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IBD-Associated Arthritis: A Guide for Gastroenterologists & Rheumatologists

DR. NANDI:
Welcome to *IBD Crosstalk* for *GI Insights* on ReachMD. I'm your host Dr. Neil Nandi. And joining me to talk about IBD-associated arthritis is Dr. Sergio Schwartzman, a rheumatologist affiliated with the Hospital for Special Surgery and Cornell Weill Medical School in New York City. Dr. Schwartzman, welcome to the program.

DR. SCHWARTZMAN:
It's a pleasure to be here.

DR. NANDI:
You know, inflammatory bowel disease and the rheumatologic world have a lot in common and in fact, many of our IBD patients do routinely describe arthralgia. Can you please provide your overview and approach to evaluating IBD-associated arthritis?

DR. SCHWARTZMAN:
Inflammatory bowel disease-associated arthritis really encompasses a very large group of conditions that rheumatologists categorize as spondyloarthritis. And the diseases here overlap in that there are many features that are similar. Genetics are similar and the overlapping symptoms and signs categorize them into specific diseases. For example, ankylosing spondylitis is in this group, psoriatic arthritis is in this group, and reactive arthritis. However, I would argue that inflammatory bowel disease-associated arthritis is a very distinct entity in which both inflammatory arthritis and either Crohn's or ulcerative colitis are present at the same time.

DR. NANDI:
You know, and this is really important to understand because putting on my IBD hat, we often associate arthralgia with gut inflammation, right? So, our mantra in our treatment paradigm is “treat the mucosa in order to help the arthralgia.” Now that doesn't always happen. What is the rheumatologic perspective, though, of how we should approach this?

DR. SCHWARTZMAN:
From a rheumatological perspective, we're very critical as to how we categorize musculoskeletal symptoms. So, for example, arthralgia does not imply an inflammatory condition. Although it can be associated with an inflammatory condition, that tends to be much more defined in illnesses such as fibromyalgia. And patients both with spondyloarthritis and with inflammatory bowel disease can have fibromyalgia.

The inflammatory arthritides, which actually denote inflammation in the synovium, which can be categorized as either peripheral spondyloarthritis or axial spondyloarthritis, however, are one of the most common manifestations in inflammatory bowel disease. In fact, it is estimated that as many as 60 percent of patients with inflammatory bowel disease will have some musculoskeletal symptoms. And the most common are the inflammatory arthritides.

DR. NANDI:
So, this is important, right? What are the most salient questions that an IBD or gastroenterologist can ask to differentiate an inflammatory or IBD-associated arthritis from other types?

DR. SCHWARTZMAN:
That's an excellent question. So, I think the perspective as I see it for the gastroenterologist, but as a rheumatologist who's very interested in this group of conditions, is that the gastroenterologists struggle with differentiating inflammatory disease, meaning the synovial inflammatory symptoms from mechanical disease, things like osteoarthritis, and finally from conditions such as fibromyalgia. And in terms of differentiating these, the salient points and the salient questions that need to be asked are: Is there any redness, swelling, or warmth of your joints? Number one. Number two: If we're asking about the axial disease, do you have morning stiffness in your cervical spine or in your lumbosacral spine? And those are a little bit of a shortcut, in terms of defining inflammatory disease and differentiating that from other musculoskeletal symptoms in patients with inflammatory bowel disease.

I should also mention that rheumatologists struggle as well, with issues referable to the bowel. We see patients who have inflammatory arthritides, but we are not trained to differentiate inflammatory bowel disease, for example, from irritable bowel syndrome. And further, many rheumatologists aren't aware that visceral abdominal pain can present as a referred pain and be misdiagnosed by the rheumatologist as a musculoskeletal illness, whereas it's really the bowel that's responsible for the symptoms.

DR. NANDI:
Well, I think this is where, rheumatology and gastroenterologists can work in partnership together for sure. In terms of how a rheumatologist can differentiate an inflammatory symptom when it comes to gut health, we often recognize that IBS versus IBD nocturnal component, or persistence of loose stools, diarrhea, or abdominal pain waking one up from sleep, that is an alarm sign that this may not be irritable bowel syndrome. Certainly, the presence of other constitutional symptoms associated with a change in bowel habits, such as weight loss, is concerning to us and may signal or herald an inflammatory bowel disease possibly.

And then lastly, we know that about 25 to 50 percent of those patients with IBD, over the course of their entire lifetime, will develop at least one extraintestinal manifestation of IBD, certainly of the four that we think of, uveitis, oral aphthous ulcers, erythema nodosum, and then the fourth, being IBD-associated arthritis. So, we kind of look for those things when we're taking GI symptoms in the context of overall review of symptoms to figure out whether the patient may have an IBD.

So hopefully, that's helpful to some of our rheumatologists, too. I certainly found your salient points of redness, irritation, and warmth, and then morning stiffness, of the axial spine. Those are very important points for the GI to take home for sure.

DR. SCHWARTZMAN:
I think the only other point that I would add to this is that we both have objective tools that we can utilize in our respective subspecialties to confirm those suspicions, and those are imaging. And both the gastroenterologist and the rheumatologists have imaging modalities that help define inflammatory disease. And luckily for you, you have endoscopy. We don't have that yet in terms of that type of direct imaging and the capacity to biopsy, although in research studies we can do that.

DR. NANDI:
For those just tuning in, you're listening to *GI Insights IBD Crosstalk* on ReachMD. I'm Dr. Neil Nandi, and I'm speaking with Dr. Sergio Schwartzman about IBD-associated arthritis.

Now, Dr. Schwartzman, we've talked a bit about an overview of IBD-associated arthritis, how GIs can ask the right questions and how rheumatologists can help differentiate a change in bowels to signal a diagnosis of IBD. Just a moment ago, we were talking about some of the imaging modalities, be it radiologic or endoscopic. Are there any other screening tools that a gastroenterologist should be aware of or rheumatologists, for that matter, in looking for IBD-associated arthritis?

DR. SCHWARTZMAN:
So, the answer is that there are. There are validated screening tools questionnaires. And probably the one that has been most vetted, and actually was recently published, is called the DETAIL questionnaire. So, this identifies axial and peripheral disease. And it's

obviously targeting patients with inflammatory bowel disease. And it's really a series of six questions. And if you have at least three of these that are positive, then you have a greater than 80 percent post-test probability of having spondyloarthritis, peripheral or axial, in association with inflammatory bowel disease.

With regards to those questions, they really address the issue of swelling in patient joints, diffuse swelling, what we call dactylitis or "sausage digits," heel pain, which is a measurement of Achilles tendonitis or plantar fasciitis, the length of time that you have had back pain, how is the back pain characterized—is it worse in the morning with stiffness, as we've already discussed, and does it improve with exercise and that indicates inflammation—and whether or not similar to the gastroenterologist, whether or not the back pain wakes you up in the middle of the night. If it does that is more likely to be inflammatory in nature.

So, this detailed questionnaire, is a great tool. It's easy, it's a yes/no answer for patients. And it addresses those questions that I've just mentioned to you.

DR. NANDI:
You know what I love about that questionnaire is, it's all about history, history, history. My old med school mentor told me 85 percent of the diagnosis is in the history, right?

So, we have now talked quite a bit about IBD-associated arthritis, but what are the treatments? You know, we like treatments that can help both the bowel and the joints. It may not always happen. But what treatments are available and when do you use them for IBD-associated arthritis?

DR. SCHWARTZMAN:
So, I think either one of the two entities, can drive the decision about utilizing a specific therapy. And I think the points to keep in mind is that we do have many overlapping therapies. For example, corticosteroids, sulfasalazine, potentially methotrexate, the anti-TNF agents. An evolving area both for gastroenterologists and rheumatologists is the biologics and the targeted synthetics that are the anti-interleukin 23 inhibitors and the JAK inhibitors. So this is an area where we could literally kill two birds with one stone. TNFs, IL-23s, and JAK inhibitors have that capacity.

However, we also need to exercise caution, because some of the medications, particularly some of the medicines that rheumatologists use, can actually make inflammatory bowel disease worse. So, nonsteroidal anti-inflammatory agents, which rheumatologists use all of the time, can exacerbate inflammatory bowel disease.

And one recent lesson that we learned the hard way is the interleukin 17 inhibitors. And right now, there are two that are approved for spondyloarthritis—that is ankylosing spondylitis, non-radiographic axial spondyloarthritis, and psoriatic arthritis—secukinumab and ixekizumab. But when these drugs, particularly one of them, secukinumab, was used in patients with inflammatory bowel disease to treat it, meaning, to actually treat Crohn's disease, the trend was for those patients to get worse, not better, from the IBD perspective. So IL-17 inhibitors, which rheumatologists frequently use to treat spondyloarthritides, should not be used in patients with inflammatory bowel disease.

DR. NANDI:
And likewise, if you're a gastroenterologist listening to this, if you have a patient who has rheumatologic disease and is coming to you for a change in bowels, then this might be one of your screening questions about what kind of medications have you been on, such as an IL-17 antagonist, in this case, as you were saying. What do you think about using topical NSAIDs? That's something we sometimes recommend to our patients who have arthralgia, we think there's limited systemic absorption, and may give some benefit, maybe not quite as good as an oral NSAID.

DR. SCHWARTZMAN:
Yeah, I think for our diseases, they don't work. So they may provide some benefit. But remember that, our diseases result in structural change, as do yours. And in most patients with spondyloarthritis, including IBD-associated arthritis, our concern is that patients, who have peripheral arthritis will have erosions in their joints. And topical NSAIDs don't prevent that, or that they'll fuse their joints, like in ankylosing spondylitis. And systemic NSAIDs may prevent that, but there's no data at all for topical NSAIDs.

So I think that the utilization of topical NSAIDs are probably more to treat symptoms, and you may get a little bit benefit, but they will not

treat the underlying disease.

DR. NANDI:
And I think that brings home how important it is not to dismiss or symptomatically treat some of these patients, but to really partner, as a gastroenterologist, really partner with a rheumatologist when treating these patients and making sure that all their symptoms are being addressed.

Dr. Schwartzman, this has been a great podcast episode with you. Really great clinical pearls that we've highlighted together in looking at IBD-associated arthritis. Thank you so much for taking the time to shed more light on this important topic.

DR. SCHWARTZMAN:
Thank you for having me.

DR. NANDI:
For ReachMD's *IBD Crosstalk*, I'm Dr. Neil Nandi. To access this and other episodes in this series, please visit ReachMD.com/GIInsights, where you can be part of the knowledge. Thanks for listening.