WDHD

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2010 – YEAR OF INFLAMMATORY BOWEL DISEASE

Frequently Asked Questions about IBD: by Doctors

Q When prescribing anti-TNF therapy should I use an immunosuppressive drug with it?

This remains a source of great debate. Initially it was considered to be necessary to enhance anti-TNF efficacy. Then with the reporting of hepatosplenic T cell lymphoma (even though this was a rare event) there was a concern about using concurrent thiopurines (azathioprine and 6-mercaptopurine). Then the COMMIT trial reporting no benefit of methotrexate over placebo as a concurrent medication was balanced by the SONIC trial reporting that concomitant azathioprine with infliximab was better than infliximab alone and twice as good as azathioprine alone. It has been shown that immunosuppressive drugs can reduce antibody formation and sustain higher drug levels. At this point there is some individualization that is necessary. If just starting someone on an anti TNF it is reasonable to use concomitant immunosuppressives especially if a) you are choosing thiopurines or b) you are not also using concomitant steroids you can also consider methotrexate. However, it may also be reasonable to withdraw the immunosuppressive medication over time if the patient has clearly responded to the anti-TNF. The withdrawal would lessen the patient's immunosuppressed state which may reduce long term risk.

Q Is one anti-TNF more effective or safe than another?

There does not seem to be much difference in terms of inducing remission or long term response rates between infliximab, adalimumab or certolizumab for Crohn's disease. However, these drugs have never been studied head to head and so we are just comparing results of completely different clinical trials with each other. There is some question whether certolizumab has as good an ability to induce remission within the first 2 months. In ulcerative colitis only infliximab is approved and it is not yet clear whether the other two agents will be as effective. It seems clear though that in Crohn's disease when one anti-TNF fails either because of intolerance or loss of response, one of the other two agents can be used with some success.

Q Are there medications that can reduce recurrence rates after surgery in Crohn's disease?

The one agent or class of agent that has been shown to reduce short and long term recurrence rates is metronidazole or tinidazole. Side effects can limit the long term use of these agents at the doses used in the studies. Thiopurines (azathioprine and 6-mercaptopurine) have some effects postoperatively but the studies have not to date been as robust as we would have hoped. 5-ASA drugs have minimal benefit in reducing recurrence rates. For patients with severe disease an anti-TNF agent can be considered and to date one small study has shown a significant reduction in recurrence rates compared to placebo.

Q Is there a role for antibiotics in managing IBD?

Antibiotics should be used to treat any infectious complications and as prophylaxis if patients are admitted with high fever or toxic megacolon. They do not have a role as primary therapy in ulcerative colitis. In Crohn's disease there has been some suggestion that they may be of benefit in ileocolonic or colonic disease. They do have a role in treating perianal fistulas based mostly on anecdotal evidence since a large placebo controlled trial has not been completed. They also have a role in treating pouchitis (for patients who receive an ileoanal pouch procedure for ulcerative colitis). For patients with bloating and diarrhea a trial of antibiotics can be considered to treat presumed bacterial overgrowth, a condition that certainly may arise in patients with Crohn's disease who have strictures.

Q How often do patients with ulcerative colitis require colonoscopy?

Patients with ulcerative colitis require colonoscopy at diagnosis and again at 8 years of disease and on a regular basis after 8 years of disease for dysplasia surveillance. I pursue dysplasia surveillance at 8 years, 9 years and then every 3 years thereafter. I then return to annual surveillance colonoscopy at 20 years unless the patients clearly have no inflammatory activity I will spread out the interval again. Patients should also have a lower endoscopy to rule out CMV (if they are on immunosuppresives) and even C difficile (if you can't wait for the stool test) if they present with acute severe disease. In terms of colonoscopy at other times there is no set rule and it depends more on the art of managing individual patients. Patients will require a colonoscopy if their symptoms are confusing or they are not responding to medications as they should be. There has been increasing debate as to the importance of mucosal healing and the need to colonoscope patients to determine if a medication has fully achieved an endoscopic remission.

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More information at: http://www.worldgastroenterology.org/wdhd-2010.html
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