

CME

ACG Clinical Guideline Update: Preventive Care in Inflammatory Bowel Disease

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Patients with inflammatory bowel disease (IBD) often consider their gastroenterologist to be the primary provider of care. To improve the care delivered to patients with IBD, health maintenance issues need to be addressed by the gastroenterology team. In particular, documentation and recommendation for vaccinations are crucial because more than 70% of patients with IBD will at some time be on immune-modifying therapies that may increase the risk for infections, many of which are preventable with vaccinations. Health maintenance recommendations addressed in this guideline include the safety and appropriate timing of vaccinations, screening for osteoporosis, cervical cancer, melanoma and non-melanoma skin cancer and screening for depression, anxiety, and need for smoking cessation. To accomplish these health maintenance goals, coordination among the primary care provider, gastroenterology team, and other specialists is necessary.

KEYWORDS: Crohn's disease; ulcerative colitis; infection; immunization; screening for cervical and skin cancer; depression; anxiety; bone health; smoking cessation

Key concept

1. Adults with IBD should follow the Advisory Committee on Immunization Practices (ACIP) recommendation and should not receive a live vaccine if on immune-modifying therapy.

Key concept

2. Adults with IBD should receive age-appropriate vaccinations before initiation of immune-modifying therapy when possible.

Key concept

3. All adult patients with IBD should receive annual influenza vaccine.
4. Adult patients with IBD receiving immune-modifying therapies and their household contacts should receive the nonlive trivalent inactivated influenza vaccine but not the live inhaled influenza vaccine.

Recommendation

1. In all adult patients with IBD aged 50 and older and no prior pneumococcal vaccination, we suggest pneumococcal vaccination with PCV20 or PCV21 (Strong recommendation, low certainty of evidence)
2. In adult patients with IBD between 19 and 49 years receiving immune-modifying therapy and with no prior pneumococcal vaccination, we suggest pneumococcal vaccination with PCV20 or PCV21 (Conditional recommendation, very low certainty of evidence)
3. In patients with IBD who have previously received pneumococcal vaccination and are either age 19–64 on immune-modifying therapy, or who are age 65 and older, should follow Centers for Disease Control and Prevention (CDC) guidance for whether to receive additional pneumococcal vaccination with PCV20 or PCV21 (Strong recommendation, low certainty of evidence)

Preventive Care in Inflammatory Bowel Disease

Age groups	PCV naïve	Incomplete PCV vaccines series [†]	Completed adult PCV vaccines series [‡]
• Age 19-49 years immunocompromised • All patients 50-64 years	PCV21 or PCV20	PCV13 $\xrightarrow{\geq 1 \text{ y}}$ PCV21 or PCV20 PCV13 + PPSV23 $\xrightarrow{\geq 5 \text{ y}}$ PCV21 or PCV20	No vaccine recommendation
Age ≥ 65 years	PCV21 or PCV20	≥ 5 yrs since last PCV $\longrightarrow$ PCV21 or PCV20	PCV20 or PCV 21*

Figure 1. Pneumococcal vaccine schedule (75). [†]Patient has completed one of the following vaccine regimens: PCV13 and 2 doses of PPSV23, PCV15 and PPSV23, PCV20, or PCV21. [‡]Unknown vaccine history, PCV7 at any age, PPSV23 only, PCV13 only, PCV13, and 1 dose of PPSV23. * Administer pneumococcal vaccine 1 additional time 5 years after previous vaccine

Key concept

5. All adult patients with IBD 75 years of age and older should receive a RSV vaccine.
6. All adult patients with IBD aged 50–74 years with certain chronic medical conditions or other risk factors for severe RSV disease should receive a RSV vaccine.

Recommendations

4. In all adults 50 and older with IBD, we suggest vaccination against HZ with the 2-dose inactive recombinant HZ vaccine (Conditional recommendation, low certainty of evidence)
5. In adults 19 and above with IBD on immune-modifying therapy or planning to start therapy, we suggest vaccination against HZ with the 2-dose inactive recombinant HZ vaccine (Conditional recommendation, very low certainty of evidence)

Key concept

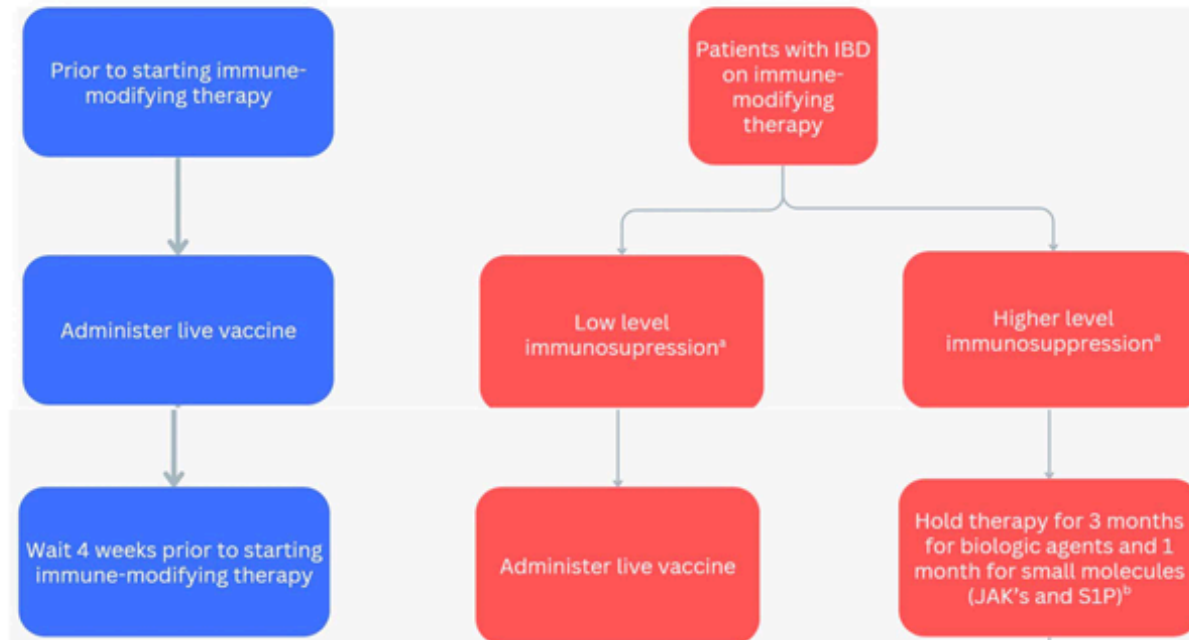
7. Adults with IBD should be evaluated for varicella immunity before initiating immune-modifying therapy, through either a documented history of chickenpox infection or completion of a 2-dose varicella vaccine series. Serologic testing is not recommended in previously vaccinated individuals because of the high false-negative rates. If nonimmune status is confirmed, vaccination should be completed before initiating immune-modifying therapy when possible.

Key concept

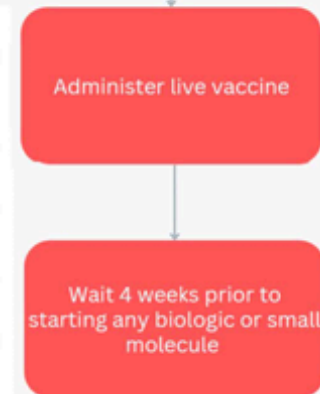
8. Household members of patients receiving immune-modifying therapies can receive live vaccines with certain precautions.

Recommendation

6. In adults with IBD, we suggest vaccination against SARS-CoV-2 in accordance with national guidelines (Conditional recommendation, very low certainty of evidence)



Low level immunosuppression *	Higher level immunosuppression *
Short term steroids (i.e., <14 days)	High-dose steroids >20 mg per day of prednisone
Low to moderate dose (i.e., <20 mg of prednisone or equivalent per day or <2 mg/kg body weight per day for a young child)	Methotrexate or azathioprine °
Long-term, alternate-day treatment with short-acting steroid preparations	
Maintenance physiologic doses (replacement therapy)	Biologic therapy (anti-TNF therapy)
Topical (skin or eyes), inhaled, or by intra-articular, bursal, or tendon injection	Non-TNF biologic agents (ustekinumab, risankizumab, mirikizumab, guselkumab)*
Vedolizumab ^d	JAK inhibitors and S1P (tofacitinib, upadacitinib, ozanimod, etrasimod)



Key concept

9. Vaccinations against Tdap, hepatitis A virus (HAV), HPV, and meningococcus should be administered according to the ACIP Recommendations.

Key concept

10. Adults with IBD should receive vaccination against hepatitis B if not immune.

Recommendation

7. We suggest that a live rotavirus vaccine may be offered in children with in-utero exposure to biologic therapy (Conditional recommendation with very low certainty of evidence)

Recommendation

8. In women with IBD on immune-modifying therapies, we suggest annual cervical cancer screening within a year of the onset of sexual activity and if younger than 30 years should continue for 3 consecutive years before increasing to every 3 years (Conditional recommendation, very low certainty of evidence)

Recommendations

9. In patients with IBD (both UC and CD), we suggest annual screening for melanoma independent of the use of biologic therapy (Conditional recommendation, very low certainty of evidence)
10. In patients with IBD on immune-modifying therapies (6-mercaptopurine, azathioprine, methotrexate, JAK inhibitors, or S1P receptor modulators), we suggest annual screening for NMSC while using these agents, particularly older than the age of 50 (Conditional recommendation, very low certainty of evidence)

Key concept

11. All patients with CD and UC should be screened for depression and anxiety at baseline and annually. Patients who screen positive for anxiety and/or depression should be referred for counseling/therapy.

Recommendation

11. In adults with IBD and conventional risk factors for abnormal bone mineral density, we suggest screening for osteoporosis with bone mineral density testing at the time of diagnosis and periodically after diagnosis (Conditional recommendation, very low certainty of evidence)

Recommendation

12. In adults with IBD who smoke, we suggest that they should be counseled to quit (Strong recommendation, low certainty of evidence)