Title: Inflammatory bowel disease – Newer models of care

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DOI: 10.17235/reed.2019.6495/2019
Link: PubMed (Epub ahead of print)

Please cite this article as:

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Editorial

Inflammatory bowel disease – Newer models of care

The model for approaching inflammatory bowel disease (IBD) has been modified, and a paradigm has been established with terms that define new strategies and perceptions. The present issue of Revista Española de Enfermedades Digestivas exemplifies this by recording the primary initiatives that have led to changes: new goals, patient at the center of the care model, and sensitivity to patient limitations.

Symptom control gave way to mucosal healing and deep remission aiming at optimal outcomes. The high percentage of consideration of these goals reported by the Portuguese Group for the Study of IBD (GEDII) (1) reflect this. In all, 80% of gastroenterologists consider deep remission -- including microscopic criteria in 51% of cases -- as their goal in daily practice, and 71% consider therapy intensification as a means to meet this goal. We remain far removed from histological healing, but the fact that 21% report transmural healing as a goal is remarkable, and reveals that demanding therapeutic strategies are used in clinical practice.

In a model of care involving exacting objectives patient perceptions play a key role. The patient is at the center of the care model and has an active role in reporting outcomes (patient reported outcomes, PROs) or experiences, and in requesting education to facilitate shared decision making. Patient information regarding symptoms or lab results (e.g., fecal calprotectin) facilitates close monitoring therapy response as recommended by target-selection approaches (STRIDE consensus) (2). Active, educated patients take part in telemonitoring and self-control strategies using mobile applications (apps) or care platforms (3), which may help reduce disease impact.

Juliana M. Costa and the other authors of another paper reported in the present issue (4) establish that coping attitude and presence of comorbidities are associated with higher disability rates. Proposals for improvement include a multidisciplinary approach and interventions to facilitate a positive outlook. Units should have disability assessment instruments available, and include disability
improvement as a goal in their model of care. Similarly, units should also have an educational support strategy available (5), which requires specific tools to quantify knowledge and its changes. Traditional instruments such as the *Crohn’s and Colitis Knowledge Questionnaire* (6) are not up-to-date, and do not contemplate newer therapies; also, as they were designed as long questionnaires, the time needed for responding becomes excessive. Dr. Casellas leads the third paper published in this journal (7), and reports on a knowledge assessment tool fit for clinical practice that might allow a measurement of the effects of educational resources in each unit.

Knowledge of the disease is crucial for both the patient and system (8,9). It should be provided by units concurrently with caring support. It is associated with lower stress, improved coping with the condition, better treatment compliance, positive effects on outcome, and reduced health-related costs (10). Units may use a number of support initiatives, brochures and other printed resources, workshops, blogs, and websites on their way to the G-Educainflamatoría project, (www.educainflamatoria.com), an up-to-date platform supported by G-EducaEII (http://geteccu.org/queesgeducaeii), a task force of *Grupo Español de Trabajo en Enfermedad de Crohn y Colitis Ulcerosa* (GETECCU). Forty-four units adhered to the project, and recommend this platform to patients as an educational site, interaction being facilitated via a forum. Websites monitored by a medical team are considered to have the highest quality and reliability levels by patients (11,12). The million visitors annually received by our educational platform clearly reflects a warm reception. To correctly evaluate the educational process tools are needed that may rapidly and reliably assess the knowledge acquired on the disease. QUECOMIICAT, the questionnaire developed by Casellas et al., meets these requirements, and allows to assess over 15 minutes any knowledge changes following an educational effort, as was shown in a group of 20 newly-diagnosed patients.

The present issue of this journal provides an opportunity to revise our IBD care model by updating strategies and patient-related indicators – knowledge, activity, disability, coping – of special significance in the present health care model.
References


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