The current standard of care of inflammatory bowel disease

To the Editor: We live in an ever-changing world in which change sometimes comes suddenly and unexpectedly. At other times it just creeps up on us, as it has with inflammatory bowel disease (IBD) (Crohn's disease and ulcerative colitis).

While the disease has been known for over 100 years, the treatment commonly harks back to the options of the 1970s - 80s, when prednisone, mesalamine and immunosuppression were the standard. The advent of powerful disease-modifying agents capable of putting patients in full remission has not yet been fully accepted by doctors, funders or even patients.

The ongoing use of toxic and ineffective agents needs to end, and the medications available for the past 26 years accepted as the standard of care for these patients.

In 1998 the first biologic therapy, infliximab, for IBD, was marketed. This anti-tumour necrosis factor (anti-TNF) agent could miraculously turn the inflammatory process off and rapidly restore patients to a normal life in quality and duration. These anti-TNF agents and other newer drugs targeting different paths in the immune cascade have been shown to be equally effective.

The question needs to be asked why, after 26 years of experience and the ever-increasing variety of agents available, all of our patients are not on these agents? Initially the price of ZAR20 000 a month was an obvious deterrent. Real and perceived side-effects further complicated the decision-making and delayed the acceptance of these agents. Fortunately the price of some is now down to ZAR3 500 a month, and decreasing.

So again, why are patients with IBD not started on modern therapy on the day of diagnosis?

In addition to the costs, inhibiting factors include:

(*i*) The main side-effect of an increased susceptibility to tuberculosis is a particular factor in South Africa, but this can be mitigated with the use of serology, chest X-rays and clinical judgement.

(*ii*) In a strange twist of logic, there remains a belief, particularly among funders, that patients need to earn the new therapies. This means they need to have been treated with largely ineffective therapy for months or years prior to commencing modern medicine. To the patient with abdominal cramps, diarrhoea and sometimes faecal incontinence, this delay is impossible to justify.

(*iii*) The final factor to consider is the long-term life-modifying benefit of these agents. The risk of colon cancer is related to the duration and extent of bowel disease, and the amount of inflammation. Patients on biologics with normal mucosa have a vastly reduced risk of cancer and surgery.

It would seem that all patients with established IBD need modern therapy. Interestingly, the University of Chicago website states that 'biological drugs have become the standard of care for people with moderate to severe Crohn's disease or ulcerative colitis'. The days of toxic medication are past. It is a tragedy that all our patients are not allowed modern therapy

In summary, IBD is now totally manageable with little risk of serious complications, so why do we resist?

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