Health Maintenance in IBD

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Overview of Health Maintenance in IBD

- IBD patients tend to see their GI docs more so than their PCPs
- IBD patients are generally younger and consider their GI doc as their PCP
- PCPs are not always well acquainted with the ways that IBD pathology and its treatments affect general health maintenance
- Special health care maintenance considerations for IBD patients needs to be addressed by both the GI doc and PCP
- Open dialogue and correspondence is critical
IMMUNIZATIONS

Despite many IBD patients being at increased risk for infections due to immunosuppression from medical therapy, they tend to be UNDER VACCINATED!

- Reasons:
  - GI doc’s lack of knowledge of importance of vaccinations
  - GI docs often do not have availability to vaccinations
  - Role of the PCP
  - Patient’s concern of exacerbating an IBD flare
  - Never been shown (whether on immunosuppressants or not)
# Table 1. Recommended Vaccines in IBD

## Inactive Vaccines

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Population</th>
<th>Serology</th>
<th>Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diptheria / Tetanus / Pertussis</td>
<td>All – Update if not given in last 10 years</td>
<td>No</td>
<td>TdaP x 1 dose and Td booster q10yrs</td>
</tr>
<tr>
<td>Pneumococcus</td>
<td>All</td>
<td>No</td>
<td>PCV13 and PPV23</td>
</tr>
<tr>
<td>Influenza</td>
<td>All</td>
<td>No</td>
<td>Annual</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>All – If anti-HBs titre &lt;10 IU/mL</td>
<td>Yes</td>
<td>3 doses at 0,1,6 months</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>At risk – liver disease, travelers, men having sex with men</td>
<td>Yes</td>
<td>2 doses at 0,6 months</td>
</tr>
<tr>
<td>HPV</td>
<td>Males 9–26 and Females 9–45*</td>
<td>No</td>
<td>3 doses at 0,2,6 months</td>
</tr>
<tr>
<td>Meningococcus</td>
<td>High risk (traveler, splenectomy)</td>
<td>No</td>
<td>2 doses of quadrivalent conjugate vaccine</td>
</tr>
<tr>
<td>Vaccine</td>
<td>Considered Immune</td>
<td>Population</td>
<td>Serology</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------------</td>
<td>------------------------------------------------</td>
<td>----------</td>
</tr>
</tbody>
</table>
| Measles / Mumps / Rubella | 2 documented doses of vaccine | Patients with unknown vaccine history | Yes      | 2 doses one month apart
|                  | Positive serology | Administer before immunosuppression starts     |          | Wait 4 weeks before starting immunosuppression                           |
| Varicella        | Born before 1970  |                                                 | Yes      | 2 doses one month apart
| Shingles         | Shingles in the last 1 year | Age >= 50                                    | Yes      | One dose 4 weeks before immunosuppression; consider in those on biologics |

LIVE vs INACTIVATED (non-live) VACCINATION?

- Ideally IBD patients should receive **INACTIVATED** (NON-LIVE) vaccines

- LEVEL OF IMMUNOSUPPRESSION dictates whether a LIVE vaccine is safe

  - **LOW LEVEL IMMUNOSUPPRESSION = LIVE vaccines safe**

    - Steroids: **20mg/day or less**
    - MTX: <0.4mg/kg/week
    - AZA (<3.0 mg/kg/d) or 6-MP (<1.5mg/kg/d)

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1 Farraye, et. al., AJG, Feb 2017
LIVE vs INACTIVATED (non-live) VACCINATION?

- **HIGH LEVEL IMMUNOSUPPRESSION** *(avoid live vaccines):*
  - Higher dose steroids within the last 3 months
  - Higher doses of AZA and 6-MP within the last 3 months
  - All anti-TNFs
  - Ustekinumab (Stelara)
  - Vedolizumab (Entyvio):
  - Tofacitinib (Xeljanz)

- Often live vaccines will need to be delayed in circumstances where the patient is requiring immediate immunosuppression
- Ideally: make sure ALL vaccinations are up to date upon diagnosing IBD!!
INACTIVATED VACCINES

- **INFLUENZA VACCINE**
  - Injectable form (IM): safe
  - Oral form is a LIVE vaccine (avoid)
  - All household members should receive the inactivated form of the vaccine

- **PNEUMOCOCCAL VACCINE**
  - Pneumonia is more prevalent in IBD patients, with worse outcomes
  - *Increased* risk IF:
    - Steroids, anti-TNFs, narcotics, PPIs
INACTIVATED VACCINES

• **HEPATITIS A VACCINE**
  • Childhood vaccine
  • HOWEVER, many unvaccinated adults
  • OK to give the vaccine again if unknown status

• **HEPATITIS B VACCINE**
  • Immunosuppressive therapy (especially biologics) can **re-activate** HBV
  • Check for infection, prior exposure or vaccination status in all IBD patients
    • Ideally at time of diagnosis> remission or prior to starting biologics
    • Check titers 1-2 months after series completed (> 10 IU/L)
    • Accelerated vaccination protocols available for more immediate treatment
  • Single or combination vaccines
INACTIVATED VACCINES

• **TETANUS, DIPTEHRIA, PERTUSSIS VACCINE**
  - Childhood vaccine
  - Rise in pertussis epidemics
  - Decreased response rates when given to patients already on immunosupps.
    - Try to administer (booster) prior to starting therapy

• **MENINGOCOCCAL VACCINE**
  - Young adulthood vaccine
  - No evidence that IBD patients are at increased risk
    - Standard guidelines

• **HUMAN PAPILLOMA VIRUS VACCINE**
  - Administered childhood, early teens (males too!)
  - Female IBD patients on immunosuppression: INCREASED RISK of cervical dysplasia
HERPES ZOSTER VIRUS

- ZOSTER (SHINGLES) VACCINE

- Herpes Zoster virus (HZV) persists as a latent infection in sensory ganglia.

  - Can re-activate!

- 1 in 3 will develop HZV reactivation in the general population.

  - Almost twice the risk of reactivation in IBD patients!

    - Especially in immunocompromised patients
    - 5-6 times more likely in patients on Xeljanz (tofacitinib)
INACTIVATED AND LIVE VACCINES

- ZOSTER (SHINGLES) VACCINE

- **2006**: Zostavax (LIVE attenuated vaccine)
  - SAFE with LOW level immunosuppression
  - AVOID with anti-TNFs and Stelara
  - Probably OK with Entyvio if benefits outweigh the risk

- **2017**: Shingrex (inactivated vaccine)

- CURRENT RECOMMENDATIONS:
  - Vaccinate all IBD patients > age 50
  - Vaccinate all IBD patients (any age) prior to starting Xeljanz
LIVE VACCINES

- MEASLES, MUMPS, RUBELLA VACCINE
  - Usually administered to young children

- However, **some adults may not be immunized!**
  - Personal parental decision
  - Loss of immunity
  - Recent pockets of measles outbreaks

- Immunity important in IBD patients about to start immunosupps/biologics

- Can be SAFELY administered AS LONG AS:
  - NO plan to start HIGH level immunosuppression within the next 6 weeks
  - HIGH level therapies have been discontinued for AT LEAST 3 months
LIVE VACCINES

- VARICELLA (CHICKEN POX) VACCINE
  - HIGHLY contagious
    - Can cause disseminated life-threatening illness in immunocompromised
    - Steroids in combination with immunomodulators/biologics: increase risk
  - Majority of adults have immunity
  - Given high risk for severe disease varicella disease in immunocompromised
    - Assess immunity prior to starting immunosuppressant/biologic therapies
  - Can be SAFELY administered AS LONG AS:
    - NO plan to start HIGH level immunosuppression within the next 6 weeks
    - HIGH level therapies have been discontinued for AT LEAST 3 months
  - Some evidence to support SAFE administration in high risk individuals (teachers, health care workers) on HIGH level immunosuppression who CANNOT stop med

\[\text{Lu, Y JPGN, May 2010}\]
TB (Tuberculosis) TESTING

- Risk of TB re-activation (can be fatal) in immunosuppressed IBD patients

- PPD (skin) or quantiferon gold (blood) AND chest x-ray PRIOR to starting immunosuppressant/biologic therapies

- Assessed annually
  - Repeat testing in **HIGH** risk populations
    - Workers (prisons, institutions)
    - Geographic considerations

- **LOW** Risk populations do NOT require annual testing
  - Often mandated by insurance carriers
Patients with ulcerative colitis and COLONIC Crohn’s disease are at approximately **2 times** the risk of developing colon cancer.

- Limited involvement of just the rectum (PROCTITIS) has NOT been proven to be a risk factor for the development of colon cancer.

**RISK FACTORS** for development of colon cancer in IBD patients:
- Duration/extent of disease
- Family history of colon cancer
- History of concomitant Primary Sclerosing Cholangitis (PSC)
- Disease onset at young age
COLON CANCER SCREENING

- SURVEILLANCE COLONOSCOPY

  - Start 8-10 years after onset of disease
    - Ideally during disease remission
    - Surveillance intervals 1-3 years

  - Stricter intervals in patients with:
    - H/O prior dysplasia or strictures
    - H/O multiple pseudopolyps
    - H/O PSC

  - Extensive systematic biopsies performed
    - Chromoendoscopy preferable
CERVICAL CANCER SCREENING

- IBD patients on thiopurines (AZA and 6-MP) shown to be at increased risk for cervical dysplasia/cancer
  - No data to show that the biologics increase risk
  - HPV vaccine has been shown to greatly reduce risk

- Women with IBD on immunosuppressants (especially thiopurines) should undergo Pap smears **ANNUALLY**, rather than every 3 years
  - Regardless of HPV vaccination
SKIN CANCER SCREENING

- IBD patients need to be aware of skin cancer risks!
  - The use of AZA/6-MP and Xeljanz: associated with an increased risk of NMSC
    - Squamous >> basal
    - Potential ongoing risk **EVEN AFTER** the AZA/6-MP has been stopped!!
  - IBD patients have a higher incidence of melanoma, regardless of therapy
    - Anti-TNF agents **DOUBLE** the risk of melanoma

- **PREVENTION:**
  - Minimize sun exposure (inc. tanning beds)
  - SPF > 30, protective clothing
  - At least **ANNUAL** dermatologist exams
    - Even after cessation of thiopurines

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3 Singh et. al., AGA, Feb 2014
BONE HEALTH

- Pts with IBD can be at increased risk of bone demineralization and fractures
  - Osteoporosis prevalence: 40%  
  - Osteopenia prevalence: 70%  

- Risk Factors:
  - Chronic inflammation associated with IBD
  - Steroid use (> 3 months or repeated use)
  - Malnutrition/ inactivity
  - Low vitamin D levels
  - Smoking/ alcohol
  - Maternal H/O osteoporosis
  - Post menopause/ amenorrhea
  - Age >50

4 Targowinik et. al, Maturitas, Dec 2013
BONE HEALTH

**PREVENTION:**

- Minimize steroid use
- Engage in physical activity
- Quit smoking
- Vitamin D / calcium supplementation
  - Monitor vitamin D levels (goal > 30-40)
  - Vitamin D3 supplements (1000-2000 IU /day)
  - Calcium >1200mg / day

- If ANY risk factors:
  - Bone mineral density measurement (**DEXA scan**)  
    - Biphosphonates?
SMOKING & ALCOHOL

- Smoking exacerbates Crohn’s disease (cessation is a must!!)

  - Smoking is associated with:
    - Increased steroid use
    - Greater risk for surgery
    - Greater recurrence after surgery
    - Decreased bone mineral density

- Alcohol:
  - Interacts with methotrexate potentiating liver disease
  - Decreased bone mineral density
DEPRESSION COUNSELING

- Up to 20-25% of IBD patients suffer from depression and/or anxiety
- Should be assessed at least annually
  - Upcoming lecture
EYE/ MOUTH/ SKIN CARE

- EYE “conditions” and SKIN rashes should be assessed every visit
  - Extraintestinal manifestations of IBD
  - Side effects of some therapies
    - Steroids (cataracts, glaucoma)
    - Anti-TNFs (visual changes, rashes, joint pain)
    - Mesalamine / AZA/ 6-MP (rashes, joint pain)

- ORAL “conditions” should be assessed every visit
  - Oral canker sores, cracked lips
    - Extraintestinal manifestations of IBD
    - Nutrition/ vitamin deficiencies
LAB MONITORING

- The armamentarium of medications continues to grow for IBD 😊
  - Specific laboratory monitoring of individual therapies
  - Prevents therapy related adverse events
<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>LAB</th>
<th>FREQUENCY</th>
<th>SPECIAL CONSIDERATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>CBC, LFTs, C-RP</td>
<td>Every 6 months</td>
<td>Add vit B12 in ileal CD</td>
</tr>
<tr>
<td>Mesalamine/sulfasalazine</td>
<td>CBC, Cr</td>
<td>Every 6 months</td>
<td>add folate supp with sulfasal</td>
</tr>
<tr>
<td>Steroids</td>
<td>HA1C</td>
<td>Every 3-6 months</td>
<td>If H/O DM and prolonged use</td>
</tr>
<tr>
<td>AZA / 6-MP</td>
<td>TPMT, CBC/d, LFTs</td>
<td>Q 2-4 weeks initially, then q 3 mo</td>
<td>Dose adjustment with low TPMT activity</td>
</tr>
<tr>
<td>Methotrexate</td>
<td>CBC, Cr, LFTs</td>
<td>“</td>
<td>Folate supp - contraind. in pregnancy and liver disease or alcoholism - CXR at 1 year</td>
</tr>
<tr>
<td>Anti-TNFs</td>
<td>PPD/quantiferon, CXR, HBV labs. CBC, Cr, LFTs, albumin</td>
<td>Initially Q 3-6 months</td>
<td>Annual Tb monitoring in high risk</td>
</tr>
<tr>
<td>Stelara</td>
<td>“</td>
<td>“</td>
<td>“</td>
</tr>
<tr>
<td>Entyvio/Tysabri</td>
<td>“</td>
<td>“</td>
<td>“ - Check JCV Ab prior for Tysabri and enter in TOUCH program</td>
</tr>
<tr>
<td>Xeljanz</td>
<td>Lipid profile</td>
<td>Initially then again 4-12 weeks</td>
<td>“ - Contra in liver disease - HZV vacc recommended - monitor for PE</td>
</tr>
</tbody>
</table>
# Health Maintenance Checklist for Adult IBD Patients

<table>
<thead>
<tr>
<th>Vaccine-Preventable Illnesses</th>
<th>Which Patients</th>
<th>How Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Influenza (inactive)</td>
<td>All</td>
<td>Annually</td>
</tr>
<tr>
<td>Pneumococcal PCV13</td>
<td>If on/planning immunosuppression</td>
<td>Once¹</td>
</tr>
<tr>
<td>Pneumococcal PPSV23</td>
<td>If on/planning immunosuppression</td>
<td>At baseline, repeat in 5 years and again after age 65</td>
</tr>
<tr>
<td>Tdap</td>
<td>All</td>
<td>Every 10 years</td>
</tr>
<tr>
<td>HPV</td>
<td>All aged 11–26 years</td>
<td>Once¹</td>
</tr>
<tr>
<td>Meningococcal meningitis</td>
<td>All adult patients at risk of meningitis</td>
<td>Once¹</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>If non-immune</td>
<td>Once¹</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>If non-immune</td>
<td>Once¹</td>
</tr>
<tr>
<td>MMR (live vaccine)</td>
<td>If non-immune²</td>
<td>Once¹</td>
</tr>
<tr>
<td>Varicella (live vaccine)</td>
<td>If non-immune²</td>
<td>Once¹</td>
</tr>
<tr>
<td>Herpes Zoster</td>
<td>All aged &gt; 50 years³</td>
<td>Once¹</td>
</tr>
</tbody>
</table>

## Cancer Prevention

<table>
<thead>
<tr>
<th>Which Patients</th>
<th>How Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical PAP smear</td>
<td>All on systemic immunosuppression*</td>
</tr>
<tr>
<td>Skin screen</td>
<td>All on systemic immunosuppression*</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>All with colonic disease for &gt; 8 years</td>
</tr>
</tbody>
</table>

## Other Screenings

<table>
<thead>
<tr>
<th>Which Patients</th>
<th>How Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>DEXA Scan</td>
<td>High risk; women with low BMI, post-menopausal, chronic steroid exposure</td>
</tr>
<tr>
<td>PPD or IGRA</td>
<td>Prior to anti-TNF or anti-IL-12/23</td>
</tr>
<tr>
<td>Smoking status</td>
<td>All</td>
</tr>
<tr>
<td>Depression check</td>
<td>All</td>
</tr>
</tbody>
</table>

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1. Recommended timing and spacing of vaccines available in ACIP recommendation
2. Patients treated with systemic immunosuppressive therapy (steroids, thiopurines, anti-TNFs) should not receive live (attenuated) vaccines e.g. measles, mumps, rubella, nasal influenza, varicella, and yellow fever
3. The CDC’s ACIP recommends the subunit vaccine (Shingrix) over the live vaccine (Zostavax), and that Shingrix can be administered to patients who have already received Zostavax. Patients receiving anti-TNFs, anti-IL-12/23 or >20 mg prednisone should NOT be given the live zoster vaccine.
4. “Systemic immunosuppression” currently includes azathioprine, mercaptopurine, methotrexate, anti-TNFs, anti-IL-12/23

### ADDITIONAL INFORMATION
- ACG
- ACIP
- ACOG
- AGA
- NCI Skin Screen
- National Osteoporosis Foundation
- PHQ-9 Depression Survey
- US Preventive Services Task Force (USPSTF)
CONCLUSIONS

- Prevention and general health maintenance is crucial in the management of the IBD patient

- Often the PCP is not aware of the special considerations (vaccinations, screening, counseling, lab monitoring) required

  - Role of the GI doc is paramount!
    - “PCP” of IBD patients
    - Constant dialogue/correspondence between the GI and the PCP
    - Knowledgeable patient is key!

- Impacts disease outcome and quality of life while reducing complications
THANK YOU!

Beaumont
Health Maintenance for Pediatric IBD Patients

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DISCLOSURES

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• NIH / National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)
• Shaevsky Family Research Fund for Crohn’s Disease
• Crohn’s & Colitis Foundation
• Pediatric Resource Organization for Kids with Inflammatory Intestinal Diseases (PRO-KIIDS)
• Patient Centered Outcomes Research Institute (PCORI)
• Blue Cross Blue Shield of Michigan Foundation
• Charles Woodson Clinical Research Fund

I have no relationships with pharma or industry
Health Maintenance for Kids with IBD

- Bone Health
- Vaccines
- Cancer prevention
- Tobacco Use

- Medication Specific Testing
- Self management
- Resources for more help
Bones
Bone Health

Peak bone mass reached by 20 yr
- Then slowly lose bone for the rest of our lives
- 10-40% have bone mass deficits
- Crohn’s disease worse than ulcerative colitis
- Significant risk for osteoporosis later in life

Steroids worsen bone density within 1-2 wk
How Can We Check and Treat Poor Bone Health?

DEXA scan

Treat:

• Keep IBD under good control
• Optimize nutrition
• Calcium and vitamin D supplementation
  • Vitamin D levels lower in dark skin and during winter
• Encourage weight bearing exercise
• Some cases may need pediatric endocrinology referral
  • Usually don’t use biphosphonates in children
Vaccines
Are Vaccines Safe for Kids with IBD?

• Yes, most vaccines are safe for kids with IBD
  • Generally follow the American Academy of Pediatrics (AAP) vaccine recommendations

• Live virus vaccines are not recommended
  • For those taking immune suppressing medications
  • Or if you’ve taken them in past 3 months
  • Or plan to take them in the next 4-6 weeks
Avoid live vaccines with immune-suppressing medications

Corticosteroids
- Prednisone (Deltasone)
- Prednisolone (OraPre)

Immunomodulators
- Azathioprine 6-MP (Imuran, Azasan, Purnethol)
- Methotrexate (Trexall)
- Tacolimus (Prograf)

Biologics
- Infliximab (Remicade), Infliximab-dyyb (Inflectra™), Infliximab-qbt (Ixifi™), Infliximab-adba (Renflexis®)
- Adalimumab (Humira®), Adalimumab-atto (Amjevita™), Adalimumab-adbm (Cyltezo™)
- Vedolizumab (Entyvio™)
- Certolizumab pegol (Cimzia®)
- Golimumab (Simponi®)
- Ustekinumab (Stelara®)

Janus kinase inhibitor
- Tofacitinib (Xeljanz®)

Note: As additional medications are approved for the treatment of Crohn’s disease and ulcerative colitis, you should ensure to check with your doctor first about the safety of vaccines for your child.

For an updated list of recently approved medications, visit: http://www.crohnscolitisfoundation.org/assets/pdfs/recently-approved-treatments.pdf
What are Live Virus Vaccines?

- Live vaccines (also known as attenuated vaccines) are created with the “weakened form of the germ that causes a disease”³

<table>
<thead>
<tr>
<th>Live Vaccines</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rotavirus (RotaTeq©)</td>
<td></td>
</tr>
<tr>
<td>Intranasal Flu vaccine (FluMist©)</td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (MMR)</td>
<td></td>
</tr>
<tr>
<td>Chicken pox (Varicella, Varivax©)</td>
<td></td>
</tr>
<tr>
<td>Oral Polio</td>
<td></td>
</tr>
<tr>
<td>Yellow Fever</td>
<td></td>
</tr>
<tr>
<td>Oral typhoid</td>
<td></td>
</tr>
<tr>
<td>BCG</td>
<td></td>
</tr>
</tbody>
</table>

Protect against cancer
 Colon Cancer

- Increased risk in UC patients or Crohn’s involving the colon
- Increased risk starts 8-10 years from diagnosis
- Screening colonoscopies every starting at 8-10 years from diagnosis
  - Then repeat every 1-3 years
- If primary sclerosing cholangitis (PSC)
  - Start screening even earlier
  - PSC is a condition that causes scarring of the bile ducts in the liver
- Lower risk if colitis is under control

Strategies to Reduce Colon Cancer Risk

- Get tested: surveillance through colonoscopy
- Take medication to keep disease controlled
- High fiber, high fruit/veggie diet (if safe)
- Less red and processed meats
- Adequate vitamin D level
- Avoid tobacco
- Exercise
Skin Cancer Risk

- Increased risk of skin cancer
  - Both melanoma and non-melanoma
- Risk is due to both IBD and medications
- Good news-mostly preventable!
  - UV light is main cause
  - Avoid tanning beds
  - Use sunscreen of SPF30 or higher and reapply every 2 hours when outside
- See a dermatologist if concerns
Cervical Cancer Risk

• Women with IBD have higher risk of cervical cancer

• Immune suppressive medications increase risk further

• Most cervical cancer is caused by HPV virus

• HPV vaccine (Gardasil©) is effective and safe
  • AAP recommends for all children
  • Safe for all IBD patients
  • 3 shot series, as early as age 9 for both boys and girls
Other important considerations for staying healthy
Tobacco use

- Smokers have 2x risk of developing Crohn’s than those who never have smoked
- Smokers have increased risk
  - Disease flares
  - Fistulas
  - Antibodies to biologics
  - Surgery
- Second-hand smoke carries similar risks for disease and surgery
- E-cigarettes contain nicotine
Lab Testing

• Important for regular blood tests
  • To monitor disease activity
  • To monitor for medication side effects
  • Generally recommended every 2-3 months for most medicines

• Stool (poop) or urine tests
  • Stool tests are sometimes more accurate than blood tests for checking disease activity
  • Urine tests (urinalysis) is sometimes needed for some medicines (mesalamine, sulfasalazine).
Mental health is important too!

- Several studies have shown that many adolescents with IBD are depressed.
- Anxiety may increase, which can cause their IBD symptoms to be more active.
- Look out for symptoms of depression and talk to your healthcare team if there are emotional concerns.
- Symptoms of depression can include:
  - Sadness or hopelessness
  - Irritability, anger, hostility
  - Tearfulness or frequent crying
  - Withdrawal from friends or family
  - Loss of interest in usual activities
  - Poor school performance
  - Changes in eating or sleeping habits
  - No longer enjoying activities
Getting help and support for your child

• Talk to your doctor for recommended mental health therapists
• Call health insurance company to obtain list of mental health providers covered
• Ideal to work with psychologists or therapists that specialize in pediatric IBD, or chronic illness
• Other options for support:
  • Attend support group
  • Connect with other parents and children
Helping your child prepare for self management

- Adherence means your child takes medications as directed by the doctor. Examples of tools that may help improve adherence include:
  - Pill boxes
  - Phone reminders
  - Psychology support
  - Learning names of medications and potential side effects
  - Begin observing or learning how to fill prescriptions

Other self management tips include:

- Keep medical appointments
- Encourage child to engage in discussion during the visit
- Increase child responsibility as they age
- Discuss with your physician if concerns
Crohn’s & Colitis Foundation Resources

On the Web

www.justlikemeibd.org
Website for teens with IBD to learn about their disease, get tips on preparing for adult care, and read stories from other patients like them!

www.crohnscolitisfoundation.org/campus-connection
Website for teens and college students with IBD to learn how to navigate college while also managing their disease.
Healthcare Maintenance Discussion guide

New resource to help parents learn more about healthcare maintenance needs for their child.

Available online-
www.justlikemeibd.org

Foundation resources (continued)

**IBD Help Center**
(877) 694 – 8872
Monday - Friday
9:00 a.m. – 5:00 p.m EST
info@crohnscolitisfoundation.org
www.crohnscolitisfoundation.org

**Brochures and publications**
- Teen Guide
- Parent Guide
- Brochure for Teachers and School staff
  And more!
www.crohnscolitisfoundation.org

**Support**
- Online support groups
- In-person support groups
- Power of Two program

www.crohnscolitisfoundation.org
Additional Resources

NASPghan
North American Society for Pediatric Gastroenterology
Hepatology and Nutrition
https://www.naspghan.org/

ImproveCareNow
https://www.improvecarenow.org/
Questions?