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Commentary

The Multidisciplinary Team in Inflammatory Bowel Diseases

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Ulcerative colitis and Crohn's disease are chronic, idiopathic, relapsing inflammatory bowel diseases (IBDs) that usually affect young people at the pick of their working life and are associated with high social costs [1]. Evidence suggests that genetic predisposition, environmental factors and gastrointestinal microbial flora modifications may trigger an overly aggressive immune response leading to elevations of proinflammatory mediators.

IBDs have been traditionally managed by gastroenterologists and, if complicated, by colorectal surgeons. Indeed physicians face a new clinical challenge every day, worsened by the possible complicated disease course (bowel damage, perianal disease, intestinal resection) and by the very frequent rate of extraintestinal immunomediated complications (almost every system can be involved, primarily joints, skin, eyes, kidneys, liver, biliary tracts and vascular system) which are important predictors of morbidity and temporary work disability [1].

IBDs are therefore a complex medical condition with signs and symptoms from a wide range of disciplines, hence "multidisciplinary"; moreover the decision making is often difficult and the complexity of IBD management is easier to handle with the contribution of multiple health professionals with complementary expertise [2]. In a such clinical scenario multidisciplinary team with different skills improves patient's outcome, allows to share decision making, handle clinical governance and share experience/expertise. Never the less it may also stimulate clinical research (Figure 1).

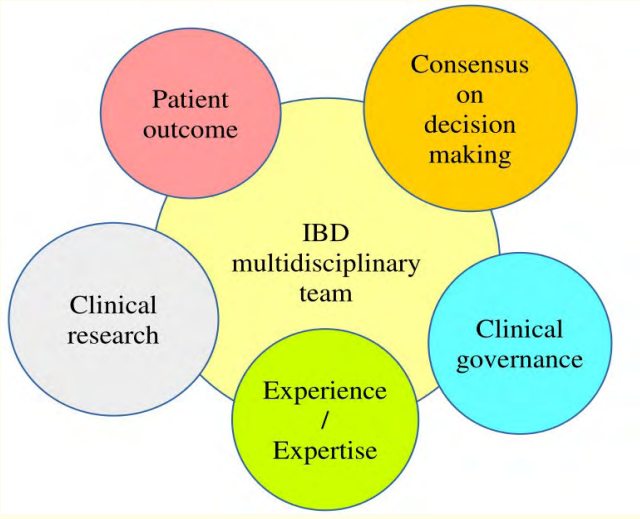

Figure 1

Improving patient outcome means giving the best quality of care: this starts with a correct diagnosis (close cooperation with the pathologist, of course, is crucial) and with an evidence based and tailored to the individual patient therapeutic strategy, taking into account the risk of disease progression and any eventual extraintestinal manifestation. And in the case of surgery improving outcome means to minimize emergency operation: this is for sure one the IBD-team chief role (outcomes are worse in this group of patients).

Sharing decision making when decisions are difficult and handling clinical governance magnifies the role of a team work approach: it's always good to compare ideas from different points of view, identify and share a common strategy and safeguard high standards of care [3].

Moreover multidisciplinary approach represents, by learning from one anothers' management algorithms, a chance to improve experience in complex disease management [4].

Gastroenterologists, rheumatologists, colo-rectal surgeons are of course key members of the team, but dermatologists, pediatricians, radiologists, pathologists and ophthalmologists also participate; nutritionists and clinical psychologists together with primary care physicians and nursing care work as support services (Table 1).

Members	Support Services
Gastroenterologist, Surgeon (colorectal)	Nurse care and primary care
Rheumatologist, Dermatologist, Ophthalmologist	Nutritionists
Pediatrician, Pathologist, Radiologists	Clinical psychologists

Table 1

Ideally there should be IBD-team meetings on a fortnightly basis to discuss the IBD patient with complex needs and of course there must be a definite arrangement for joint discussion for patients whose clinical condition doesn't permit delays. All team members should be part of these meetings and all decisions should be recorded in the Hospital notes.

A multidisciplinary approach to diagnosis and treatment of IBD has the potential to improve quality of care and of course patient's outcome and satisfaction; it may even reduce disease burden and morbidity and could be cost effective.

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