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EDITORIAL

Specialist care in the management of inflammatory bowel disease

Inflammatory bowel disease (IBD) includes Crohn's disease (CD) and ulcerative colitis (UC), both chronic, relapsing, incurable conditions. Phenotypical expression may vary, and a fraction of patients respond appropriately to conventional drugs without complications or need for hospitalization. At the opposite end of this spectrum, 30-40% of patients have severe, aggressive disease poorly responsive to conventional drugs. These latter patients urgently need more advanced therapy options, which also represent additional safety concerns. IBD management has become increasingly complex, and specialist care is deemed associated with better outcomes in the management of patients with IBD (1).

In the present issue of *The Spanish Journal of Gastroenterology (Revista Española de Enfermedades Digestivas),* Barreiro de Acosta et al. report the results of the GESTIONA-EII survey, which assessed IBD management in Spanish gastroenterology units (2). The survey separates gastroenterologist assessments according to their being IBD specialists or otherwise, hence providing an overall view of real-world IBD management in our country. This is a valuable approach to identify those limitations in IBD patient care that are amenable to improvement through measures encouraged by the governments or medical societies involved. According to the data provided by the GESTIONA-EII survey gastroenterologists specializing in IBD work in sites with specific structures devoted to the management of patients with IBD, whether IBD units or monographic IBD clinics. However, up to 26% of non-IBD gastroenterologists claim they care for their patients personally, lacking resources such as an IBD nurse or free-access visit scheduling (2).

What benefits does specialist care offer to patients with IBD and healthcare structures? IBD is quantitatively increasing in southern European countries, with an annual incidence of 11 to 21 patients per 100,000 population (3,4). Between 30% and 40% of these belong in the segment of severe, difficult-to-manage patients, where quality care may make a difference in results. These patients require without delay an indication of therapies effective against IBD, which includes immunosuppressants and biologic therapies.

For a local prevalence of 200-300 cases per 100,000 population (5), 1,000 to 1,500 potential IBD patients are to be expected in a large health care area with an assigned population above 500,000 inhabitants. According to the evidence available, it is considered that at least 30% of patients with IBD require treatment with immunosuppressants (6), which means that 300 to 450 patients will need to be treated with such drugs in a health care area the above. Bearing in mind the adverse effects these medications exert, most particularly the possibility of severe spinal myelotoxicity, which requires scheduled clinical and laboratory monitoring with safety follow-up visits specific for chronic therapies, it is hardly reasonable that such load of patients on immunosuppressants should be managed without a specific, specialized follow-up structure. This structure is no other than an IBD unit, which on these and other grounds we consider essential for any health care area with a high number of patients.

Biologic therapy has positively modified the management of our most complex cases. Quantitatively, it is deemed that at least 15% of patients with IBD require biologics for treatment (6), which represents between 150 and 225 patients for a large health care area. These drugs may induce occasionally serious side effects that differ from those seen with immunosuppressants. Serious infection is particularly relevant (7), which makes screening and vacunation or chemoprophylaxis protocols mandatory. Furthermore, intravenous biologics must be administered in specialist day hospitals, always in contact with prescribers. Patients may self-administer subcutaneous biologics at home, but must be previously instructed on how to proceed by a specialist nurse. Smaller health areas serving a population of 200,000 inhabitants may expect between 400 and 600 potential IBD patients. Of these, 120-180 would be eligible for immunosuppressive therapy, and 60-90 will require biologic therapy. In our mind, these figures warrant at least one monographic IBD clinic staffed by doctors who are specialists in biologic therapy monitoring.

An IBD unit offers integral care for IBD patients by professionals, doctors and nurses, exclusively dedicated to these conditions. The role of a specialist IBD nurse is currently considered crucial for the management of IBD. As IBD often changes patient habits and impacts occupational, reproductive, and familial functioning, specialist nursing advice is of utmost importance for patients and their relatives. Another added value any IBD unit should have available is offering patients free-access visits by telephone or in person (8). The alternating nature of IBD, with remission intervals and flare-ups that may develop suddenly, often with severe symptoms of concern to patients, is an issue requiring prompt assessment and treatment. Therefore, a flexible system providing efficient visit scheduling, and covering both patient prospects and organizational capabilities for care, is advisable in order to

adequately manage IBD. Care in IBD sites and clinics should be patient-oriented, and patient preferences delineate which organizational approach will work best (9).

An issue deserving consideration in the management of patients with IBD is its financial cost, most particularly regarding biologic therapy. Biologics are highly effective in the treatment of IBD and their dosing may restrain direct hospital stay and surgery costs (10-12). However, biologics are expensive and should be used by experts to streamline their use. Admission and surgery rates tended to increase in the years before the advent of consistent biologic therapy use (13,14), and these factors were traditionally responsible for most of the direct costs related to patients with IBD (15,16). However, recent studies reveal a change in that, presently, it is biologic therapy rather than hospital stay and surgery that is driving most hospital-related costs (6). In this respect 2 out of 3 respondents points out that hospital pharmacy costs represent a major concern in th management of IBD (2).

To conclude, while IBD care has considerably improved over the past few years, we still find room for improvement in the specialized structures involved in IBD management. To this end, the encouragement of studies to increase our understanding of IBD by medical associations is of great value for gaining insight into the needs and strategies of excellent IBD care.

C. Taxonera has received honoraria for lecturing and/or advisory boards from MSD, AbbVie, Ferring, Falk Pharma, Shire Pharmaceuticals, Pfizer, Takeda, and Gebro Pharma.

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