

## Relevance of Multidisciplinary Teams (MDTs) in the Management of Inflammatory Bowel Disease (IBD)

**Medina Melean Nora E\***

*Gastroenterology at Central University of Venezuela, Caracas and Internal Medicine at Centroccidental University Lisandro Alvarado, Barquisimeto, Venezuela*

**\*Corresponding Author:** Medina Melean Nora E, Gastroenterology at Central University of Venezuela, Caracas and Internal Medicine at Centroccidental University Lisandro Alvarado, Barquisimeto, Venezuela.

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### Abstract

Inflammatory Bowel Disease (IBD) is an autoimmune, chronic disorder that evolves people in the productive age (both, in academic and occupational sense), and usually have a great impact on their quality of life. Epidemiological data shows a prevalence increase in high-income countries, and lower in low-income countries, although the incidence has been increasing rapidly in the second ones.

Knowing the incidence and prevalence of IBD allows to Health Care Providers (HCPs) designing health-care plans, that include the provision of proper structure (physical and health personnel) in order to offer solutions beyond disease itself: IBD, as a complex disease, demands an integrative management team, focusing not only in physical wellness, but psychological advice and even in certain clinical situations, selection of optimal timing for surgical management.

The patient-centered approach everyday gains more relevance, and as gastroenterologists, we are committed to move forward. This is a challenge: provide day by day specialized and integrative support thorough the spectrum of the disease, benefiting the IBD community members.

**Keywords:** *Inflammatory Bowel Disease; Multidisciplinary Teams*

### Abbreviations

IBD: Inflammatory Bowel Disease; HCPs: Health Care Providers; CD: Crohn's Disease; UC: Ulcerative Colitis; QoL: Quality of Life

### Multidisciplinary team in the gastroenterologist context

When we speak about Multidisciplinary Teams (MDTs) in Inflammatory Bowel Disease (IBD), it is relevant highlights the meaning in terms of epidemiology (prevalence/incidence/morbidity/mortality), burden of disease (personal/laboring/health-care resources), and for physicians, the impact of improving the quality of care. IBD is a chronic, idiopathic disorder that affects over 2 million and 1.5 million in Europe and North America respectively, being less clear the incidence in areas beyond western world, including South America, Asia and Africa [1,2]. In the last years, physicians have observed an increased number of patients affected by any of two clinical types, Crohn's Disease (CD) and Ulcerative Colitis (UC). According reports [3], this shift has been related with socioeconomic development, and has im-

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plications for the understanding of which triggers are associated on this disease. IBD affects primarily young people in productive ages, and therefore, with a high societal cost.

In 2016, Ng Siew., *et al.* [4] published a systematic review of population-based studies on the incidence and prevalence of IBD around the world, from 1990 to 2016, finding since 1990 a stable or falling incidence in western countries, in contrast with a higher prevalence in North America, Oceania and most countries in Europe. This fact represents a challenge for Health Care Providers (CHPs), for learning to manage the impact in costs (infrastructure and personnel) for patients' Quality of Life (QoL).

In Latin America, Calderon., *et al.* [5], conducted a meta analyses of observational studies in epidemiology guidelines from 2000, in order to estimate the epidemiology and burden of IBD.

The authors found a high heterogeneity in data and scarce of high-quality epidemiologic studies on IBD: UC incidence varied from 0.74 to 6.76/100,000 inhabitants; CD incidence varied from 0.42 to 2.46/100,000 inhabitants. On the other hand, UC prevalence varied from 0.99 to 44.3/100,000 inhabitants, and for CD was from 0.42 to 38.22/100,000 inhabitants. They concluded the unmet need of more studies with adequate methodological quality from representative samples and the use of standardized definitions and outcomes.

Regarding etiopathogenic causes, we can observe that there have been implicated different factors: environmental ("western lifestyle" as trigger of intestinal inflammation in genetically predisposed individual), food and dietary habits as influencers in gut microbiota dysfunction, reciprocal effects of gut microbiota in mucus properties and innate lymphoid cells, presence of epigenetic, transcriptomic, proteomic, and metabolomic alterations in IBD patients [6,7]. The wide spectrum of clinical manifestations and several organ-related implications, which goes beyond gastrointestinal sign and symptoms, has changed the approach of specialists about how to guarantee the best attention that patient should receive, from an individual approach to a working group management. IBD is both chronic and fluctuating disease, and an early detection of intestinal/extra intestinal manifestations, also a proper reference to the specialized personnel can diminish both, the probability of disability and burden of the disease [8].

In response to a new mindset, gastroenterologists and other specialties worldwide have designed Multidisciplinary Teams (MDTs) and/or Centers of Excellence, in response to patients' unmet needs of assistance in an integrated manner. The aim is to allow interdisciplinary collaboration for optimize attention and costs [9].

Originally, the recognition about the improvement of IBD patient care was introduced in Europe (UK), in 2004.

The Health Foundation "engaging quality initiative", funded two rounds of a national audit on IBD, published in 2007 [10] and 2009 [11]. Both demonstrated that 75% of participating institutions undertook a weekly meeting for IBD patients. It was reported also a high variability in their work structure. For 2013, UK IBD standard protocols were established [12] and furthermore European guidelines sat up the relevance of MDTs offering patient's high quality of care. In January 2018, was published the IBD audit programme 2005 2017 [13], concluding that this system has positively changed the IBD care methodology, existing for now areas of improvement, like dietician, early escalation of treatment, and emphasizing that stakeholders should work in IBD teams to help facilitate these improvements.

Regarding DMTs history, in 2015, NICE QS81 recommended that: "Services provide age-appropriate support from a multidisciplinary team for people with inflammatory bowel disease, and their family members or cares" (statement 2) [14].

### What does Multidisciplinary Team (MDT) mean?

MDT is a specialized team disposed to offer patients all the support needed during the course of their disease.

These groups have had an established role in the management of many chronic diseases, with one element in common: provide an environment to convene bases and structure for discuss and manage patient care. This structure allows an interdisciplinary collaboration in determine what would be the best strategy for any particular patient [15].

MDTs in IBD patients does not only focus on disease: they face challenges like the management of surgical care, obstetrics care, nutrition and exercise, and psychosocial care. For that reason, in the design of a MDT, there has been settle several proposals regarding who specialists should be part of the “core team”, named the group of physician who frequently attend IBD patients, and the “complementary/extended team”: HCPs who will attend IBD patients in certain timelines of their disease [15].

In 2014, several authors [12], designed a consensus meeting for proposed aims, overall design, format and function for MDT-driven care within an IBD service, based on The Delphi methodology. The panel of this consensus was represented by 24 expert participants, who defined the primary objective of a MDT-driven care in IBD patients, the provision of multidisciplinary input for the patient’s care plan, also a consensus on the management of an IBD patient, in order to provide the best patient outcomes. Authors were agreed considering that colorectal surgeons, radiologists, gastroenterologists, IBD nurse specialist, dieticians, histopathologists and the MDT coordinator should be “core” MDT members, in concordance with UK IBD standards. Taking into consideration the high costs of MDTs, they suggested focusing the discussion on complex cases requiring surgery, biologic treatment, in both all newly diagnosed and patients who have undergone recent IBD surgery.

Panés., *et al.* [16], in a review article recommended several changes in the approach and management of an IBD patient, concluding that the best care of IBD patients should be provided by a MDT, ideally located in a center of excellence. These centers should have offered not only specialized attention, but promote communication between patients and physicians, and networking for stimulate the cooperation, self empowerment, in order to help patients to reduce long-term disability.

The authors proposed a list of who specialists could be part of an IBD Multidisciplinary Team:

- **Core Team:** Gastroenterologists, IBD nurse specialists, Surgeons, Radiologists, Pathologists and Specialist pharmacists.
- **Complementary Team:** Dieticians, Psychologists, Social workers, Pediatricians, Rheumatologists, Dermatologists, Ophthalmologists, Infectious disease specialists.

### How do we design a MDT?

As MDT, the first step is determining who will be the core members of the group, based on the objectives and expectations, according local realities (e.g., more local prevalent disease, more frequent reasons for consultations, surgical, nutritional needs, etc.). This step is important for establish what will be your strategic plan. The identification of critical steps in patient’s journey contribute to identify gaps to overcome.

Once MDT priorities/objectives/expectations are arranged, it is important setting up the resources/facilities (personnel and infrastructure) the MDT counts on. There are several articles with recommendations on what could be, in an escalator concept, the key elements that a MDT should base on [8,9,15].

It is crucial to understand that this is a continuous and active process, with rearrangements according new technological, cultural, and professional realities emerge. Developing programs to provide a continuity from pediatrics to adult status e.g., needs to be carefully managed, to allow a proper psychosocial development [15].

Another step will be establishing MDT frequency meetings, not only for patients and physician’s communication (through patients’ association, IBD nurse specialist, social network, etc.); the establishment of development and training program for MDT members is necessary. Self-evaluation methods, in order to reevaluate themselves: efficacy, effectiveness of their activities (in terms of patient-centered goals, also resources utilization and cost effectivity) is part of the DMT program [15].

### New challenges

In the context of IBD management, persistent unmet needs will depend on local realities. According to these, MDT members will face how to establish a tailored patient treatment and improve channels of communication (telemedicine as an option?). The DMT proactive position will be a key factor for improve their efficacy in getting a better patients’ QoL [15].

Regarding this theme, Panés., *et al.* [16] recommended on their review article, what did they consider were the unmet needs on IBD management, among others:

- Overcome gaps in diagnosis and intervention delay, also diversity and outdated guidelines;
- Broaden the concept of the progressive and disability nature of the disease, preconizing early treatment and treatment switching, according patient needs;
- Fostering physician-patient collaboration, in order to optimize treatment adherence;
- Improving communication/IBD network/involve patient in decision making process.

I recognize the gap between guidelines/expert recommendations and the reality of many hospitals; however, there is no barrier high enough to take step by step for offering a better care to IBD patients.

### Conclusion

IBD, as a complex /long-life disease disorder, deserves a multidisciplinary approach management. Every DMT should be based on local needs/facilities/resources, and going escalating to a standardized worldwide DMT structure, step by step. This is a continuous and active process and should always have a patient-centered vision as a main goal.

As gastroenterologists, we are committed to move forward.

### Conflict of Interest

The author was former IBD Medical Manager in AbbVie Venezuela; now is Oncohematology/Neurosciences Medical Manager in Roche Uruguay.

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