

The missing “C”: Crohn's, colitis and coping

Over the past several years, the care of patients with inflammatory bowel disease (IBD) has evolved from targeting simple control of their symptoms to utilizing more objective measures of resolution of inflammation. This includes corticosteroid-free remission, mucosal healing documented on endoscopy, and more recently normalization of inflammatory markers such as C-reactive protein (CRP) and fecal calprotectin.^[1] In addition to the physical manifestations of the illness, the psychological impact of IBD on patients cannot be overestimated. The study by Chao *et al.*^[2] published in this issue of the Journal offers insights into coping mechanisms recorded by IBD patients in a Canadian tertiary care center.

We have come to understand from previous publications how much negative impact the IBD diagnosis can have on a patient's quality of life. A large survey that was conducted in Europe, that included 4670 patients with IBD, examined this relationship. Subjects in this study were asked to answer 52 questions that belonged to 6 main categories. Around half of those surveyed felt that their lives were significantly impacted by IBD even during periods of remission. One-third of the patients viewed their disease as an obstacle against pursuing intimate relationships and 56% thought that it affected their career path.^[3]

Psychological comorbidities including depression and anxiety have been identified as factors associated with poor outcomes.^[4] This includes higher chances of requiring surgery or steroid prescription.^[5,6] In a population-based study from Alberta, a new diagnosis of depression significantly increased the risk of developing IBD. The authors suggested that this increased risk might be mitigated by using antidepressant agents.^[7]

In their study, Chao *et al.* looked at factors that were associated with adverse patients reported outcomes (PROs). This included modifiable social constructs of coping and self-efficacy in a population of IBD patients in a tertiary care center.^[2] In a cross-sectional design over a 6-month period, the authors recruited consecutive adult IBD patients that attended McGill University Health Center. Quality of life, disability and productivity were assessed using validated scores. Coping strategies were assessed using the Brief Coping Operations Preference Enquiry (Brief COPE) tool. This tool focuses on evaluating specific behaviors

such as active coping, emotional support, instrumental support, positive reframing, planning, humor, acceptance, and religion. Maladaptive mechanisms including denial, substance use, behavioral disengagement, venting, self-blame, self-distraction were also assessed using the Brief COPE tool.

A little over 200 patients were included in this study. The majority of these had confirmed Crohn's disease (CD). Over half of the patients were actively receiving biologics. One-fourth of the participants had active disease based on clinical criteria. Corticosteroid use was reported by 7.2% of patients. Around 1 in 4 patients had significant depressive symptoms and one-third had anxiety. Substance abuse was reported by 1 in 5 patients. Other maladaptive coping strategies were also identified. Self-distraction was reported by 55.1% of patients and venting in 23.3%. Self-blame and denial were reported by 18.8% and 17.2%, respectively. Behavioral disengagement was seen in 13.2% of patients. Emotion based strategies of coping including humor and emotional support were reported by one-third of the patients. More than half of the participants reported turning to positive reframing as a coping mechanism. Higher self-efficacy was less likely to be associated with disability (OR = 0.70, 95% CI = 0.57–0.89, $P < 0.001$).

Despite the authors' efforts, there are some important limitations to consider. The study population was recruited from a tertiary care center. Research findings from patients with complex diseases requiring advanced care may not be applicable to the wider IBD population. The reliance on clinical indices alone to identify active disease is another important limitation. In this study, the correlation between clinical indices and fecal calprotectin level was weak ($r = 0.258$, $P = 0.007$). This may indicate that an underlying functional gastrointestinal disorder (FGID) could exist in these patients in addition to their IBD diagnosis. In a cross-sectional analysis within the CCFA Partners Study, the diagnosis of IBS among IBD patients was associated with higher narcotic use, compared to those with UC or CD without a concomitant diagnosis of FGID. Coexisting FGID was associated with depression, anxiety fatigue, sleep disturbances and a decrease in social satisfaction.^[8]

Nevertheless, this study adds an important piece to the big jigsaw puzzle of managing patients with IBD. Future

research is required to identify factors associated with healthy, emotion-based strategies of coping with this particular illness. In the meantime, we believe that providers ought to look beyond the patient’s Crohn’s or colitis, and into methods that help them cope with IBD.

Turki AlAmeel, Mahmoud Mosli¹

Department of Medicine, King Fahad Specialist Hospital, Dammam, ¹Department of Medicine, King Abdulaziz University, Jeddah, Saudi Arabia

Address for correspondence: Dr. Mahmoud Mosli, Department of Medicine, King Abdulaziz University Hospital, King Abdulaziz University, Jeddah, Saudi Arabia. E-mail: mmosli@kau.edu.sa

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Access this article online	
Quick Response Code:	Website:
	www.saudijgastro.com
	DOI:
	10.4103/sjg.SJG_224_19

How to cite this article: AlAmeel T, Mosli M. The missing “C”: Crohn’s, colitis and coping. *Saudi J Gastroenterol* 2019;25:143-4.