

# Multidisciplinary teams as standard of care in inflammatory bowel disease

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Inflammatory bowel diseases (IBD), ulcerative colitis and Crohn disease have been associated with extraintestinal manifestations. These include arthralgia and arthritis, erythema nodosum, pyoderma gangrenosum, primary sclerosing cholangitis and autoimmune hepatitis, episcleritis and uveitis. Increasingly, other conditions, such as psoriasis and multiple sclerosis, have been described to be associated with IBD. It may be proper to consider IBD to be one of a spectrum of immune-mediated inflammatory diseases (IMIDs) clustered according to genetic predisposition and immunological imbalance. In general, IMIDs affect young people at the peak of their working life and, therefore, are associated with a high societal cost (1). Extraintestinal manifestations are important predictors of morbidity and temporary work disability (1).

IBD is managed by gastroenterologists and, when required, by colorectal surgeons, but ideally should be managed in the setting of a multidisciplinary team. In the current issue of the *Canadian Journal of Gastroenterology*, this is illustrated by the report from Maastricht (The Netherlands) by Stolwijk et al (2) (pages 199-205) demonstrating the high prevalence of self-reported musculoskeletal spondyloarthritis (SpA) in patients with IBD. However, one-half of these patients never consulted a rheumatologist. The population-based cumulative incidence of SpA in Crohn disease is reported to be 6.7% at 10 years, 13.9% at 20 years and 18.6% at 30 years. However, this may have missed patient-reported musculoskeletal symptoms. Lack of rheumatology referral misses an opportunity for accurate diagnosis, appropriate imaging and management strategies. SpA may follow a disease course separate from the activity of IBD and, therefore, may warrant therapeutic strategies dictated by musculoskeletal disease burden and morbidity. These include consideration of nonsteroidal anti-inflammatory drugs (NSAIDs) in the context of IBD, immunosuppressive drugs and anti-tumour necrosis factor (anti-TNF) agents. SpAs are also a group of overlapping, chronic inflammatory rheumatic diseases; therefore, accurate phenotyping is important for management. Musculoskeletal symptoms may also be a side effect of drug therapy in IBD such as delayed hypersensitivity reactions to anti-TNF agents, thiopurines, nutritional deficiencies and corticosteroid withdrawal. Equally important is to recognize that gastrointestinal symptoms in patients with SpA may be a manifestation of IBD and require investigation by a gastroenterologist.

In general, the extraintestinal manifestations of IBD and the associated IMIDs respond to anti-TNF therapy, except primary sclerosing cholangitis. However, the use of etanercept may rarely be associated with development of IBD. Etanercept is ineffective in IBD and, therefore, SpA in the presence of IBD should be treated with the anti-TNF monoclonal antibodies. Other IMIDs, such as psoriasis and drug-induced lupus, may manifest while under treatment with anti-TNF

agents. While some of these manifestations may require discontinuation of anti-TNF therapy, others may be managed while continuing anti-TNF therapy (such as methotrexate for psoriasis).

Multidisciplinary IMID clinics are, therefore, a very effective organizational structure that can assess the entire disease spectrum in patients with IBD to determine the full burden of disease. Although rheumatologists, dermatologists and gastroenterologists represent key members of such multidisciplinary IMID teams, ophthalmologists and hepatologists also participate (Box 1). Such teams are effective in coordinating trials, learning from one another's management algorithms and ensuring effective management of the entire disease burden (Box 2). In academic centres, this should become the standard of care. Such collaborative teams enhance quality of care and may reduce disease burden and morbidity.

## BOX 1 Collaborative clinical care teams in inflammatory bowel disease

### Multiple specialties

Surgeons: colorectal, general  
Rheumatologists  
Dermatologists  
Hepatologists  
Ophthalmologists

### Multiple support services

Radiologists  
Nutritionists  
Nurse practitioners  
Clinical psychologists  
Social workers  
Primary care

## BOX 2 Collaborative models in inflammatory bowel disease (IBD)

### Research

Clinical trials  
Traditional studies  
Genetic studies  
Biomarker studies

### Clinical

IBD care teams

### Educational

Patients  
Physicians  
Health care providers

## REFERENCES

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