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In what proportion of IBD patients coming to resection surgery was there an opportunity to optimise preoperative care? A one year audit of a tertiary referral hospital

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Introduction: One of the many goals of recently promulgated IBD treatment guidelines is to avoid the need for surgery where possible. We therefore sought to determine the proportion of patients coming to resection surgery where preoperative management left opportunities for improvement, with regard to published guidelines.
Methods: As part of a larger audit, all IBD patients admitted in relation to resection surgery from January 2007 to March 2008 at a tertiary hospital were identified from electronic records. Case notes were reviewed for patient and disease characteristics. In particular, medical therapy preoperatively was compared to guidelines. The presence of preoperative specialist gastroenterologist care, the operation performed, its indication, emergency vs. elective nature, whether the surgery was decided in collaboration with a gastroenterologist and postoperative medications were also recorded. Subjects where therapy was "suboptimal" were judged as having "potentially avoidable" surgery, any recorded reason for this was sought from available records.
Results: 22 subjects were identified, 15 males, 7 females; 17 had CD and 5 UC; 9 were smokers (8CD & 1UC), average disease duration 9 yr. Preoperative therapy was deemed to be optimal in (9/22 – 41%), "suboptimal" in 11/22 (50%), with 2 patients on no preoperative therapy (9%) due to acute (new CD) presentations as suspected appendicitis. In the 11 cases where there had been an opportunity to optimise management preoperatively, the reasons for judging therapy "suboptimal" included: smoking in CD (n = 8), subtherapeutic dosing with thiopurines (with no recorded explanation) (n = 5), and declining standard therapy (n = 1); 3 CD subjects were both smoking and on low thiopurine doses. The patient who declined thiopurines opted for alternative therapy. Thus, even after disounting the effect of smoking, 6 (27%) subjects were judged to have had "potentially avoidable" surgery. This proportion did not differ between CD vs UC (4/17 CD; 2/5 UC). The 2 most common indications for surgery were: inflammatory mass/abscess (8/22) & failing medical therapy (7/22). The majority of patients had seen a gastroenterologist prior to surgery (20/22 – 91%), although several had not had regular review. Most surgery was elective (17/22 – 77%). Although most resections were undertaken in collaboration with a gastroenterologist (15/22 – 68%) a substantial number were not (7/22). Of the 6 having potentially avoidable surgery, in only 3 was the decision was taken in collaboration with a gastroenterologist.
Conclusion: Despite newer therapies, there are still significant gains to be made, in terms of "potentially avoidable" surgery if all recognised IBD patients receive optimal standard medical therapy. Reasons for failure to receive available, effective therapy deserves greater attention to optimise outcomes.

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Efficacy of adalimumab in patients with Crohn's disease and failure to therapy with infliximab

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Aim: To evaluate the efficacy of adalimumab for at least three months, in patients with Crohn's disease (CD) and failure to previous treatment with infliximab.
Methods: Twenty-five patients with CD were enrolled (15 females/10 males); average age 38.32±12.39, and average duration of CD 10.64±5.46 years. Three (12 %), fourteen (56 %) and eight (32 %) of patients had ileal, ileo-colonic and colonic CD respectively. The average time of treatment with IFX was 30±20.81 months. The main cause of infliximab withdrawal was loss of response 80 % (20), primary nonresponders 8 % (2), adverse events 8 % (2), and technical problems 4 % (1). We analyze clinical response to treatment with adalimumab by the Crohn's disease Activity Index (CDAI) and plasma concentration of C-reactive protein (CRP) before and after therapy, steroid sparing and complete fistula closure.
Results: Sixteen out of twenty-five patients (64%) improved, twelve of them (12/16; 75 %) achieved clinical remission (CDAI score <150); 2/25 (8%) patients worsen, 7/25 (28 %) patients didn't changed CDAI score. Sixteen out of twenty-five (64 %) patients reduced levels of CRP. Nine out of fifteen patients (60 %) treated with corticosteroids were able to discontinue steroids. Five out of eleven patients (45 %) with fistulizing Crohn's disease had complete fistula closure after the treatment. There was a statistically significant difference ($p < 0.01$) in CRP serum levels, CDAI and need for steroids before (21.94±26.96; 208.14±78.53; 60%) and after adalimumab treatment (10.07±11.78; 124.34±72.74 and 6%). Five out of twenty-five patients (20 %) had adverse events; two of them (8 %) with serious adverse events (tuberculous meningitis and abdominal abscess) that forced the withdrawal of treatment.
Conclusions: According to these data, adalimumab provides a clinical and analytical improvement in patients with CD and failure to previous therapy with infliximab.

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How often does infliximab lose its effect and dose intensification is required? A review

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Introduction: There is a paucity of data providing insight into the durability of Crohn's disease treatment with infliximab for periods longer than 12 months. For patients who lose their initial response, consideration can be given to dose "intensification" to regain therapeutic benefit.
Aim: To review how often infliximab loses its effect and dose intensification is required.
Methods: Bibliographical searches were performed in MEDLINE looking for the following words: infliximab AND "Crohn's disease" AND (lose OR lost OR loss OR "dose escalation" OR intensification). We also conducted a manual search of abstracts from European (ECCO) and American (DDW) Congresses. Inclusion criteria: studies evaluating loss of efficacy and requirement of infliximab dose intensification (defined either as an increase of the infliximab dose – generally from 5 mg/kg to 10 mg/kg – or as a decrease in the frequency of infusion – to as often as every 4 weeks) in Crohn's disease patients.
Results: Sixteen studies evaluating the incidence of loss of response to infliximab in Crohn's disease patients were found. A total of 2,236 patients were included (the majority of them receiving a 3-dose induction regimen at weeks 0, 2, and 6, followed by maintenance therapy every 8 weeks), providing 6,284 patient-years of follow-up. The mean percentage of patients with loss of infliximab response was 37%. However, as the follow-up time markedly varied among studies, the risk of losing response to infliximab is better expressed as the incidence of this complication per patient-years of follow-up. Therefore, the annual risk for loss of infliximab response was calculated to be 13% per patient-year.
Conclusion: A variable but relevant proportion of Crohn's disease patients on long-term infliximab treatment lose response.