Mild-to-moderate IBD management: Challenges beyond inflammation

Disclaimer: The views and opinions expressed are those of the speakers and not necessarily of Tillotts Pharma. The satellite symposium is not affiliated with the European Crohn’s and Colitis Organisation (ECCO).

The satellite symposium sponsored by Tillotts Pharma was introduced by the Chair, Prof. Gerhard Rogler, Zürich, Switzerland. He briefly highlighted the treatment paradigm and treatment goals of ulcerative colitis (UC), the challenges of treating the elderly and the use of patient reported outcomes (PROs) in inflammatory bowel disease (IBD).

The text below is a summary of the presentations of the three speakers.

Treatment of UC

Treatment strategies in UC are dependent on the disease severity. The ECCO guideline on the diagnosis and management of UC [1] considers mesalazine as the gold standard for the treatment of mild-to-moderate UC, with more severe UC cases being treated with corticosteroids and biologics. Regardless of the disease severity, the treatment goals in UC remain the same; these include reducing mortality, number of colectomies and hospital admissions, whilst optimising treatment adherence, surveillance/monitoring, and most importantly inducing mucosal healing.

Clinical trials tend to exclude elderly patients, thus presenting challenges to treating physicians with respect to treating this population.

Patient reported outcomes (PROs)

The patients’ and the physician’s perspectives on disease severity and activity often do not correlate. There is the opinion of the regulators that physician reported outcomes do not reflect the patient’s disease burden; hence PROs are becoming more widely applied in the assessment of disease activity.

The advantages of PROs are that they engage patients in their disease management (i.e., providing a sense of empowerment), leading to bidirectional communication and educating patients and physicians to speak a common language. In contrast, the disadvantages are that PROs are currently not well-validated in clinical trials, comparison to efficacy data from older trials is no longer possible and lastly, PROs are subjective by definition. These topics were discussed in more detail by Dr. Ian Arnott, Edinburgh, Scotland and Prof. Jonas Halfvarson, Örebro, Sweden.

The delay in diagnosis has been reported to be longer in the elderly (15 months vs. 5 months) [5] and IBD specific mortality is higher in this group, with the leading cause of death being due to solid malignancies [6]. As elderly IBD patients can be affected by unrelated diseases and health problems, it is important that all relevant specialists talk to each other. For example, in elderly patients with diabetes, the use of steroids may alter glycaemic control, whilst psychiatric disorders may have an effect on medication compliance.

The clinical course tends to be mild in elderly IBD patients, with less presentation of abdominal pain and weight loss, lower frequency of fistulising disease and family history. In Crohn’s disease (CD), there tends to be a higher percentage of colonic disease, and in UC, left-sided colitis is the most typical phenotype.

Therapeutic considerations for the elderly

The discussion of the case study continued with the question: “What treatment should be given now? (a) 5-ASA, (b) corticosteroids (with/without 5-ASA), (c) immunomodulators/biologics.” Dr. Arnott highlighted that mesalazine, corticosteroids, immunomodulators and surgery are potential treatment options for the elderly IBD population as detailed below.

Mesalazine [1, 7, 8]:

- First drug of choice in the treatment of mild-to-moderate UC.
- Mesalazine is effective for inducing and maintaining remission in UC. Efficacy is comparable between young and older patients.
- Once daily dosing and foam formulations of topical therapy may increase compliance.
- Creatinine clearance should be monitored regularly during therapy (particularly in case of long-term high dose usage).
- Drug interactions with warfarin, 6-mercaptopurine and azathioprine should be considered.

Corticosteroids [9, 10]:

- Use of corticosteroids carries the risk of precipitating/exacerbating pre-existing conditions (e.g. diabetes, congestive heart failure, hypertension, altered mental status and osteoporosis) – more frequent compared to a younger population.
- Bone densitometry needs to be repeated annually.
- Budesonide might be considered as it interferes less with bone metabolism.
- Potential drug interactions include: phenytoin, phenobarbital, ephedrine and rifampicin.

Immunomodulators [10-12]:

- Should be considered in patients with corticosteroid dependence to maintain patients in remission.
- Age is a risk factor for skin cancer and lymphoma in patients exposed to thiopurines.
- Allopurinol could potentially reduce the thiopurine dose (however its concomitant use with immunomodulators increases the risk for infections in those patients with lower absolute lymphocyte counts).

Prof. Gerhard Rogler, Ian Arnott, Prof. Jonas Halfvarson © Tillotts Pharma
PROs according to the FDA:

- Treatment was reduced to 1.5 g/day mesalazine.
- Normalisation of bowel habit (stool frequency ≤1).

Case study continued

Mr. RF was in steroid-free remission; he had no disease. He tapered off for two weeks. In mid-March 2001, Dr. Ian Arnott concluded that a bottom-up approach (e.g. mesalazine > corticosteroids > thiopurines > biologic therapy) is the preferred therapeutic strategy in the elderly. He emphasised that one should be cautious with using biologic therapy (e.g. anti TNFs) in the elderly as this is associated with a risk of severe bowel perforation. The audience learned that Mr. RF was treated with 2 g mesalazine liquid enema. He initially had no rectal bleeding, his Ulcerative Colitis-Disease Activity Index score was less than 2, and a Mayo endoscopic subscore of 0. Subsequently, his treatment was reduced to 1.6 g/day mesalazine.

Conclusions: Therapeutic strategy in the elderly

- Elderly IBD patients are a growing patient population. Physicians need to take into account comorbidity, polypharmacy and cognitive decline when deciding on IBD treatments in elderly Crohn’s disease patients.
- PROs and biomarkers are becoming increasingly important in the assessment of disease activity.

References

2. UK population consensus.
3. www.kingsfund.org.uk/time-to-think-differently/

HELEN THORNE

ECCO NEWS 1/2017

Sponsored Satellite Symposium Report – Tillotts Pharma