TV-106-110719-20

SYLLABUS AND COURSE GUIDE

Who's in Charge: You or Your Ulcerative Colitis?

A Free, 60-Minute Live and On-Demand Activity for Patients with UC

Premiere Date: Thursday, November 7, 2019

7:00 PM - 8:00 PM ET (live)

On the Web: http://bit.ly/TV-106

FACULTY: David T. Rubin, MD, FACG, AGAF, FACP, FASGE

Take advantage of our LIVE Q&A segment during this webcast!

During the webcast **type a question in the box under the presentation**

Email your question or comment: **questions@cmeoutfitters.com**

All other questions: Call CME Outfitters at 877.CME.PROS

This continuing education activity is provided by

CME Outfitters

INFORMATION FOR PARTICIPANTS

Statement of Need

We don't have to tell you that managing your ulcerative colitis (UC) is challenging. At times it seems like you need to be a physician yourself in order to understand the data and the decisions that are best for you. Practice guidelines are designed for gastroenterologists and their care teams; however, knowledge about how the guidelines are developed and how they apply to the individual are important for understanding your doctor's decisions in managing your UC.

Dr. Rubin has you covered! In this live and on-demand webcast, Dr. Rubin will share his insights and take your LIVE questions to help you manage your disease and take back control of your UC.

What you will learn:

At the end of this activity, participants should be able to:

- Recognize the importance of practice guidelines and how they apply to UC.
- Establish long-term treatment goals to heal the inflamed bowels instead of masking the symptoms.
- Identify key markers of inflammation in inflammatory bowel disease and how they are used in practice.
- Evaluate the risk of colorectal cancer and colostomy in UC.
- Engage with your UC doctor to discuss your disease and strategies to establish and maintain clinical remission.

Target Audience

Individuals with ulcerative colitis

Financial Support

Supported by an educational grant from Takeda Pharmaceuticals U.S.A., Inc.

FACULTY BIO & DISCLOSURES

David T. Rubin, MD, FACG, AGAF, FACP, FASGE

Dr. Rubin is Chief of the Section of Gastroenterology, Hepatology & Nutrition and the Co-Director of the Digestive Diseases Center at The University of Chicago Medicine. Dr. Rubin earned a medical degree with honors at The University of Chicago Pritzker School of Medicine. He completed his residency in internal medicine and fellowships in gastroenterology and clinical medical ethics at the University of Chicago, where he served as Chief Resident and Chief Fellow. Prior to his current appointments, Dr. Rubin served for 11 years as Director of the Gastroenterology, Hepatology and Nutrition fellowship program. He also currently serves as an associate faculty member at the MacLean Center for Clinical Medical Ethics and as an associate investigator at the University of Chicago Comprehensive Cancer Center.

Dr. Rubin is a Fellow of the American Gastroenterological Association (AGA), the American College of Gastroenterology (ACG), the American Society for Gastrointestinal Endoscopy (ASGE), and the American College of Physicians (ACP) as well as an active national member of the Crohn's & Colitis Foundation (CCF) and is on the Board of Trustees for the ACG. Among numerous awards and honors, Dr. Rubin was chosen by his peers as a member of Best Doctors (recognized for superior clinical ability) and America's Top Physicians (gastroenterology). Additionally, he twice received the ACG's Governor's Award of Excellence in Clinical Research (2003 and 2013), the Cancer Research Foundation Young Investigator's Award (2004), and the UC Postgraduate Teaching Award in recognition of significant contributions for fellowship education (2006). In 2012, he received the CCF Rosenthal Award, a national leadership award bestowed upon a volunteer who has contributed in an indisputable way to the quality of life of patients and families. He is currently the Chair-Elect of the National Scientific Advisory Committee of the CCF. He is an Associate Editor of the journal Gastroenterology and Co-Editor of the ACG On-Line Educational Universe.

Dr. Rubin is the editor of a best-selling book on inflammatory bowel disease (IBD), now in its 3rd edition, and an author or coauthor of many peer-reviewed articles on treatment and management of IBD as well as cancer in IBD and novel paradigms. He is also first author of the in-progress ACG Guidelines for ulcerative colitis. His current research is in the area of progressive complications from uncontrolled inflammation, the doctor-patient relationship in IBD, and a variety of collaborative studies related to the microbiome and intestinal disease. He is also a featured media contact for issues related to IBD (satellite radio, television, and print media) and maintains a popular twitter feed @IBDMD (> 6,000 followers). His principal research interests include novel IBD therapies and outcomes, colon cancer prevention, and clinical medical ethics.

Disclosure of Relevant Financial Relationships with Commercial Interests

It is the policy of CME Outfitters, LLC, to ensure independence, balance, objectivity, and scientific rigor and integrity in all of their CE activities. Faculty must disclose to the participants any relationships with commercial companies whose products or devices may be mentioned in faculty presentations, or with the commercial supporter of this CE activity. CME Outfitters, LLC, has evaluated, identified, and attempted to resolve any potential conflicts of interest through a rigorous content validation procedure, use of evidence-based data/research, and a multidisciplinary peer review process. The following information is for participant information only. It is not assumed that these relationships will have a negative impact on the presentations.

Dr. Rubin reports that he receives grants from AbbVie Inc.; Genentech, Inc./Roche; Janssen Pharmaceuticals, Inc.; Prometheus Laboratories Inc.; Shire; and Takeda Pharmaceuticals U.S.A., Inc. He is a consultant for AbbVie Inc.; AbGenomics; Allergan; Arena Pharmaceuticals, Inc.; Biomica; Bristol-Myers Squibb Company; Dizal Pharmaceutical; Eli Lilly and Company; Ferring Pharmaceuticals Inc.; Genentech, Inc./Roche; Janssen Pharmaceuticals, Inc.; Medtronic; Merck & Co., Inc.; Napo Pharmaceuticals, Inc.; Pfizer Inc.; Shire; Takeda Pharmaceuticals U.S.A., Inc.; and TARGET PharmaSolutions, Inc. He receives other financial or material support as a member of the Board of Trustees for the American College of Gastroenterology; as Co-Founder, CFO of Cornerstones Health, Inc. (non-profit); and as Co-Founder of GoDuRn, LLC.

Olga Askinazi, PhD (planning committee) has no disclosures to report.

Jan Perez (planning committee) has no disclosures to report.

Sharon Tordoff (planning committee) has no disclosures to report.

Disclosures were obtained from the CME Outfitters, LLC staff: No disclosures to report.

Unlabeled Use Disclosure

Faculty of this CE activity may include discussions of products or devices that are not currently labeled for use by the FDA. The faculty have been informed of their responsibility to disclose to the audience if they will be discussing off-label or investigational uses (any uses not approved by the FDA) of products or devices.

Activity Slides

The slides that are presented in this activity will be available to download and print out at the CME Outfitters website: **www.cmeoutfitters.com**. Activity slides may also be obtained via fax or email by calling **877.CME.PROS**.

CME Outfitters
CONTINUING MEDICAL EDUCATION

Who's in Charge: You or Your Ulcerative Colitis?

Thursday, November 7, 2019

CME Outfitters, LLC, gratefully acknowledges an educational grant from Takeda Pharmaceuticals U.S.A., Inc. in support of this activity.

The course guide for this activity includes slides, disclosures of faculty financial relationships, and biographical profiles.

View and/or print the course guide from the ***Materials*** tab.

The faculty have been informed of their responsibility to disclose to the audience if they will be discussing off-label or investigational uses (any use not approved by the FDA) of products or devices.

CME Outfitters
CONTINUING MEDICAL EDUCATION

David T. Rubin, MD, FACG, AGAF, FACP, FASGE

Joseph B. Kirsner Professor of Medicine
Section Chief, Gastroenterology, Hepatology and Nutrition
Co-Director, Digestive Diseases Center
University of Chicago Medicine
Chicago, IL

David T. Rubin, MD, FACG, AGAF, FACP, FASGE

Disclosures

- ***Research Support:*** AbbVie Inc.; Genentech, Inc./Roche; Janssen Pharmaceuticals, Inc.; Prometheus Laboratories Inc.; Shire; Takeda Pharmaceuticals U.S.A., Inc.
- ***Consultant:*** AbbVie Inc.; AbGenomics; Allergan; Arena Pharmaceuticals, Inc.; Biomica; Bristol-Myers Squibb Company; Dizal Pharmaceutical; Eli Lilly and Company; Ferring Pharmaceuticals Inc.; Genentech, Inc./Roche; Janssen Pharmaceuticals, Inc.; Medtronic; Merck & Co., Inc.; Napo Pharmaceuticals, Inc.; Pfizer Inc.; Shire; Takeda Pharmaceuticals U.S.A., Inc.; TARGET PharmaSolutions, Inc.
- ***Other Financial or Material Support:*** Board of Trustees for the American College of Gastroenterology; Co-Founder, CFO of Cornerstones Health, Inc. (non-profit); Co-Founder of GoDuRn, LLC

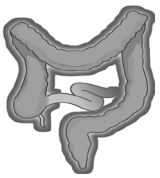
CME Outfitters
CONTINUING MEDICAL EDUCATION

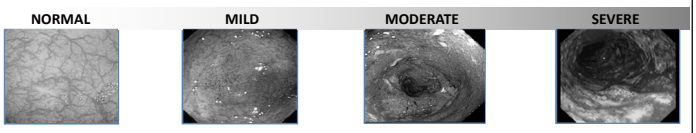
New Guidelines in Ulcerative Colitis:

Why Should I Care?

What Is Ulcerative Colitis?

- Chronic inflammation of large intestine
- Cause unknown
- Relapsing + remitting
- Treatable! New treatments and treatment goals

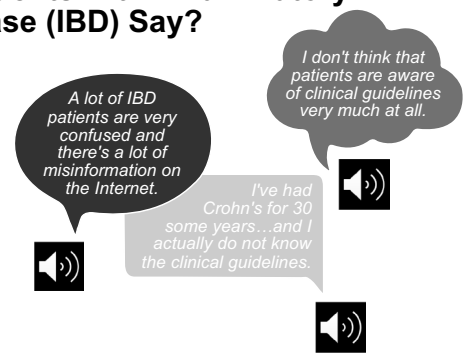




Who's in Charge: You or Your Ulcerative Colitis?

What Do Patients with Inflammatory Bowel Disease (IBD) Say?

Are you aware of clinical guidelines for the care of patients with IBD?



Why Are Clinical Practice Guidelines Important?

- Guidelines are written by experts in the field
- They contain recommendations for clinicians about patient care
- These recommendations are based on the most recent clinical research and are usually updated every few years
- Clinicians should refer to the guidelines to ensure that their treatment decisions are in line with the current standards

Remember!
You have a right to confirm that your doctor is aware of and considering guideline recommendations

Rubin DT, et al. *Am J Gastroenterol.* 2019;114(3):384-413; Ko CW, et al. *Gastroenterology.* 2019;156(3):748-764.

Limitations of Guidelines

- Can become out-of-date quickly
- Don't apply to ALL patients
- Sometimes ignored by payers

Levels of Evidence

Increasing quality + strength of evidence

- Opinion of experts without research
- Cases reported
- Randomized trials that are blinded
- Multiple randomized trials

Who's in Charge: You or Your Ulcerative Colitis?

U.S. Ulcerative Colitis (UC) Guidelines

- In 2019, two U.S. societies updated their UC guidelines:
  - American College of Gastroenterology (for mild, moderate, and severe UC)
  - American Gastroenterological Association (for mild and moderate UC)

ACG Clinical Guideline: Ulcerative Colitis in Adults

CLINICAL PRACTICE GUIDELINES

AGA Clinical Practice Guidelines on the Management of Mild-to-Moderate Ulcerative Colitis

Rubin DT, et al. Am J Gastroenterol. 2019;114(3):384-413; Ko CW, et al. Gastroenterology. 2019;156(3):748-764.

What's New in the 2019 UC Guidelines?

- Shift from reactive management of flares to proactive monitoring and **prevention** of flares
- Treatment choice based on both inflammatory activity and prognosis
- Healing of the bowel is a target of treatment
- New therapies: **budesonide**, **golimumab**, **vedolizumab**, **tofacitinib**, and **ustekinumab**
- Infection with bacterium *C. difficile* should be ruled out in all patients
- Stool test (calprotectin) instead of colonoscopy

Rubin DT, et al. *Am J Gastroenterol.* 2019;114(3):384-413; Ko CW, et al. *Gastroenterology*. 2019;156(3):748-764.

Goals of Management of UC

- Clarify disease activity and severity
  - How much bowel is involved?
  - What is the risk for surgery?
- Induction of remission (fast!)
  - Clinical remission
  - Healing the bowel
- Prevention of relapse (maintenance)
  - No steroids
- Prevention of disease + drug related complications (infections, hospitalization, surgery, cancer)

What Do Patients with IBD Say?

What would remission look like to you?

Remission looks like being able to live my life fully without suffering from IBD, without putting things aside. I have activities that I can't participate in just from the symptoms and the pain from IBD. I have had to sit out from things. I've had to leave work early because of my symptoms. So remission to me is not having to do things like that where my life is impacted in a negative way.

The Different Levels of UC Activity

American College of Gastroenterology Index

	Remission	Mild	Moderate-Severe	Fulminant
Stools (#/day)	Formed stools	< 4	> 6	> 10
Blood in stools	None	Intermittent	Frequent	Continuous
Urgency	None	Mild, occasional	Often	Continuous
Hemoglobin	Normal	Normal	< 75% of normal	Transfusion required
ESR	< 30	< 30	> 30	> 30
CRP (mg/L)	Normal	Elevated	Elevated	Elevated
FCP (µg/g)	< 150-200	> 150-200	> 150-200	> 150-200
Endoscopy (Mayo subscore)	0-1	1	2-3	3
UCEIS	0-1	2-4	5-8	7-8

CRP = C-reactive protein; ESR = erythrocyte sedimentation rate; FCP = fecal calprotectin; UCEIS = UC Endoscopic Index of Severity.
Rubin DT, et al. *Am J Gastroenterol*. 2019;114(3):384-413.

Prognosis (Severity) of UC

Factors Associated with Increased Risk of Colectomy
Being diagnosed **younger** than age 40
Extensive colitis (involvement of more of the large intestine)
Severe inflammation seen on scope
Needing **hospitalization** for the colitis
Elevated CRP (blood test of inflammation)
Low serum albumin (blood test of nutrition and health)

Rubin DT, et al. *Am J Gastroenterol*. 2019;114(3):384-413.

Questions for Dr. Rubin?

Type a question in the box under the presentation

E-mail: **questions@cmeoutfitters.com**

Tweet Questions: **#TakeChargeofUC**

CME Outfitters
CONTINUING MEDICAL EDUCATION

Controlling Symptoms and Inflammation:

Why Do Both Matter?

What Do Patients with IBD Say?

Has your clinician discussed with you the difference between symptom control and healing of the bowel?

For me, my clinicians have always explained both, the mucosal healing of the intestine as well as symptom control.

No, I have never actually had that compared by a doctor. He's actually never discussed healing. It's pretty much always the discussion on how to keep it at bay; how to keep it under control.

What Is Clinical Remission of UC?

- Formed stool
- No blood
- No urgency
- Sleeping through the night without bowel movement
- Able to pass gas without fear of leaking

Clinical Remission = Improved Quality of Life

Clinical remission is NECESSARY but NOT SUFFICIENT for control of UC

Why Is Clinical Remission Not Enough?

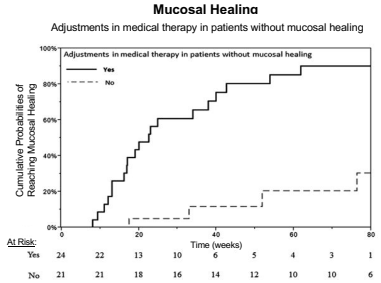
- Up to 50% of patients in clinical remission have persistent inflammation
- Inflammation that persists increase risk of relapse
- UC causes ulcerations in the lining of the bowel called the mucosa
- Mucosal healing means healing of the ulcers in the bowel lining
- Studies show that mucosal healing lowers the risk for relapse, colectomy, and colon cancer

Goals for managing patients with ulcerative colitis

4 We suggest treating patients with UC to achieve mucosal healing, defined as resolution of inflammatory changes (Mayo endoscopic subscore 0 or 1)) to increase the likelihood of sustained steroid-free remission and prevent hospitalizations and surgery (conditional recommendation, low quality of evidence).

Rubin DT, et al. *Am J Gastroenterol.* 2019;114(3):384-413; Magro F, et al. J Crohns Colitis. 2017;11(6):649-670.

Adjustments in Treatment Can Heal the Bowel



Bouguen G, et al. *Inflamm Bowel Dis.* 2014;20(2):231-239.

Questions for Dr. Rubin?

Type a question in the box under the presentation

E-mail: **questions@cmeoutfitters.com**

Tweet Questions: **#TakeChargeofUC**

CME Outfitters
CONTINUING MEDICAL EDUCATION

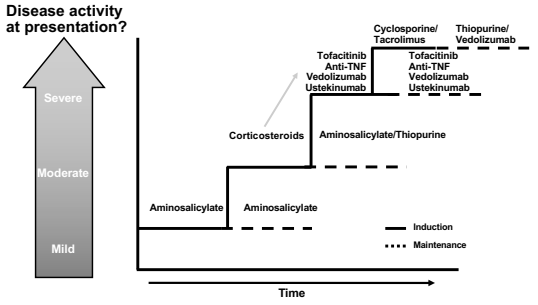
Treatments for UC

Available Therapies for UC

- Aminosalicylates (**5-ASA**)
- Biologics and small-molecule therapies
  - Anti-TNF therapies: Remicade® (**infliximab**), Humira® (**adalimumab**), Simponi® (**golimumab**)
  - Anti-integrin therapy: Entyvio® (**vedolizumab**)
  - JAK inhibitor: Xeljanz® (**tofacitinib**)
  - Anti–interleukin 12/23 therapy: Stelara® (**ustekinumab**)
- Surgery

Rutgeerts P, et al. *N Engl J Med.* 2005;353(23):2462-2476. Sandborn WJ, et al. *Gastroenterology.* 2012;142(2):257-265. Sandborn WJ, et al. *Gastroenterology.* 2014;146(1):96-109. Feagan BG, et al. *N Engl J Med.* 2013;369(8):699-710. Sandborn WJ, et al. *N Engl J Med.* 2017;376:1723-1736. Sands BE, et al. *N Engl J Med.* 2019 381(13):1201-1214.

Historical Treatment Strategies for IBD:
Symptom-Based, Short-Term Goals



Why Immune Therapy for UC?

- UC is a state of increased and apparently uncontrolled immune activity of the colon
- The goal of immune therapy is NOT to immune suppress a patient
- The goal of immune therapy is to modify or turn down the active immune system long enough for the body to "reset" itself and to heal

General Principles of Treatments for IBD

1. **Start with symptom resolution**
2. **Get to a healed bowel and normal labs**
   - Objective evidence of disease control
3. **Developing customized treatment plans**
   - Do you know where your disease is located?
   - What is your individual prognosis?
   - Does your IBD flare seasonally?
   - What is your plan at the earliest sign of relapse?

General Principles of Treatments for IBD (cont.)

4. **Choose induction therapy based on activity (how sick now) and severity (prognosis)**
   - Use non-immune therapies first for milder disease
   - Use organ selective therapies before systemic therapies when possible
   - Optimize first therapy
   - Don't use steroids too long!
5. **Choose maintenance therapy based on severity of disease and induction therapy**
6. **Monitor for stable disease control over time!**

General Principles of Treatments for IBD (cont.)

7. Prevention is key to good health!

- Vaccination for preventable illnesses
- Cancer prevention
  - Colon cancer prevention with scheduled colonoscopies
  - Skin cancer monitoring with annual dermatology visits
  - Annual Pap smears
- Regular visits to your IBD doctor

Mild or Moderate UC: ACG and AGA Recommendations 2019

Condition	ACG and AGA Recommendations	
Extensive mild-moderate UC	**5-ASA** therapy	
Left-sided mild-moderate UC	Rectal **5-ASA (enema or suppository)** + oral **5-ASA**	
Mild-moderate UC w/suboptimal response to **5-ASA**	**Budesonide MMX**	**Oral prednisone or budesonide MMX**
Mild-moderate proctitis	Rectal **5-ASA (enema or suppository)**	
Opinion on systemic steroids	Recommendation against systemic steroids	Not addressed

Rubin DT, et al. *Am J Gastroenterol*. 2019;114(3):384-413. Ko CW, et al. *Gastroenterology*. 2019;156(3):748-764.

Induction of Remission: Moderate or Severe UC

- UC failing to respond to **5-ASA** therapy → **oral systemic corticosteroids**[1-4]
- Moderate UC → **oral budesonide MMX**[1]
- Moderate-severe UC of any extent → **oral systemic corticosteroids**[1,3,4]
- **Biological therapies:**
  - **Anti-TNF therapy** using **adalimumab**, **golimumab** or **infliximab**[1-5]
  - **Vedolizumab**[1,4]
  - **Ustekinumab**
- **Infliximab** in combination with a **thiopurine**[1-4]
- **Tofacitinib**[1]
- If failed **anti-TNF** → **vedolizumab**[1-4] *or* **tofacitinib**[1] *or* **ustekinumab**

1. Rubin DT, et al. *Am J Gastroenterol*. 2019;114:384-413. 2. Hardbord M, et al. *J Crohns Colitis*. 2017;11(7):769-784.
3. Bressler B, et al. *Gastroenterology*. 2015;148(5):1035-1058.e3. 4. Coi CH, et al. *Intest Res*. 2017;15(1):7-37.

Maintenance of Remission: Moderate or Severe UC

- **Recommend against systemic steroids**[1,3,5]
- **Thiopurines**[1-5]
- **Recommend against** using **methotrexate**[1-3]
- **Biological therapies:**
  - **Anti-TNF therapy** using **adalimumab**, **golimumab** or **infliximab**[1-5]
  - **Vedolizumab**[1,4]
  - **Ustekinumab**
- **Tofacitinib**[1]

1. Rubin DT, et al. *Am J Gastroenterol*. 2019;114:384-413. 2. Hardbord M, et al. *J Crohns Colitis*. 2017;11(7):769-784.
3. Bressler B, et al. *Gastroenterology*. 2015;148(5):1035-1058.e3. 4. Coi CH, et al. *Intest Res*. 2017;15(1):7-37.
5. Wei CS, et al. *Intest Res*. 2017;15(3):266-284.

Who's in Charge: You or Your Ulcerative Colitis?

Phew. I'm in Remission, Now What?

- Monitoring
- Stool tests for calprotectin and lactoferrin are efficient ways to monitor remission
- Long-term, sustained healing is maintained through regular monitoring and testing

Remember!
If you stop your medications, you risk returning to inflammation and IBD symptoms

Rubin DT, et al. *Am J Gastroenterol.* 2019;114(3):384-413;

What Do Patients with IBD Say?

Has your clinician discussed with you markers of disease activity, why they are important, and how often they need to be evaluated?

When I am having any type of symptoms, my doctor will order labs and I know that she is looking for specific markers. I never have discussions with her about what the markers are specifically that she is looking for. I wish that I did have a better idea of what it is in the labs that she is trying to get.

Why Do Therapies Stop Working?

- Reasons for loss of response:
  - Body finds a new pathway of inflammation
  - Infection on top of the UC
  - For biological therapies, your body can develop immunity to the therapy (like a reaction to a vaccination)
  - You stop taking the medicine

What to Do if Your Medicine Stops Working

- Confirm inflammation
- Rule out infection
- Check on the drug level
- Consider dose changes
- Consider short-term fix (steroids?...)
- Cycle to another therapy in the same class
- Swap to a new mechanism

Questions for Dr. Rubin?

Type a question in the box under the presentation

E-mail: **questions@cmeoutfitters.com**

Tweet Questions: **#TakeChargeofUC**

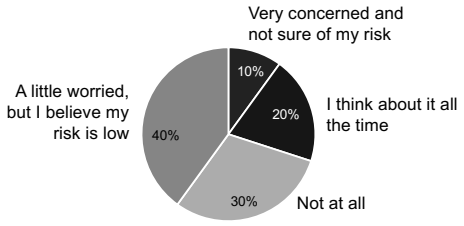
CME Outfitters
CONTINUING MEDICAL EDUCATION

Cancer in UC:

Am I at Risk?

What Do Patients with IBD Say?

How worried are you about colorectal cancer?



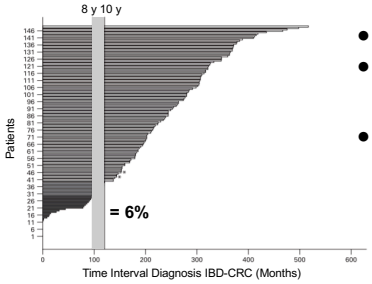
CME Outfitters [data on file]. 2019.

Am I at Risk for Colorectal Cancer?

- Individuals with UC are at increased risk for developing colorectal cancer
- However, only 5% of people with severe UC develop cancer
- Your doctor should schedule regular cancer screenings

Did you know?
Colorectal cancer is one of the most preventable and treatable cancers when identified early

When Should I Be Screened?



- N = 149
- Diagnosis of IBD to colorectal cancer (CRC) varied from 0 to 45 years
- Earlier surveillance at 8 years instead of 10 years captures an additional 6% of patients developing CRC

Lutgens MW, et al. *Gut.* 2008;16:1106-1113.e3.

What Do Guidelines Say About Cancer Prevention?

- Cancer most often occurs 8-10 years after UC symptoms begin
- Annual colonoscopies should be scheduled for those who have had UC for 8 or more years or are age ≥ 45
- Doctor will look for cell dysplasia, or changes in the cells that may progress to cancer
- High-risk patients may undergo endoscopy with a special dye that highlights dysplasia

Rubin DT, et al. *Am J Gastroenterol.* 2019;114(3):384-413; Wolf AMD, et al. *CA Cancer J Clin.* 2018;68(4):250-281.

Questions for Dr. Rubin?

Type a question in the box under the presentation

E-mail: **questions@cmeoutfitters.com**

Tweet Questions: **#TakeChargeofUC**

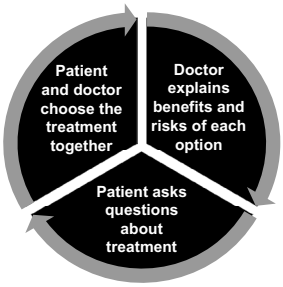
CME Outfitters
CONTINUING MEDICAL EDUCATION

Open Communication with the Doctor:

What Should I Ask and How?

Who's in Charge: You or Your Ulcerative Colitis?

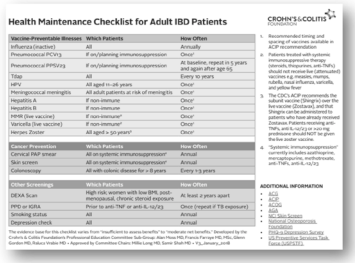
What Is Shared Decision-Making?



BOTTOM LINE:

You, as a patient, have a right to participate in decisions about your treatment. **Do not hesitate to ask questions, request clarifications, and do your own research!**

Why So Many Questions? Checklists Are Important for You and Your Doctor



Health Maintenance Checklist for Adult IBD Patients

CROHN'S & COLITIS FOUNDATION

Vaccine-Preventable Illnesses	Which Patients	How Often
Influenza (inactive)	All	Annually
Pneumococcal PCV13	If on/planning immunosuppression	Once[1]
Pneumococcal PPSV23	If on/planning immunosuppression	At baseline, repeat in 5 years and again after age 65
Tdap	All	Every 10 years
HPV	All aged 11–26 years	Once[1]
Meningococcal meningitis	All adult patients at risk of meningitis	Once[1]
Hepatitis A	If non-immune	Once[1]
Hepatitis B	If non-immune	Once[1]
MMR (live vaccine)	If non-immune[2]	Once[1]
Varicella (live vaccine)	If non-immune[2]	Once[1]
Herpes Zoster	All aged > 50 years[3]	Once[1]

Cancer Prevention	Which Patients	How Often
Cervical PAP smear	All on systemic immunosuppression[4]	Annual
Skin screen	All on systemic immunosuppression[4]	Annual
Colonoscopy	All with colonic disease for > 8 years	Every > 5 years

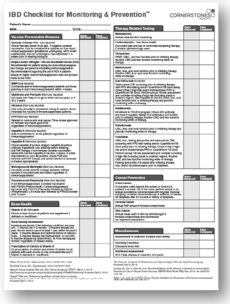
Other Screenings	Which Patients	How Often
DEXA Scan	High risk; women with low BMI, post-menopausal, chronic steroid exposure	At least 2 years apart
PPD or IGRA	Prior to anti-TNF or anti-IL-12/23	Once (repeat if TB exposure)
Smoking status	All	Annual
Depression check	All	Annual

The evidence base for this checklist varies from "insufficient to assess benefits" to "moderate net benefits." Developed by the Crohn's & Colitis Foundation's Professional Education Committee Sub-Group: Alan Hoie MD, Francis Farraye MD, MSc, Glenn Gordon MD, Rabya Vrabie MD – Approved by Committee Chairs Millie Long MD, Sunir Shah MD – Vs. January_2018

1. Recommended timing and spacing of vaccines available in ACIP recommendation
2. Patients treated with systemic immunosuppressive therapy (steroids, thiopurines, anti-TNFs) should not receive live (attenuated) vaccines e.g. measles, mumps, rubella, nasal influenza, varicella, and yellow fever.
3. The CDC's ACIP recommends the use of Zostavax, the shingles live vaccine (Zostavax), and that Shingrix can be administered to patients who have already received Zostavax. Patients receiving anti-TNF, anti-IL-12/23, and prednisone should NOT be given the live zoster vaccine.
4. "Systemic immunosuppression" currently includes azathioprine, mercaptopurine, methotrexate, anti-TNFs, anti-IL-12/23

ADDITIONAL INFORMATION

- ACG
- ACIP
- AGA
- Asco
- Bcc Skin Screen
- National Osteoporosis Foundation
- Crohn's Impression Survey
- Crohn's & Colitis Advocacy Task Force (USPSTF)



IBD Checklist for Monitoring & Prevention™ CORNERSTONES4CARE

Crohn's and Colitis Foundation. http://www.crohnscolitisfoundation.org/science-and-professionals/programs-materials/health-maintenance-checklist.pdf. Accessed February 5 2019.
Cornerstones Health. http://www.cornerstoneshealth.org. Accessed October 9 2018.
Farraye FA, et al. *Am J Gastroenterol*. 2017;112:241-258.

Tips for Communicating with Your Doctor

- Prepare for your appointments ahead of time by keeping track of your symptoms
- Make a list of your questions from the most important to the least important; start the appointment by bringing up your list; go through your list and make notes or bring a voice recorder
- Consider bringing a close family member who can ask questions from their perspective
- Set treatment goals with your doctor and ensure you're checking them at each appointment

There is an app for this!
You can use your smartphone to track your symptoms and more. Check out **CMEO GI Hub** to find this and other useful info

What Questions Should I Ask?

- *How active is my disease?*
- *How much of my bowel is involved?*
- *What is my risk of needing surgery?*
- *What is the goal of my treatment?*
- *Am I on target to achieve mucosal healing?*
- *How do my medications work?*
- *What are the side effects of these medications?*
- *What will my insurance cover?*
- *How long might it take before I see an improvement?*
- *How is my disease activity being monitored?*
- *Am I at risk for cancer? How is it being monitored?*

Questions for Dr. Rubin?

Type a question in the box under the presentation

E-mail:
questions@cmeoutfitters.com

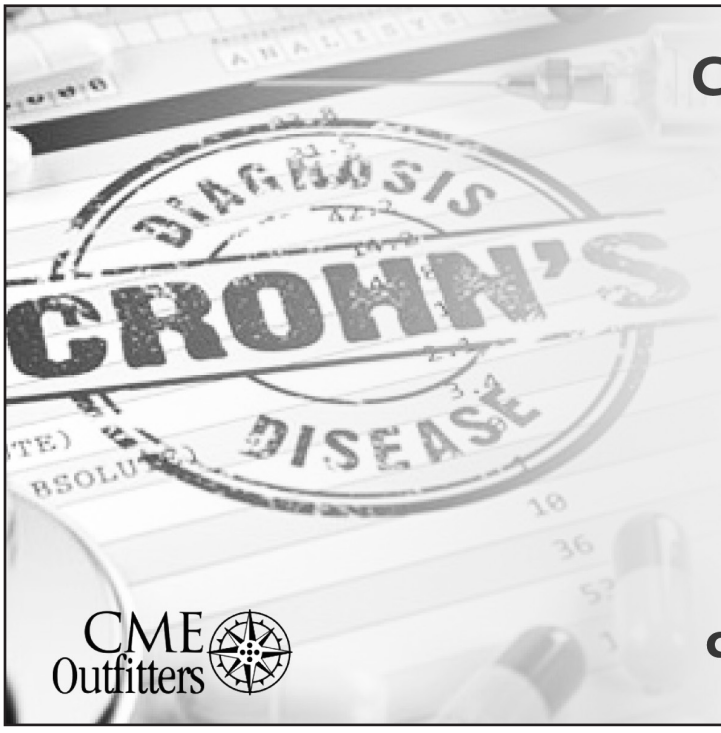
Tweet Questions:
#TakeChargeofUC

CME Outfitters
CONTINUING MEDICAL EDUCATION

Visit the NEW
Gastroenterology Patient Hub

Free resources & education to help you better understand and manage your disease.

www.cmeoutfitters.com/gastrohubPT



Crohn's Patients: Don't Miss This Upcoming Webcast

Who's in Charge: You or Your Crohn's disease?

Thurs., December 12, 2019
7:00 PM – 8:00 PM ET

cmeoutfitters.com/CDpatient

CME Outfitters