



New tools and approaches for improved management of inflammatory bowel diseases☆

Subrata Ghosh^{a,*}, Benjamin Pariente^b, Diane R. Mould^c, Stefan Schreiber^d, Joel Petersson^e, Daniel Hommes^f

^a Department of Medicine, Division of Gastroenterology, University of Calgary, Calgary, Alberta, Canada

^b Department of Hepatogastroenterology, Saint-Louis Hospital, Paris, France

^c Projections Research Inc., Phoenixville, PA, USA

^d Department of General Internal Medicine, Christian-Albrechts University, Kiel, Germany

^e Global Medical Affairs Gastroenterology, AbbVie, Rungis, France

^f Division of Digestive Diseases, University of California, Los Angeles, CA, USA

Received 26 November 2013; received in revised form 25 February 2014; accepted 26 February 2014

KEYWORDS

Crohn's disease;
Ulcerative colitis;
Disease monitoring;
Healthcare delivery;
Individualised medicine;
Value

Abstract

Background and aims: Inflammatory bowel diseases are part of a wider conglomeration of immune-mediated inflammatory diseases. New management approaches need to be developed as we understand more of the epidemiology and aetiology of inflammatory bowel diseases and medical care becomes more complex.

Methods: Selected new tools and approaches for improved management of inflammatory bowel diseases are presented, based on published evidence and clinical experience.

Results: Setting quality of care standards that are consistent across different inflammatory bowel disease care settings will be paramount and require collaboration between specialist and non-specialist centres. Alongside this, the value of care will need to be evaluated in terms of maximising outcomes over the entire care cycle for a patient. In moving towards a value-based approach to management, it is important to determine the progression rate of the disease by measuring cumulative bowel damage. As well as understanding the course of disease in individual patients, it is also becoming more feasible to individualise therapy and exploit drug

Abbreviations: 5-ASA, 5-aminosalicylates; IMID, immune-mediated inflammatory diseases; IPNIC, International Program to develop New Indexes in Crohn's disease; mAb, monoclonal antibody.

☆ This manuscript summarises presentations made during the 'Leading Change in IBD' meeting held in Madrid on 18–19 January 2013 and sponsored by AbbVie.

* Corresponding author at: Department Head and Professor of Medicine, Immunology and Microbiology, Department of Medicine, Division of Gastroenterology, University of Calgary, 9th Floor, North Tower, Foothills Medical Centre, 1403-29th Street NW, Calgary, Alberta, T2N 2T9, Canada. Tel.: +1 403 944 48222; fax: +1 403 944 1095.

E-mail address: subrata.ghosh@albertahealthservices.ca (S. Ghosh).

pharmacology to achieve better and more long-term responses. Finally, it is timely to consider formal collaborations between specialists in immune-mediated inflammatory diseases to ensure more cohesive patient care.

Conclusions: The potential for improved management of patients with inflammatory bowel diseases continues to increase as we look to understand when and how to intervene in the disease process and how to adopt a collaborative management approach that promotes networking and reduces heterogeneity of care across different care settings.

© 2014 European Crohn's and Colitis Organisation. Published by Elsevier B.V. Open access under

CC BY-NC-ND license.

1. Introduction

Inflammatory bowel diseases (IBD) represent a chronic and complex spectrum of diseases that are part of a wider conglomeration of immune-mediated inflammatory diseases (IMIDs) such as rheumatoid arthritis, psoriatic arthritis, psoriasis, spondyloarthropathies and systemic lupus erythematosus. As we understand more of the epidemiology and aetiology of IBD and medical care becomes more complex, new management approaches need to be developed. This will involve setting quality standards that are consistent across different IBD care settings, careful evaluation of the value of IBD care, developing more sophisticated methods to monitor disease progression, tailoring drug therapy to individual patients and synergistic collaborations with other IMID specialists.

2. Reducing discrepancies across different IBD care settings

In an ideal scenario, patients would be able to access the same standard of care irrespective of where they lived or went for treatment. In reality, notable variations in an individual IBD patient's care exist. This is influenced by a number of variables including the patient's type of care facility, their geographical location (within and between countries), standards of treatment, philosophies of treatment, adherence to clinical guidelines, patient and physician preferences, access to support staff and payer perspectives.

Several retrospective or cross-sectional studies have illustrated country-specific and care setting-specific variations in IBD care, although it is not yet clear as to whether such differences are detrimental to clinical outcomes.^{1,2} A recent comparison of prescription rates among elderly patients with IBD in the USA, UK, Denmark and Canada found a high degree of variability between the four countries.³ In Crohn's disease (CD), the USA had the highest rate of thiopurine usage and Canada had the highest rate of methotrexate prescriptions. Both North American countries prescribed higher rates of oral 5-aminosalicylates (5-ASA) and infliximab than the UK or Denmark. In patients with ulcerative colitis (UC), oral steroid prescriptions were highest in the USA and lowest in the UK, and oral 5-ASA use was highest in the USA and Canada. Infliximab and adalimumab prescriptions were significantly higher in the USA than other countries. However, while this analysis shows notable differences in prescription patterns across regions, it gives us little insight into the actual impact (if any) of

these differences in care on clinical outcomes. Most recently, the POLARIS study has provided interesting insight into variance in treatment patterns and quality of care from the perspective of patients with CD and their healthcare providers (HCPs), with preliminary results showing greater use of immunomodulators and biologics in IBD centres compared with non-IBD centres.⁴ Of course, it is likely that patients attending IBD centres have more severe disease and, therefore, are more likely to be prescribed aggressive therapy than those attending non-specialist centres. Further analysis of this study should evaluate whether care setting (both in terms of country and in terms of specialist vs. non-specialist centre) has an independent effect on clinical outcome in CD patients.

Efforts to set standards in quality of care are underway in various geographical and specialist society jurisdictions. Clinical quality indicators to guide, monitor and improve the quality of IBD care have been developed by several groups over the past few years and provide an important step towards delivery of consistent, evidence-based care that meets a specific minimum standard.⁵⁻⁷ In addition to this, we require well-designed prospective studies to understand this variation in care in terms of outcome. The cluster-randomised REACT study (NCT01030809), which is evaluating a treatment algorithm compared with usual care for the management of CD, should provide valuable insight into the impact of tailoring therapy to meet precise treatment goals on the likelihood of remaining in remission at 24 months' follow-up. This is the first cluster-randomised study to be performed across different IBD care settings.

Given the wide variation in IBD care, it is proposed that a network model is used within an IBD centre to reduce heterogeneity in care, with an example shown in Fig. 1. This type of model would allow non-IBD centres to reach out to IBD centres that, in turn, could access important specialist services, allowing care to be harmonised across different settings.

3. Moving towards value-based healthcare for IBD

IBD is an expensive chronic disease, with substantial direct and indirect costs.⁸⁻¹¹ These are further increased in patients with fistulising disease,¹² patients with more severe disease¹³ or patients who are non-adherent to therapy.¹⁴ While improving quality of care in IBD is a laudable goal, this may also result in increases in cost that need to be balanced against longer term improvements in patient outcomes.

Download English Version:

<https://daneshyari.com/en/article/6099186>

Download Persian Version:

<https://daneshyari.com/article/6099186>

[Daneshyari.com](https://daneshyari.com)