Gastroenterology

Twelve Things Clinicians and Patients Should Question

by
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Canadian IBD Network for Research and Growth in Quality Improvement
Crohn's and Colitis Canada

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Choosing Wisely Canada™
In collaboration with the Canadian Medical Association

1 Don't maintain long term Proton Pump Inhibitor (PPI) therapy for gastrointestinal symptoms without an attempt to stop/reduce PPI at least once per year in most patients.

PPIs are effective drugs for the treatment of gastro-esophageal reflux disease (GERD). Patients should always be prescribed the lowest dose of drug that manages their symptoms. Even though GERD is often a chronic condition, over time the disease may not require acid suppression and it is important that patients do not take drugs that are no longer necessary. For this reason patients should try stopping their acid suppressive therapy at least once per year. Patients with Barrett's esophagus, Los Angeles Grade D esophagitis, and gastrointestinal bleeding would be exempt from this.

2 Avoid using an upper GI series to investigate dyspepsia.

Upper GI series are often requested for the investigation of upper gastrointestinal symptoms. This investigation has a significant proportion of false positive and false negative results compared with endoscopy, and studies have consistently found that this is not a cost-effective approach compared to other strategies of managing dyspepsia.

3 Avoid performing an endoscopy for dyspepsia without alarm symptoms for patients under the age of 60 years.

Endoscopy is an accurate test for diagnosing dyspepsia, but organic pathology that does not respond to acid suppression or Helicobacter pylori eradication therapy is rare under the age of 60. Most guidelines therefore recommend as the first line approach for managing dyspepsia either empirical proton pump inhibitor therapy or a non-invasive test for Helicobacter pylori and then offering therapy if the patient is positive. If the patient has alarm features such as progressive dysphagia, anemia or weight loss, endoscopy may be appropriate.

4 Avoid performing a colonoscopy for constipation in those under the age of 50 years without family history of colon cancer or alarm features.

Constipation is a common problem and systematic review data suggests this is not an accurate symptom in diagnosing organic disease. If the patient is also under the age of 50 and does not have a family history of colon cancer and there are no alarm features such as anemia or weight loss, then the risk of colorectal cancer is very low and the risks of colonoscopy usually outweigh the benefits in these patients.

5 Don't routinely perform colonoscopy in IBS patients <50 years of age without alarm features.

Data is conflicting, and while some evidence suggested that IBS patients are at increased risk for organic disease over the long-term compared with individuals in the general population, absolute rates remain low. With respect to CRC, the risk is low in the general population <50 years of age, and IBS is not a recognized risk factor for CRC. There appears to be little or no evidence that IBS increases the risk of CRC over the short-term compared with the general population, with the exception of a study from Taiwan that suggested a 3.6 times higher 10-year risk in the IBS group compared with the non-IBS group Finally, data do not support the idea that patients may be reassured by a normal colonoscopy. Therefore, the consensus group concluded that routine colonoscopy is generally not warranted in IBS patients <50 years of age, and alarm symptoms do not appear to increase the risk of CRC sufficiently to warrant routine colonoscopy. Alarm features that warrant investigation include, but are not limited to, rectal bleeding, weight loss and anemia.

GRADE: Strong recommendation, very low-quality evidence

6 **Don't prescribe oral corticosteroids in adults with Crohn's disease of any severity in order to maintain complete remission.**

The adverse effects of long-term corticosteroid use are well-known and well-documented. In the TREAT registry, prednisone therapy was independently associated with serious infections (hazard ratio [HR], 1.57; 95% CI, 1.17–2.10; P = .002). No safe lower limit of dosing has been identified in which patients are spared from the adverse effects. The risks of long-term corticosteroid therapy and the lack of evidence supporting efficacy over placebo in this setting led the consensus group to recommend against the use of maintenance corticosteroid therapy.

GRADE: Strong recommendation, low-quality evidence

7 **Don't prescribe oral corticosteroids in children with CD of any severity in order to maintain clinical remission.**

There is a lack of demonstrated efficacy of steroids in preventing relapse and concerns around the adverse events associated with long-term use, particularly in children.

GRADE: Strong recommendation, low-quality evidence.

8 **Don't use opioids long-term to manage abdominal pain in inflammatory bowel disease (IBD).**

While opioids may be used to manage abdominal pain in select acute settings in IBD patients, their prolonged use may mask the symptoms of active IBD or its complications (e.g., bowel perforation or megacolon). Chronic opioid use has been proven ineffective for non-malignancy associated chronic pain and is associated with excess mortality. Moreover, because of their potential risk for dependence, their long-term use for managing IBD-related abdominal pain should be avoided especially in the context of the opioid crisis in North America.

9 **Don't unnecessarily prolong the course of intravenous corticosteroids in patients with acute severe ulcerative colitis (UC) in the absence of clinical response.**

Non-response to intravenous corticosteroids for acute severe UC can be predicted after the first 72 hours of treatment. However, about a third of non-responders receive systemic steroid monotherapy beyond 7 days. This prolonged use of ineffective systemic steroids may unnecessarily lengthen hospitalization days and increase risk of postoperative complications in those who eventually require colectomy.

10 **Don't initiate or escalate long-term medical therapies for the treatment of inflammatory bowel disease (IBD) based only on symptoms.**

Clinical symptoms often prompt initiation or escalation of medical treatments for inflammatory bowel disease (IBD). However, functional bowel disorders (e.g., irritable bowel syndrome) coexist in 20% of IBD patients and can mimic symptoms of the latter. Clinical symptoms, in fact, do not correlate well with IBD disease activity. Consequently, relying on only clinical symptoms without confirming active disease may commit patients to long-term treatments that have potentially significant adverse effects and resource implications.

11 **Don't use abdominal computed tomography (CT) scan to assess inflammatory bowel disease (IBD) in the acute setting unless there is suspicion of a complication (obstruction, perforation, abscess) or a non-IBD etiology for abdominal symptoms.**

Abdominal CT scanning is effective for the time-sensitive diagnosis of IBD complications such as obstruction, perforation, or non-IBD related causes of abdominal pain when these are suspected. The effective ionizing radiation dose from a single conventional abdominal CT scan (10-20mSv) is within acceptable safety limits (<50mSv). However, minimizing inappropriate utilization of CT is a priority because repeated exposure to ionizing radiation over a lifetime, particularly among younger IBD patients, may potentially increase the risk of malignancy. In the acute setting (e.g., emergency department), abdominal CT scan should only be used when there is suspicion of a complication of IBD and should not be used for the assessment of disease activity.

12 Don’t conduct in-person visits for GI care when a virtual visit can be performed and is clinically appropriate (for example - routine follow-up visit, post-endoscopy review of normal biopsy results, etc.,) and is preferred by the patient. There is an increasing volume of literature which shows that delivery of health care in digestive health by telemedicine can be safe and effective.

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Driving is one of the activities with a high carbon footprint. Cars emit an average of 206g of CO_2e per kilometer. To put this in context a mature tree metabolizes about 20 kg of CO_2 per year, the equivalent of driving less than 100km. Travel to and from health facilities by patients, visitors and staff accounted for 10% of the UK NHS emissions. Travel is a significant contributor to health care emissions.

In a cross-sectional study of more than 10 million patients and 63 million virtual care visits, virtual care was associated with avoidance of 3.2 billion km of patient travel, 545 to 658 million kg of carbon dioxide emissions, and $569 to $733 million (Canadian [US $465-$599 million]) in expenses for gasoline, parking, or public transit.

How the list was created

This list was created by polling the Canadian Association of Gastroenterology (CAG) Quality Leads on items that were felt to meet the goals of Choosing Wisely Canada. The five items were selected for being the most frequently identified and reflected common GI disorders managed by health care professionals. This list was then voted on by the CAG Quality Leads and the statements were further modified for language by the group.

The recommendations related to IBD were developed by the Canadian IBD Network for Research and Growth in Quality Improvement (CINERGI) in collaboration with Crohn's and Colitis Canada (CCC) and the Canadian Association of Gastroenterology (CAG). The CINERGI group comprises 14 gastroenterologists specialized in the care of inflammatory bowel disease representing 12 academic centres across Canada. A preliminary survey was sent to the CINERGI working group to solicit candidate recommendations. The top ten recommendations were selected by the working group members through an online voting platform. During a face-to-face consensus meeting in Toronto on November 4, 2016 that included CINERGI working group members, two radiologists, representatives from CCC and CAG, and two patient representatives, a modified Delphi process was used to select the top five recommendations. This list was submitted to the CAG Quality Affairs Committee, the Executive Board, and the CAG general membership for feedback and approval.

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About the Canadian Association of Gastroenterology

The CAG represents more than 1,100 members across Canada, including physicians, basic scientists, and affiliated health care providers who work in the field of gastroenterology. The CAG is a memberfocused organization with a mission to support and engage in the study of the organs of the digestive tract in health and disease, as well as to promote and advance gastroenterology by providing leadership in patient care, research, teaching and continuing professional development.

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About the Canadian IBD Network for Research and Growth in Quality Improvement

CINERGI is a research network of 14 inflammatory bowel disease (IBD) specialists representing 12 Canadian academic institutions spanning 7 provinces. Collectively, we have research expertise in epidemiology, clinical trials, health services research, economic analysis, and quality improvement. We are committed to a diverse array of initiatives to improve healthcare delivery in IBD.

About the Crohn's and Colitis Canada

Crohn's and Colitis Canada is the only national, volunteer-based charity focused on finding the cures for Crohn's disease and ulcerative colitis and improving the lives of children and adults affected by these diseases. Crohn's and Colitis Canada focuses on transforming the lives of people affected by Crohn's and colitis (the two main forms of inflammatory bowel disease) through research, patient programs, advocacy, and awareness.

About Choosing Wisely Canada

Choosing Wisely Canada is a campaign to help physicians and patients engage in conversations about unnecessary tests, treatments and procedures, and to help physicians and patients make smart and effective choices to ensure high-quality care.

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