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What you may have missed at UEG Week Virtual 2021: expert-curated digest of hot topics in IBD

The United European Gastroenterology (UEG) Week Virtual Congress, held from 3 to 5 October 2021, started off the gastroenterology community's autumn congress season with a host of exciting data on a wide variety of topics, ranging from the predictive value of intestinal ultrasound for inflammatory bowel disease (IBD) outcomes to the wide differences observed across various European countries in IBD care and education.

We caught up with two IBD experts, **Professor Jimmy Limdi** and **Dr Ayesha Akbar**, to hear about the data they found the most impactful at this year's congress. Check out their insights below, and make sure you don't miss listening to their discussion in full on our **Hot topics** page.

Intestinal ultrasound parameters may have prognostic value for long-term outcomes in patients with IBD

One-year interim results of the TRUST BEYOND study showed that intestinal ultrasound could be a valuable monitoring and prognostic tool in everyday clinical practice

With the treat-to-target approach to IBD management requiring frequent and objective monitoring to allow for quick adjustment of treatment regimens to achieve treatment goals,[1] finding new monitoring and prognostic tools is of key importance for optimising treatment outcomes.

Building on their previous research into intestinal ultrasound (IUS) use in monitoring Crohn's disease (CD) activity,[2,3] in the ongoing prospective, observational TRUST BEYOND study, Kucharzik T et al. are evaluating the predictive value of IUS parameters for long-term IBD outcomes.[4] The study is recruiting 400 patients with CD or ulcerative colitis (UC) undergoing treatment intensification to advanced therapy with either a biologic or a JAK inhibitor and following them for 24 months. The primary endpoint of the study is the proportion of patients achieving either clinical or steroid-free remission at Week 52 (**Box 1**).[4]

We report here the results of an interim analysis of the TRUST BEYOND study with patients who had completed the Week 52 study visit. The aim of this analysis was to assess the predictive value of clinical remission and IUS-evaluated transmural response at Week 12 following treatment intensification for outcomes at Week 52.[5]

Box 1: TRUST BEYOND study definitions

Clinical remission was defined as a Harvey Bradshaw Index (HBI) of <5 (for CD) or a Simple Clinical Colitis Activity Index (SCCAI) of ≤2 (for UC).

Clinical flare was defined as HBI >7 for CD and SCCAI ≥5 for UC.

Steroid-free remission was defined as no steroids for ≥8 weeks.

Transmural response was defined as a reduction in bowel wall thickness (BWT) of ≥25%, as evaluated by IUS.

Transmural healing was defined as normalised BWT and vascularity at the most affected segment.

The interim analysis included 41 patients with active IBD (17 had CD, 24 had UC). All were in clinical flare at baseline, with increased BWT and a median disease duration of 8.7 years (interquartile range [IQR]: 2.37–11.53).[5]

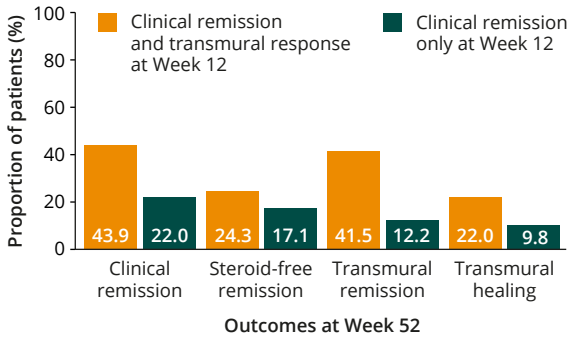
At Week 12, 70.7% of patients (n=29) achieved transmural response, with 41.5% of patients (n=17) achieving transmural healing. At Week 52, these rates remained almost unchanged, with 68.3% of patients achieving transmural response and 39% of patients achieving transmural healing. Patients who experienced transmural response in addition to clinical remission at Week 12 were more likely to be in clinical remission at Week 52 than patients who experienced only clinical remission at Week 12 (43.9% of patients [n=18] vs. 22.0% of patients [n=9]; **Figure 1**).[5]

Date of preparation: December 2021 | UK-IBD-NA-202110-00020

The results of this interim analysis of the TRUST BEYOND study data suggest IUS can detect meaningful transmural improvements in patients with IBD as early as 12 weeks following treatment intensification and that these parameters can be used to predict long-term treatment outcomes in IBD. This highlights the possible value of IUS as a monitoring and prognostic tool in everyday clinical treatment of patients with IBD.[5]

1. Peyrin-Biroulet L, et al. *Am J Gastroenterol* 2015;110:1324–1338.
2. Kucharzik T, et al. *Clin Gastroenterol Hepatol* 2017;15:535–542.
3. Maaser C, et al. *Gut* 2020;69:1629–1636.
4. Kucharzik T, et al. UEG Week 2020. P340.
5. Kucharzik T, et al. UEG Week 2021. OP123.

Figure 1. Treatment outcomes at Week 52 in patients achieving clinical remission and transmural response at Week 12 vs. patients achieving only clinical remission at Week 12



"I thought this was interesting because we currently do not use as much intestinal ultrasound in the UK as they do in Europe. And in America it's a similar story. The study does stimulate interest in intestinal ultrasound in capable hands, but availability of intestinal ultrasound is limited. If this expertise exists, then it is something [...] that we might be able to adopt."

Professor Jimmy Limdi, Consultant Gastroenterologist and Head of the IBD Section, Northern Care Alliance NHS Foundation Trust, Salford, UK, and Clinical Professor at the University of Manchester, Manchester, UK

Abnormal frailty screening is independently associated with all-cause and disease-related hospital admissions in older patients with IBD

Frailty screening may be used for risk stratification for hospitalisation in elderly patients with IBD

In this study, Maljaars J et al. evaluated the association of frailty screening results with hospital admissions and functional and quality of life decline in elderly patients with IBD.[1]

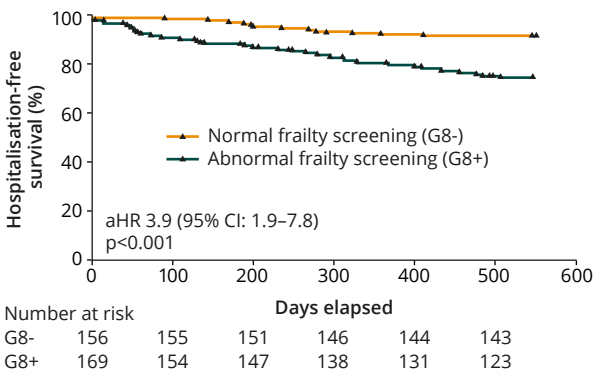
Overall, 405 elderly patients with IBD from outpatient departments and infusion centres were prospectively followed up for at least 18 months. The median age of the patients included was 70 years (IQR: 67–74). Most patients (79%) were considered in remission (HBI <5 or partial Mayo Score <2) and without biochemical disease activity (C-reactive protein levels <10 mg/L and calprotectin <250 µg/g).[1]

Frailty screening was carried out at baseline using the Geriatric 8 (G8) questionnaire, with a score of less than or equal to 14 considered abnormal. After 18 months, data regarding hospital admissions and mortality were retrieved from medical records. Functional status and health-related quality of life (HRQoL) were assessed at baseline and at 18 months' follow-up.[1]

In total, 74 all-cause and 33 IBD-related hospitalisations occurred during the study; abnormal frailty based on G8 score was found in 48% of patients (n=198). Abnormal frailty was associated with a significantly higher rate of both all-cause (p<0.001; **Figure 2**) and IBD-related hospitalisations (p=0.012), and with a higher rate of hospitalisation in patients with active biochemical disease than in patients with a normal frailty score (p=0.026). Furthermore, abnormal frailty scores were associated with functional (p=0.009) and QoL decline (p=0.002) but not with HRQoL decline (p=0.336).[1]

These results show that an abnormal frailty score is associated with increases in hospital admissions, and with functional and QoL decline in older patients with IBD. Frailty screening may therefore be a useful risk stratification tool in this patient population.[1]

Figure 2. Hospitalisation-free survival in patients with normal or abnormal frailty scores



aHR, adjusted hazard ratio; CI, confidence interval; G8, Geriatric 8.

1. Maljaars J, et al. UEG Week 2021. P0273.

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"[In our practice] we don't actually use a score formally [to assess frailty in patients with IBD]. We do have IBD multidisciplinary management discussions, we will bring mortality, morbidity, etc., into our discussion potentially, depending on comorbidities. But it is nice to see a piece like this where they've used comprehensive scoring systems. And perhaps that will revise the way that we manage our patients."

Dr Ayesha Akbar, Consultant Gastroenterologist, St Mark's Hospital and Academic Institute, London North West University Healthcare NHS Trust, London, UK

Are you keen to hear more about the management of elderly patients with IBD? Listen to Consultant Gastroenterologist Dr Dan Gaya share his insights with Nurse Consultant Vikki Garrick in Episode 3 of our 'Managing difficult conversations' podcast series, titled 'Managing IBD in different stages of life', on our **Expert insights** page.

Should we expect a clinical benefit from achieving histological remission and complete endoscopic mucosal healing in patients with UC who are in endoscopic remission?

Histological activity and remission appear to have no correlation with relapse rates in patients with UC in endoscopic remission

This investigation by Kevrekidou P et al. explored whether there is any correlation between histological activity and histological remission, and disease relapse.[1]

Patients with UC who were in clinical and endoscopic remission were recruited in this study to investigate whether there was any correlation between histologic activity and disease relapse (**Box 2**). Patients were prospectively followed up to assess disease relapse for at least 12 months.[1]

The study included 71 patients; 39 of whom were in histological remission at baseline. All were receiving stable treatment throughout the study, including mesalamine (73% of patients), biologic treatments (34% of patients), azathioprine (21% of patients) and steroids (9% of patients). A total of 99% of patients had a disease duration of more than 2 years, and the median length of study follow-up was 25.6 months (95% confidence interval: 22.04–29.08).[1]

No significant difference in relapse rates was observed between:

- Patients with MES=0 vs. MES=1 (7/37 patients vs. 5/34 patients, p=0.756)
- Patients with MES=0 and histological activity vs. those with MES=0 and in histological remission (1/13 patients vs. 6/24 patients, p=0.383)
- Patients with histological activity vs. those in histological remission (3/32 patients vs. 9/39 patients, p=0.328; **Figure 3**).[1]

These results suggest that achieving either histological remission or complete mucosal healing (MES=0) had no clinically meaningful impact on patients with UC in endoscopic remission.[1] These findings are in line with the recently published Selecting Therapeutic Targets in Inflammatory Bowel Disease (STRIDE-II) guidance, which recognises histological healing as a measure of remission depth in UC but does not support its inclusion among formal UC treatment targets.[2]

1. Kevrekidou P, et al. UEG Week 2021. MP006.
2. Turner D, et al. *Gastroenterology* 2021;160:1570–1583.

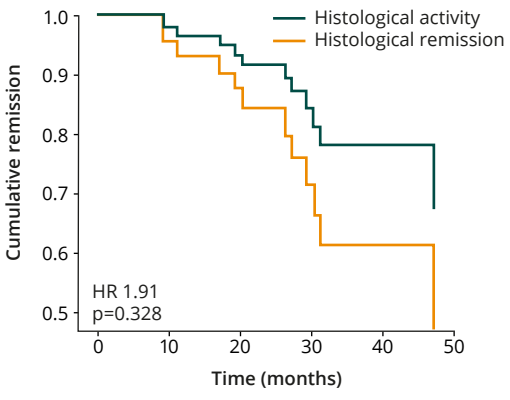
Box 2: Definitions

Endoscopic remission was defined as a Mayo endoscopic score (MES) of 0 or 1, with a MES of 0 constituting complete **mucosal healing**.

Histological remission was defined as the absence of neutrophil infiltration into the epithelium, evaluated by two independent pathologists.

Disease relapse was defined as clinical and endoscopic relapse necessitating steroid administration or treatment change/escalation.

Figure 3. Endoscopic and clinical remission in patients with histological activity and those achieving histological remission



HR, hazard ratio.

"This is a new paradigm for us to consider. We do know that histological healing, when possible, does seem to correlate with reduction in some important surrogates, such as hospitalisation, surgery, and even the risk of colorectal cancer complicating IBD. […] For those that do use it, it will be nice to see some data using histological scoring systems. But whether I would treat to histological healing, that is a matter of perspective, based on each patient."

Professor Jimmy Limdi, Consultant Gastroenterologist and Head of the IBD Section, Northern Care Alliance NHS Foundation Trust, Salford, UK, and Clinical Professor at the University of Manchester, Manchester, UK

Are you interested in listening to an expert discussion on the importance of histological healing as a treatment goal in UC and the evolving treatment targets in IBD? Listen to Dr Rachel Cooney and Professor James Lindsay discuss the updated STRIDE-II guidance[2] on our **Resources** page.

Patients with CD have improved coping strategies after a 3-month course of cognitive behavioural and mindfulness-based stress reduction (COBMINDEX)

Cognitive behavioural and mindfulness-based stress reduction interventions may be a valuable complementary treatment approach in patients with mild-to-moderate CD

Over time, patients with CD can learn to handle their disease burden by developing coping strategies to address specific problems and emotions. However, coping is moderate to poor in many patients. Building on their previous work demonstrating the effectiveness of COBMINDEX in reducing psychological distress and improving QoL in patients with IBD,[1] Goren G et al. have now evaluated its efficacy in improving the coping strategies of patients with CD.[2]

Patients with mild-to-moderate CD (defined as a Harvey Bradshaw Index of 5–16) were randomly assigned to COBMINDEX (n=60) or a wait list group (n=66). Clinical and psychological assessments were carried out at baseline (T1) and after 3 months (T2). COBMINDEX was taught on a digital platform between T1 and T2, with daily self-practice required.[2]

T1 and T2 scores across 10 of the clinical and psychological characteristics evaluated are shown in **Table 1**. At baseline, the two study groups had similar scores in all the categories measured. The COBMINDEX group showed significant improvement between T1 and T2 in the scores of 10 of the categories studied ($p<0.05$), whereas in the control group improvement was observed in disease activity and physical health only ($p<0.05$; **Table 1**). In addition, use of emotion-focussed coping increased between T1 and T2 by 72% in the COBMINDEX group vs. 41% in the wait list group ($p=0.002$); this represented the dominant change in the coping pattern between the patient groups at 3 months.[2]

Table 1. Clinical and psychological characteristics at baseline (T1) and after 3 months (T2) for the COBMINDEX and wait list study groups

Characteristic, median value	COBMINDEX group (T1)	COBMINDEX group (T2)	Wait list group (T1)	Wait list group (T2)
HBI	8	4	8	7
CRP (µg/mL)	0.6	0.39	0.5	0.36
Calprotectin (µg/g)	102	62.7	128.5	54.5
Satisfaction with life	20.5	24	19	No change
SF-12 physical health	44.5	47.5	41.4	43
SF-12 mental health	39.7	42.3	39.3	No change
Mindfulness	33	38	32.5	No change
Emotion-focussed coping	25.5	29	25	No change
Problem-focussed coping	18	19	17.7	No change
Perceived Stress Scale-4	7	4.5	8	8

Significant ($p<0.05$) improvement between T1 and T2.
Perceived stress was higher in the control group at T1 ($p=0.027$).

CRP, C-reactive protein; HBI, Harvey Bradshaw Index; SF-12, 12-item Short Form survey.

Overall, patients receiving the COBMINDEX treatment had reduced disease activity, increased satisfaction with life and improved mental and physical health vs. baseline, while patients in the control group experienced no improvement in psychological measures or coping strategies.[2]

These results emphasise the value of psychological interventions used in the context of a more holistic approach to remission for improving the QoL and coping strategies of patients with CD.[2]

1. Goren G, et al. *Inflamm Bowel Dis* 2021; doi:10.1093/ibd/izab083 [Epub ahead of print].
2. Goren G, et al. UEG Week 2021. MP056.

"We're all aware that with a chronic disease, mental health and wellbeing is extremely important. And you can see that in this study the quality of life was better in those who were given the cognitive behavioural therapy. They managed better on a day-to-day basis, their emotions, wellbeing and their coping was better. And interestingly during the study, patients' fatigue improved as well, which is a massive thing for a lot of us who have to manage IBD patients."

Dr Ayesha Akbar, Consultant Gastroenterologist, St Mark's Hospital and Academic Institute, London North West University Healthcare NHS Trust, London, UK

Are you interested in additional expert insights into complementary psychological interventions that may help to improve the coping strategies of patients with IBD? Head over to our **Hot topics** page to listen to Dr Alexa Duff's thoughts on the use of emotional systems to help patients with IBD make changes in their lives.

Are you interested in hearing about a holistic approach to remission in IBD from our panel of international IBD experts? Check out the 'Holistically Approaching Remission (HAPPI-R)' section on our **Hot topics** page.

Large differences exist in IBD care and education across Europe

According to the first results of the pan-European Variation In ibd PracticE suRvey, large variability may be found in IBD care and education available in different European countries

Nakov R et al. conducted a Variation In ibd PracticE suRvey (VIPER) across European countries to investigate potential differences in IBD care across Europe. A trainee-initiated survey, consisting of 47 questions focussing on basic demographics, IBD training and clinical care, was distributed online in 40 European countries between December 2020 and January 2021. The results were compared according to countries' gross domestic product (GDP) per capita, with countries being assigned either a low- or a high-income status.[1]

The survey was completed by 1285 participants from 40 countries. Most respondents felt confident in treating IBD, with a small difference between high- and low-income countries (77.2% vs. 72.0%, p=0.04). Factors increasing confidence in treating IBD included a higher number of patients with IBD seen per week, availability of IBD boards and IBD-specific training.[1]

Availability of multiple IBD care and educational resources was significantly higher in high-income countries than in low-income countries (p<0.001; **Table 2**). Although treat-to-target approaches and faecal calprotectin as a routine monitoring tool were used in almost all countries regardless of their GDP status, access to advanced treatments such as biologics or small molecules differed, and IUS use was reported in only 47.9% of the countries.[1]

Table 2. Proportion of VIPER survey respondents from European high- and low-income countries* reporting resource availability in their country

Care or education resource	High-income countries (%)	Low-income countries (%)	p value
IBD-specific training	56.4	38.5	<0.001
Dedicated IBD units	58.5	39.7	<0.001
Multidisciplinary team meetings	72.6	40.2	<0.001
IBD nurses	86.2	36.0	<0.001
IBD nurse-led clinics	40.6	13.8	<0.001
IBD dietitians	32.4	16.6	<0.001
IBD psychologists	16.7	7.5	<0.001
Telemedicine	58.4	21.4	<0.001
Urgent flare clinics	58.6	38.7	<0.001

*Based on their GDP per capita (per World Bank criteria).
GDP, gross domestic product; IBD, inflammatory bowel disease.

The results of the VIPER survey highlight a significant variability in IBD practice across Europe, with marked inequality in the resources available to low- vs. high-income countries. It is crucial to address these inequalities to standardise IBD care across Europe.[1]

1. Nakov R, et al. UEG Week 2021. P0271.

"Although we think there's a huge statistically significant difference between high- and low-income countries, the high-income countries aren't doing very well, actually, in many spheres. Fewer than a third of our patients have any access to psychology or dietetic care. That's humbling. […] But despite that, it does highlight some important gaps in care in what was classed as low-income countries in this study, and disparities. Because unfortunately patients do have different outcomes based on which clinician is looking after them."

Professor Jimmy Limdi, Consultant Gastroenterologist and Head of the IBD Section, Northern Care Alliance NHS Foundation Trust, Salford UK, and Clinical Professor at the University of Manchester, Manchester, UK

Are you keen to explore the guidance pieces and consensus recommendations available to UK IBD experts but short on time to find these online? Check out our IBD guidance and recommendations library in our **Resources** section.

Are there any topics you find difficult to discuss with your patients with IBD? For insights from gastroenterologists, clinical nurse specialists and patient advocates, head over to our **Expert insights** page to explore our 'Managing difficult conversations' podcast series.