DIGESTIVE HEALTH *Specialists*

GI NEWSLETTER

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Meet the Providers of DIGESTIVE HEALTH *Specialists*

Left to right: Jill Metzler, NP-C, Norman Zitomer, MD, Noelle Daniels, PA-C, Suzanne Skoog, MD, Adam Harris, MD, and Bradford H. Jones, MD

The members of Digestive Health Specialists welcomed Dr. Adam Harris to the practice in November 2015. He completed his Fellowship in Gastroenterology at Brown University in Providence, Rhode Island. He then joined the faculty of Brown University where he specialized in the diagnosis and treatment of Crohn's and colitis. He is Board Certified in Internal Medicine and Gastroenterology. Dr. Harris is a member of the American College of Gastroenterology, the American Gastroenterology Association, and the Crohn's and Colitis Foundation of America.

We want to thank you for allowing us to care for your patients and your continued support. We promise to continue to strive to make your patients our top priority. Please always feel free to contact us any time to let us know how we can help you and your patients.

MARCH IS COLON CANCER AWARENESS

March is National Colon Cancer Awareness month! Colorectal cancer is the second leading cause of cancer deaths in the United States. Every year, about 140,000 Americans are diagnosed with colorectal cancer, and more than 50,000 people die from it. But this disease is highly preventable by getting screened beginning at age 50.

Digestive Health Specialists is doing its part to help prevent this disease by offering an Open Access program for healthy patients to get screened without a prior office consultation. This is a convenient and cost effective way for patients to obtain a screening colonoscopy while maintaining the highest quality of care. To learn more about our Open Access program, call us today or visit our website, www.digestiveaz.com.

What You Need to Know About Inflammatory bowel disease (IBD)

By Adam Harris, MD

What is it?: Inflammatory bowel disease (IBD) is comprised of two main disorders: ulcerative colitis (UC) and Crohn's disease (CD).

Who gets it?: IBD affects over 1.4 million people in the United States alone. The primary age of diagnosis is between 15 and 30 years old. A second, smaller peak occurs between the ages of 50 and 70.

What causes it?: The etiology of IBD is unknown. Numerous gene loci have been identified and continue to be discovered. IBD is thought to result from a complex interaction between genetics, environmental factors, response to intestinal flora, and alterations in innate and adaptive immunity. Approximately 10-25% of patients have a first degree relative with IBD.

How does it present?: A HIGH INDEX OF SUSPICION is necessary to detect IBD at an early stage. The most common symptoms of CD include ABDOMINAL PAIN and FATIGUE. Other common symptoms include bloating, cramping, and diarrhea. For UC, symptoms usually involve bloody diarrhea, urgency, pelvic pressure, and a sensation of incomplete evacuation.

Other symptoms?: Joint involvement can include peripheral and axial arthropathies (ankylosing spondylitis and sacroileitis). Skin manifestations can consist of pyoderma gangrenosum or erythema nodosum. Eye manifestations include episcleritis and uveitis. Other extra-intestinal manifestations include oral aphthous ulcers and primary sclerosing cholangitis.

Once diagnosed, how to treat?: Steroids, which used to be a mainstay of therapy, should only be used as a SHORT-TERM transition to treat acute flares. Opiates SHOULD NOT BE GIVEN for IBD. Antibiotics DO NOT have a role in treatment. Mesalamine is the mainstay of treatment for mild to moderate UC. Moderate to severe UC should be treated with anti-TNF biologic medications. These medications include Infliximab (Remicade), Adalimumab (Humira), or Golimumab (Simponi). Vedolizumab (Entyvio) is a recently approved biologic medication for moderate to severe UC with a different mechanism of action. Immunomodulators such as 6-mercaptopurine or azathioprine can be used in conjunction with these biologics. ALLOPURINOL should be given carefully in conjunction with immunomodulators, so please contact us immediately if a patient needs this. For Crohn's disease, the mainstay of treatment are the biologic medications: Infliximab, Adalimumab, Certolizumab (Cimzia), or Vedolizumab.

Are vaccines ok?: If patients are on biologic or immunomodulatory medications, live vaccines SHOULD NOT be given. Inactivated vaccines are ok. Call us immediately with any questions.

Which IBD patient should get a DEXA?: Any IBD patient who has had prolonged steroid exposure (over 3 months), has history of a low trauma or fragility fracture, post-menopausal females or males over the age of 50.

What labs should be checked?: CBC, LFT's and vitamin D should be periodically followed.

What if my patient is pregnant?: Most IBD medications are compliant with pregnancy. PLEASE DO NOT TAKE YOUR PATIENT OFF THEIR MEDICATIONS WITHOUT TALKING TO US FIRST.

Pro-thrombotic condition?: YES! Hospitalized patients need DVT prophylaxis. Outpatient IBD patients are at higher risk for DVT or PE, particularly if their disease is not controlled well.

For more information about Inflammatory Bowel Disease (IBD) or to be scheduled, contact our office at (480) 563-5757.