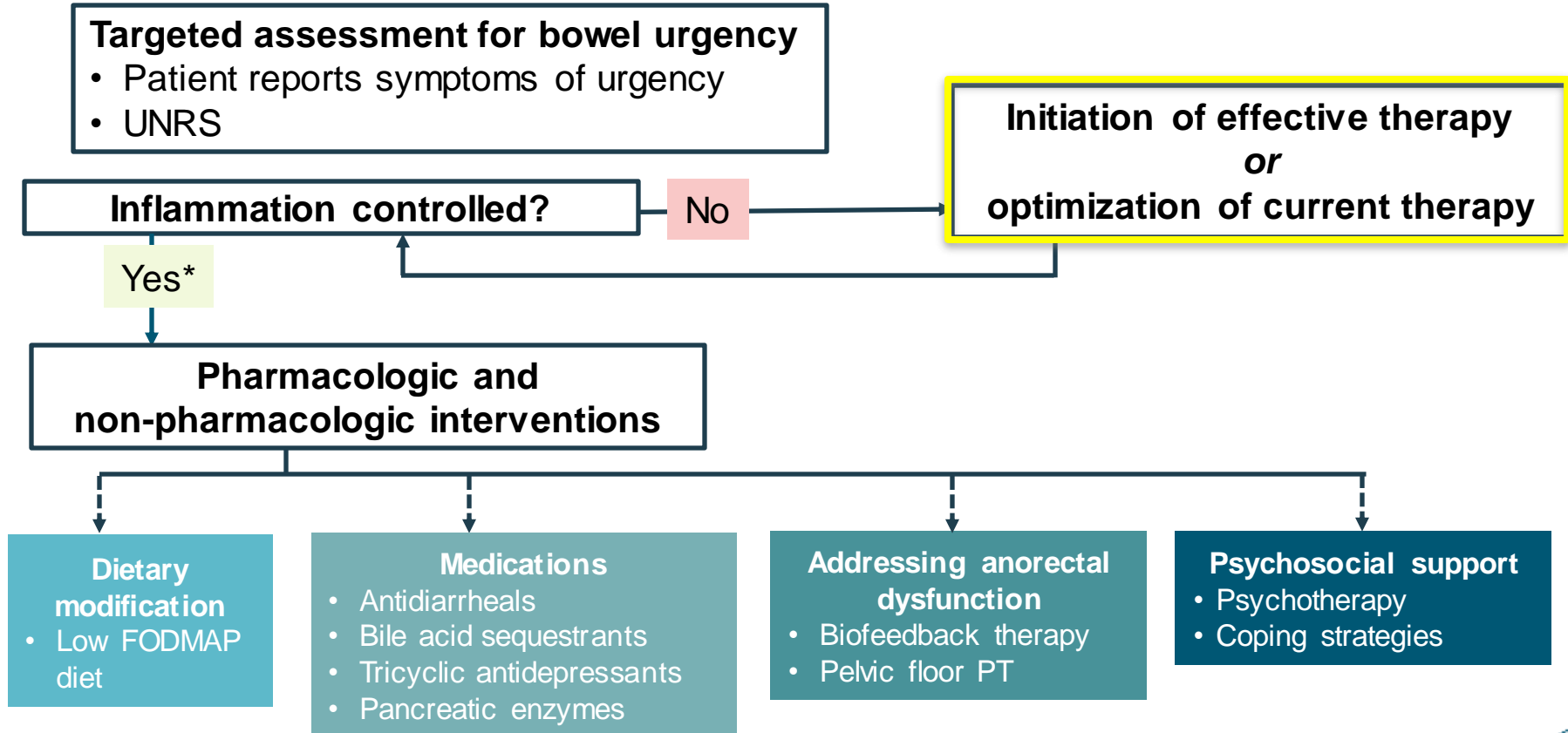
Approach to Bowel Urgency



*Inflammation is controlled but urgency remains.

FODMAP = fermentable oligosaccharides, disaccharides, monosaccharides, and polyols; PT = physical therapy.

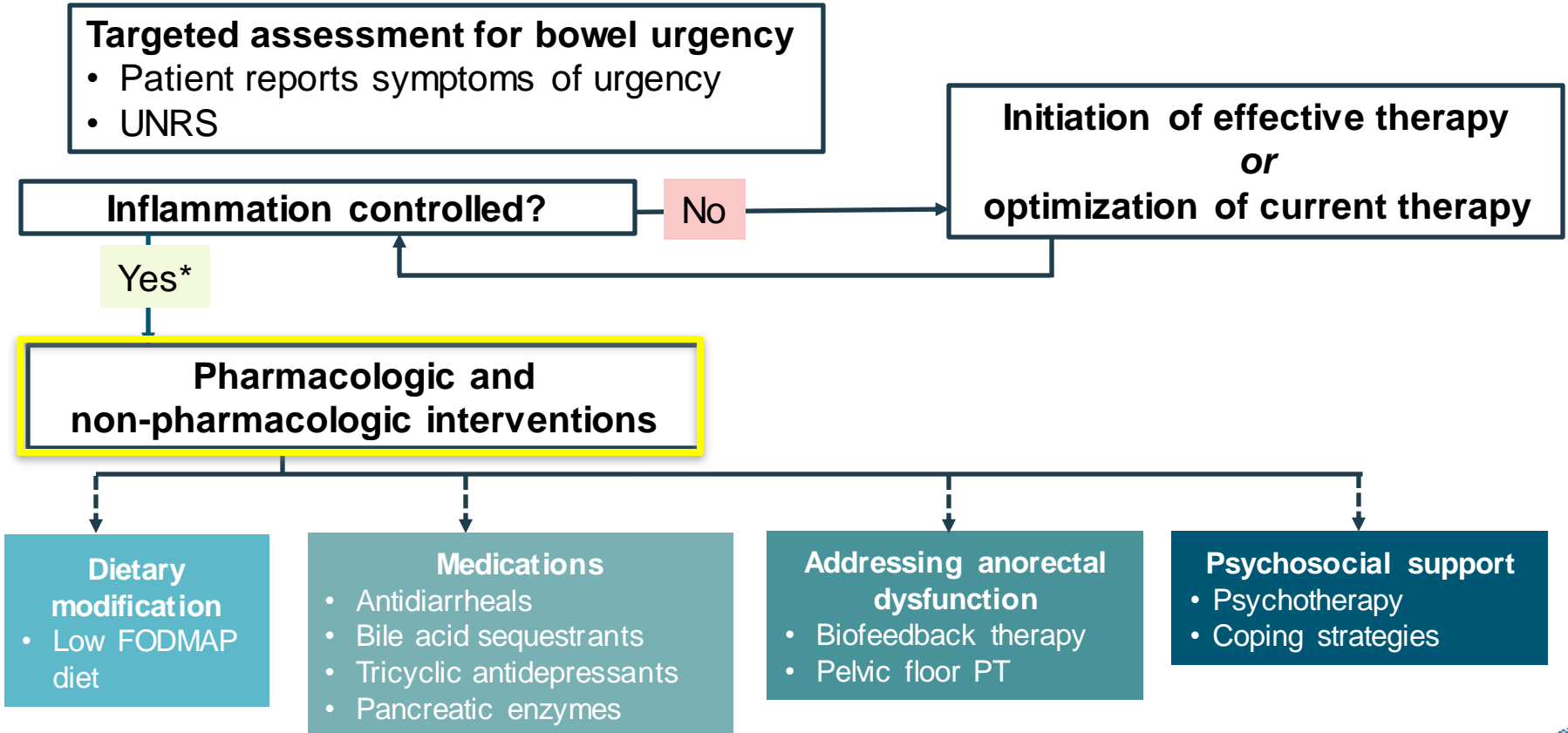
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Approach to Bowel Urgency



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When Inflammation Is Under Control

Pharmacotherapy



Antidiarrheals*

- ▶ Antidiarrheal agents (e.g., loperamide) can improve bowel urgency caused by both inflammatory and non-inflammatory mechanisms
- ▶ Normalizes colon transit time and is thought to increase internal anal sphincter (IAS) tone

*Not an FDA-approved indication.

Dubinsky M, et al. *Am J Gastroenterol.* 2023;118(11):1940-1953. Read M, et al. *Dig Dis Sci.* 1982;27(9):807-814. Sun WM, et al. *Scand J Gastroenterol.* 1997;32(1):34-38.

When Inflammation Is Under Control

Pharmacotherapy



Antidiarrheals

Studies have indicated that loperamide decreases several functional gastrointestinal symptoms, such as **fecal urgency and stool frequency**, and can **improve stool consistency** and resting anal sphincter function in individuals with **diarrhea-predominant IBS and inactive IBD**.

Patients with CD

Loperamide vs placebo over 1 week (van Outryve and Toussaint)

After first week (1 mg after each unformed stool):

- Both investigator's and patients' evaluations of global efficacy* were significantly in favor of loperamide ($p = .025$ and $p = .020$)
- Patient-reported severity of diarrhea was improved with loperamide compared to placebo ($p = .046$)
- Change in abdominal pain was significant for loperamide oxide ($p = .020$) but not for placebo

After second week (responders to first week continued to 1 mg twice daily)

- Both the investigator's and the patients' assessments of global efficacy and symptom improvement continued to favor loperamide (difference was not significant)

*Improved stool consistency, **decreased fecal urgency** and stool frequency.

Pezzone MA, Wald A. *Gastroenterol Clin North Am.* 2002;31(1):347-357. Efskind PS, et al. *Scand J Gastroenterol.* 1996;31(5):463-468. van Outryve M, Toussaint J. *J Int Med Res.* 1995;23:335-341.

When Inflammation Is Under Control

Pharmacotherapy



Tricyclic Antidepressants*



Idiopathic fecal incontinence (IFI)
n = 18 with IFI
▶ 8 (44%) complained of urgency of defecation
n = 24 controls



Amitriptyline 20 mg daily x 4 weeks



Evaluated before and after 4 weeks of therapy:
▶ Idiopathic fecal incontinence scores
▶ Number of bowel movements
▶ Computerized ambulatory anorectal pressures
▶ Pudendal nerve terminal motor latencies



After 4 weeks, 13 (72%) of patients with IFI experienced a "satisfactory result" (no soiling episodes or **urgency of defecation** at all and full continence to fluid and solid stool)

Incontinence		
Median pretreatment score	16	$p < .001$
Median posttreatment score	3	

Bowel Frequency (BM/day)		
Median pretreatment	3	$p < .001$
Median posttreatment	1	

*Tricyclic antidepressants are not FDA approved for treatment of bowel urgency.

BM = bowel movement; NS = not significant.

Santoro GA, et al. *Dis Colon Rectum*. 2000;43(12):1676-1681.

When Inflammation Is Under Control

Pharmacotherapy

Tricyclic Antidepressants*



Results of Pretreatment and Posttreatment Anorectal Physiology Measurements in Patients with Idiopathic Fecal Incontinence

	Pretreatment	Posttreatment	P Value
Median resting and pressure			
Daytime	64	68	NS
Nocturnal	26	16	NS
Median resting rectal pressure			
Daytime	32	32	NS
Nocturnal	12	12	NS
Median maximum and squeeze pressure	108	123	NS
Internal sphincter relaxations			
Median no. per hour	3.1	3.3	NS
Median anal pressure	38	34	NS
Median rectal pressure	30	32	NS
Rectal motor complexes			
Median no. per hour	4.5	1.2	< .05
Median anal pressure	49	66	< .001
Median rectal pressure	94	58	< .05

*Tricyclic antidepressants are not FDA approved for treatment of bowel urgency. NS = not significant; pressures are in centimeters of water. Santoro GA, et al. *Dis Colon Rectum*. 2000;43(12):1676-1681.

Patient Case: Henry T., 55 y/o man



- ▶ **HPI:** diagnosed with CD 3 years ago
 - ▶ No previous surgeries for Crohn's disease, prior cholecystectomy
- ▶ **Current treatment:** Ustekinumab 90 mg every 8 weeks (previously on infliximab)
- ▶ **Current symptoms:** reports fatigue, making it difficult to concentrate at work, and bowel urgency, making it difficult to leave the house or be away from a restroom after eating any food
- ▶ **Previous interventions for urgency:**
 - ▶ Previously tried prn loperamide 2 mg after meals, then 4 mg after meals with limited relief to urgency
 - ▶ Amitriptyline 10 mg at bedtime x 3 month trialed, limited improvement to urgency
 - ▶ Difficulty following a low-FODMAP diet and gave up after 2 weeks

What is your plan for this patient?

Next Steps: Henry T.

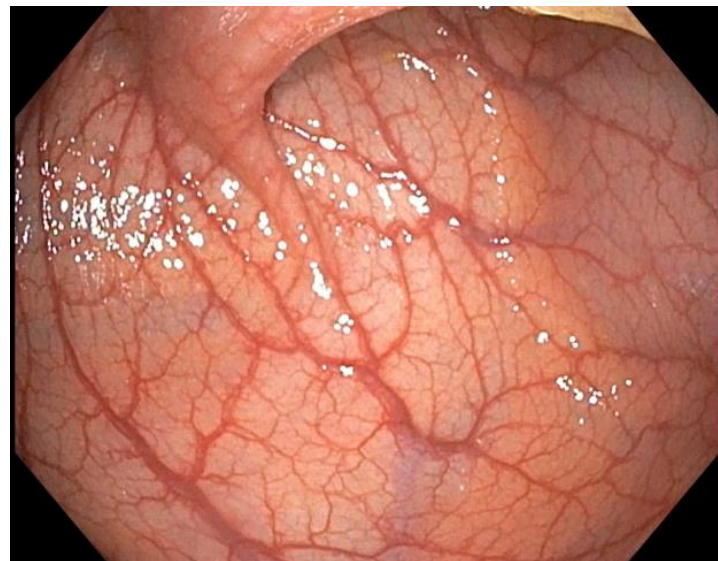


- ▶ Laboratory and stool studies
 - ▶ FCP, CRP
 - ▶ Consider infectious workup (enteric pathogens, *Clostridioides difficile*, ova/parasite testing)
- ▶ Plan for colonoscopy
- ▶ Review for changes in home, work, and social life
 - ▶ Identify potential stress or anxiety triggers for bowel urgency

Patient Case: Henry T. (continued)



Lab (normal range)	Patient Values
CRP (< 5 mg/L)	4 mg/L
Fecal calprotectin (50-200 µg/mg)	45 µg/g
Stool culture, enteric pathogens	Negative
Clostridioides difficile	Negative
Ova and parasite negative	None seen



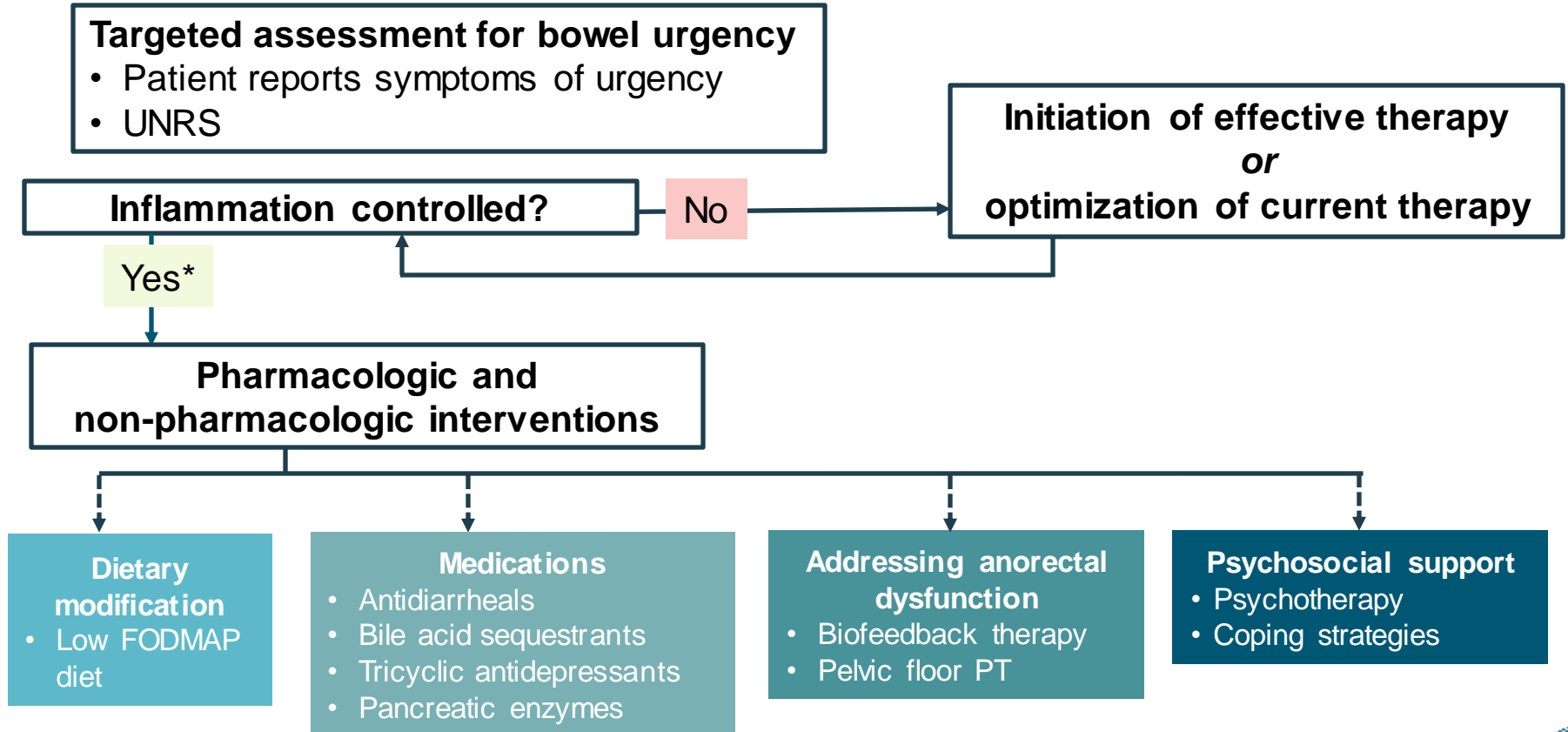
- ▶ **Colonoscopy report:** normal vascular pattern visible throughout (possible tertiary arborization), no spontaneous bleeding or bleeding to light touch

Discussion: How would you have conversations about treatment options with Henry?



Faculty Discussion

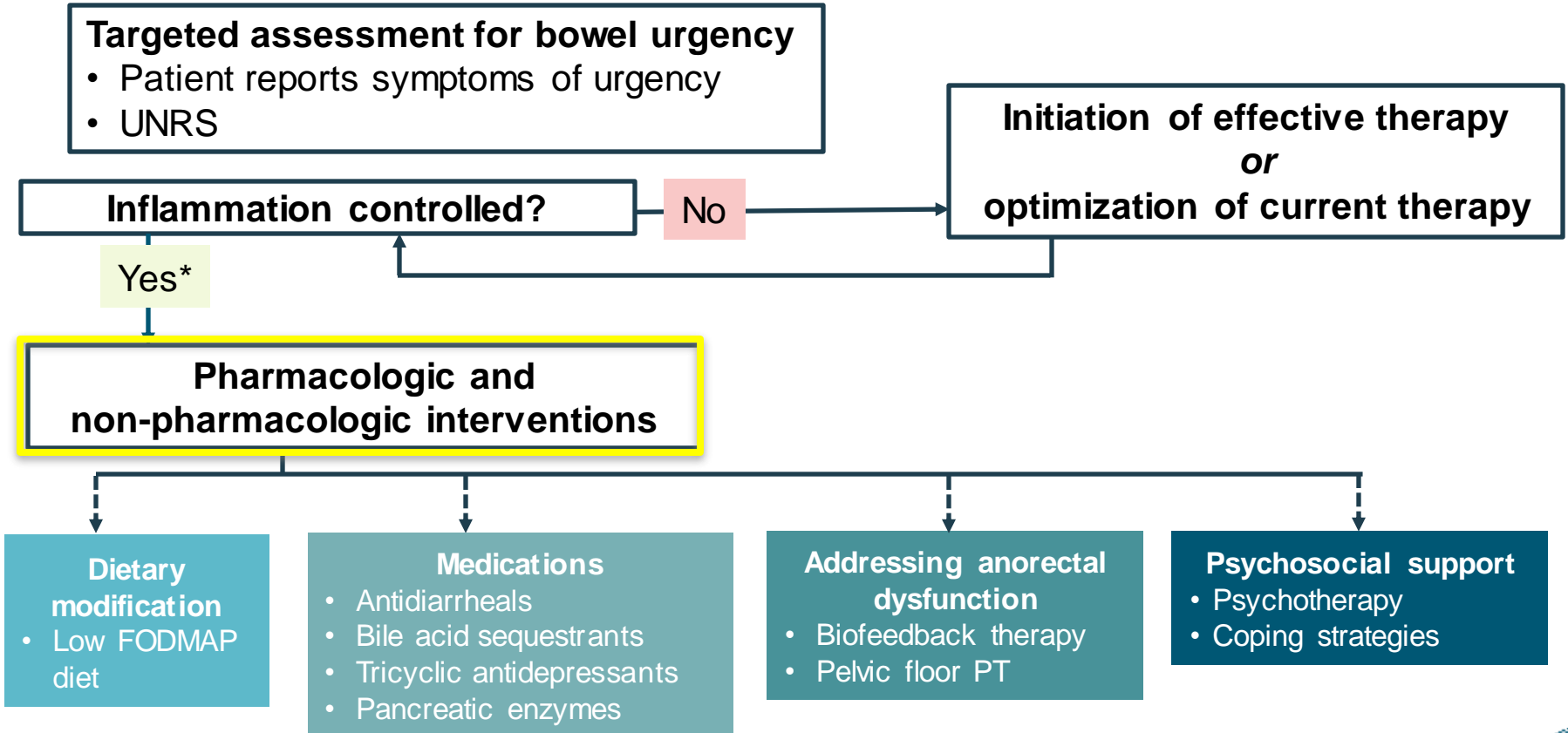
Approach to Bowel Urgency



*Inflammation is controlled but urgency remains.

FODMAP = fermentable oligosaccharides, disaccharides, monosaccharides, and polyols; PT = physical therapy.

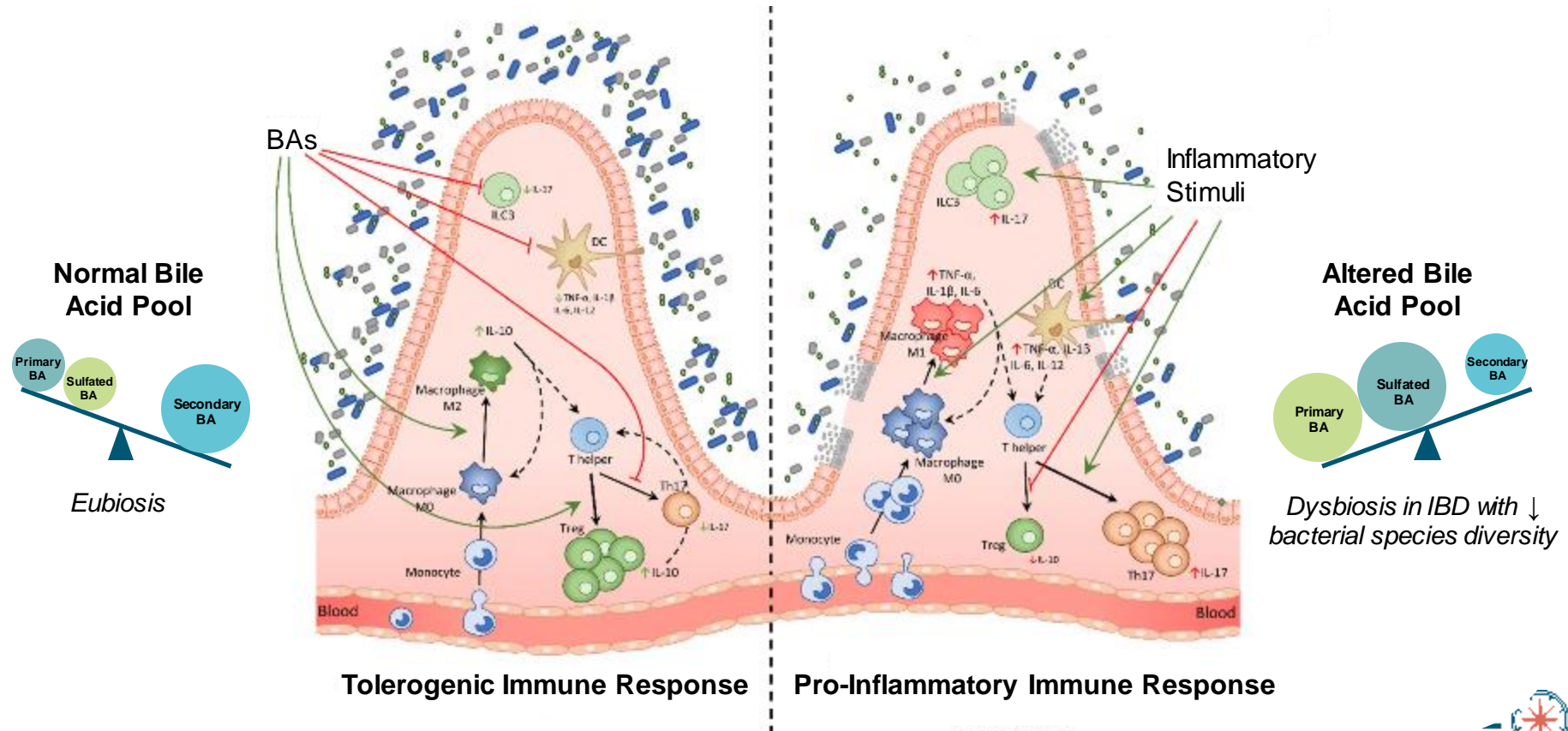
Approach to Bowel Urgency



*Inflammation is controlled but urgency remains.

FODMAP = fermentable oligosaccharides, disaccharides, monosaccharides, and polyols; PT = physical therapy.

Bile Acid Malabsorption (BAM) in IBD



BA = bile acid.

Adapted from Biagioli M, et al. *Cells*. 2021;10(6):1281.

Bile Acid Malabsorption (BAM) in IBD



Abnormal SeHCAT retention seen in:

90% of patients *with*
bowel resections

28% of patients who had
not undergone resection

Addressing Anorectal Dysfunction



Rectal inflammation is the main cause of bowel urgency in IBD

Other potential causes:

IBS

Bile acid
malabsorption

Small intestinal
bacterial overgrowth

Poor rectal
compliance

Neurologic

Anal sphincter
dysfunction

When Inflammation Is Under Control



Biofeedback Therapy

Components of Biofeedback Therapy for Fecal Incontinence and Bowel Urgency

Phase 1: Assessment and Education

- Evaluation of defecation behavior with manometry or electromyography (EMG) probe

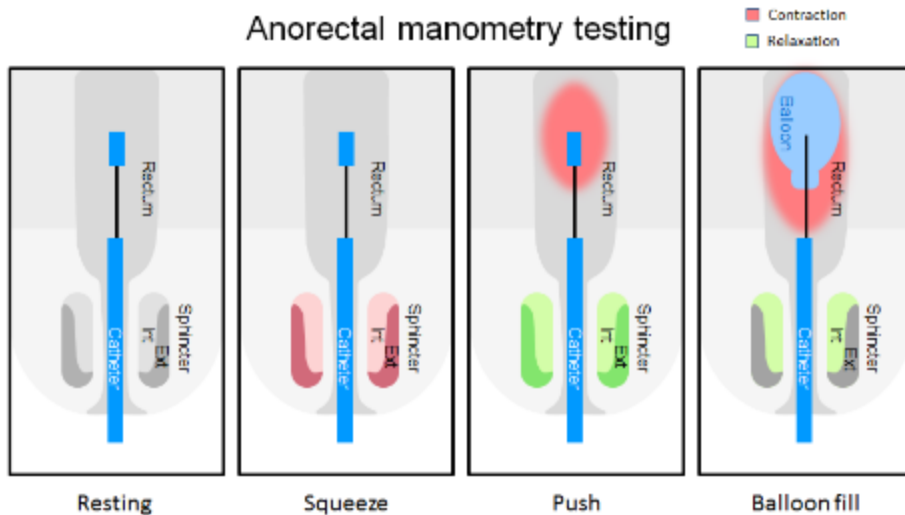
Phase 2: Active Exercise and Training

- Strength training—improve speed, duration, and timing of voluntary contractions of the external anal sphincter
- Rectal sensory training—**tolerate larger volumes until a normal level of urge sensation is achieved**
- Coordination training—increase voluntary anal contraction in response to rectal filling **to increase threshold for urgency**

Phase 3: Weaning and Reinforcement

- As patient gains confidence in muscle control, the frequency of therapy is reduced
- Number, frequency, intensity, and duration of sessions highly individualized for each patient

Biofeedback is a self-regulation technique that attempts to teach patients with defecatory defects to strengthen pelvic floor muscles, retain rectal sensation, and coordinate pelvic floor muscles during evacuation



When Inflammation Is Under Control



Biofeedback Therapy

Frequency of dyssynergic defecation in IBD

45-97% patients w/out IPAA

25-75% of patients with IPAA

Pooled response rate to biofeedback therapy

70%
(95% CI 55%-84%) w/out IPAA

86%
(95% CI 67%-98%) with IPAA

When Inflammation Is Under Control



Pelvic Floor Training

- ▶ Pelvic floor muscle training, with or without biofeedback therapy, improved fecal incontinence in 20/25 (80%) of patients with quiescent IBD
- ▶ Patients with IBD completing treatment (n = 29) demonstrated improved symptom scores ($p < .001$), IBD-specific QoL ($p = .008$) and illness perception scores ($p = .0030$)
- ▶ Those who are most likely to benefit are **individuals experiencing fecal incontinence or impaired evacuation and exhibit dysfunction in pelvic floor or anal sphincter muscles**
 - ▶ Pelvic floor dysfunction diagnosis: anal manometry, balloon expulsion testing, EMG, defecography, or ultrasound

Pelvic muscle contraction strength can be diminished in shortened, tight, or tense muscles



Affects continence and the ability to evacuate effectively

When Inflammation Is Under Control



Pelvic Floor Training

- ▶ Pelvic floor muscle training does not solely include strength training. Incorporates exercises to:
 - ▶ Improve the awareness of muscle contraction and relaxation
 - ▶ Coordinate with abdominal and diaphragm muscles for the normal functions of continence and effective defecation

Behavioral Treatments Tailored to Individual Patient Symptoms

- Pelvic floor muscle training, with or without biofeedback
- Toileting behavior modifications
- Urge resistance or deferral techniques
- Lifestyle changes
- Emotional support

Patient Case: Victoria M. (continued)



Urgency-Related Symptoms

“I worry about having access to a bathroom at work and have cut back my hours.”

“I have stopped going out with friends and family if I am unsure of the bathroom situation.”

“I haven’t been able to make it to the bathroom in time twice this month and have started carrying extra clothes.”

Patient Treatment Goals

Identify the ideal number of hours/shift length and develop a work bathroom plan.

Identify “rescue interventions” to support social and family activities.

Identify potential bowel urgency triggers. Trial interventions to improve overall bowel control.

Patient Case: Shared Decision-Making



Assess

Patient's beliefs, behavior, knowledge

Advise

Provide specific information about health risks and benefits of change

Agree

Collaboratively set goals based on patient's interest and confidence in ability to change behavior

Assist

Identify personal barriers, strategies, problem-solving techniques, and social support

Arrange

Specify a plan for follow-up

Shared Decision-Making Considerations

- ▶ How do we approach conversation with our patient who is accepting their “new normal”?
- ▶ How do we discuss the connection between urgency and fatigue with our patient?
- ▶ How do we present the concepts of mind/body, brain/gut dysregulation to our patient?
- ▶ How do we approach the conversation of home environment and lifestyle/life events going on in the patient's life?

Audience Response



Which of the following assessments captures bowel urgency impact in patients with CD?

- A. CDAI
- B. HBI
- C. UNRS
- D. IBDQ

Audience Response



Now, how often will you incorporate bowel urgency assessments into your evaluation of patients with Crohn's disease (CD)?

- A. Always
- B. Usually
- C. Seldom
- D. Never

SMART Goals

Specific, Measurable, Attainable, Relevant, Timely



- ▶ Proactively screen patients with CD for bowel urgency symptoms, using a meaningful assessment tool such as the UNRS.
- ▶ Increase the percentage of patients with CD who have an individualized treatment plan to address bowel urgency during periods when inflammation is controlled.
- ▶ Improve the proportion of patients with CD who identify personalized treatment goals for addressing the impact of bowel urgency and other CD symptoms on daily life.



QUESTIONS & ANSWERS

Thank you for joining us.
Don't forget to collect your
credit.

Additional Resources

To learn more about bowel urgency in CD, scan the QR code to access additional educational resources.

QR code placeholder



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