Despite their name, the IBDs are systemic diseases in which gut manifestations are the predominant, and usually the initial, features. As such, IBD patients may require cross-specialty referrals through the course of their disease. With increasing specialisation within medicine, it is not surprising that gastroenterologists may feel uncomfortable with the assessment and management of extraintestinal manifestations of IBD.1 However, ever increasing demand within health care systems does not always allow for unrestrained interdisciplinary referrals. Hence, expansion of gastroenterologists’ familiarity with problems manifesting outside the gastrointestinal tract allowing them to initiate the diagnostic work-up and basic management of extraintestinal manifestations has value. Not only does this augment gastroenterologists’ ability to provide holistic care to their IBD patients, but it should also improve the appropriateness of referrals.

It is within this context that the paper by Varkas et al2 should be commended for two main reasons. First, it is authored by an appropriate mix of IBD and rheumatology experts. Second, the algorithms presented address a variety of rheumatological presentations that are simple to follow and achievable within the everyday practice of a gastroenterologist.

While most of the algorithms are based on expert consensus, the approach to diagnosing axial spondyloarthritis in an IBD patient with chronic back pain is based on evidence from a general population. The importance of the response to a trial of a nonsteroidal anti-inflammatory drug (NSAID) as a predictor of inflammatory arthritis may, as the authors acknowledge, be problematic for some patients with IBD. Non-selective NSAIDs may exacerbate IBD.3,4 While short-term use may be safe, particularly with low-dose NSAIDs, high-dose NSAIDs have been associated with increased Crohn’s disease activity.5 With regard to COX-2-selective NSAIDs, the available randomised placebo-controlled trials in IBD patients show no significant increased risk of flare. However, these studies are small, only available for celecoxib and etoricoxib, and predominantly include patients in clinical remission.6,7 However, large controlled trials of selective vs non-selective NSAIDs in non-IBD patients, have shown differing results with respect to lower gastrointestinal events; lower rates were seen with celecoxib and similar rates with etoricoxib relative to non-selective NSAIDs.8,9 This discrepancy has been attributed to their differing chemistry and pharmacodynamics.10 Hence, whether COX-2-selective NSAIDs as a class are safe in IBD is unknown. Given these uncertainties, we agree that caution or indeed NSAID avoidance should be applied in patients with active bowel inflammation, with referral for a gastroenterologist.

In a multi-system disorder such as IBD, a multidisciplinary, cross-specialty approach is to the benefit of patients with extraintestinal manifestations. The guidelines presented by Varkas et al2 will enhance our ability to manage rheumatological complaints in patients with IBD efficiently and appropriately, and are a model to follow for other crossover presentations in IBD and beyond.

ACKNOWLEDGEMENTS

Declaration of personal and funding interests: RPL: None. PMI has received fees for speaking on behalf of or acting in an advisory capacity for AbbVie, Arena, Celgene, Ferring, Prometheus, Shire, Warner Chilcott.
Editorial: effects of vedolizumab during pregnancy in the CONCEIVE study

Management of inflammatory bowel diseases (IBD) has become increasingly complex with the development of newer therapeutic agents. Numerous studies, including the prospective PIANO registry, have investigated safety profiles and adverse effects of medications during pregnancy, birth outcomes and adverse effects on offspring from medications used to treat IBD. Recent studies have shown that vedolizumab (VDZ) is of low risk during pregnancy, with comparable rates of preterm birth and mean birth rate compared to anti-tumour necrosis factor (anti-TNF) and no biologics. A higher rate of spontaneous abortion was reported in one study; however, the women receiving VDZ had already failed on at least one biologic, and likely represent a population with more severe IBD. A pregnancy clinical care pathway was published with recommendations to continue VDZ throughout pregnancy, planning for the last dose to be given 6-10 weeks before estimated date of confinement.

The paper by Moens et al compares the effects of VDZ with anti-TNF and with conventional/non-biologic medications. This is a retrospective multicenter case-control study that included 79 pregnancies in 73 women exposed to VDZ (VDZE) with control groups of women exposed to anti-TNF (TNFE) and those who were immunomodulator and biologics unexposed (CON IBD). Data were prospectively collected in collaboration with specialised IBD pregnancy clinics for those in the control groups; data for the VDZE group were retrospectively collected. Differences in the groups existed; fewer VDZE women had Crohn's disease (CD) (55% compared to 83% TNFE) and greater percentages had clinically active disease based on the physician global assessment. In addition, VDZ discontinuation rates were high; 49% discontinued treatment during pregnancy and only 40 women continued VDZ throughout pregnancy. The rate of live born infants was lower in the VDZE compared to CON IBD group.