Letters to the Editor

Crohn's disease: an overview and update on medical and dietary therapies

DEAR EDITOR: Thank you to Dr Alexander T. Elford and Associate Professor Britt Christiansen, authors of the article 'Crohn's disease: an overview and update on medical and dietary therapies' published in the January/February 2024 issue of *Medicine Today,* for their authorative article and review, particularly of the current treatment strategies.[1]

Regarding nutritional deficiencies, the authors recommended screening for vitamin D deficiency and, if present, this can be indicative of a risk for osteoporosis. Osteoporosis is more prevalent in patients with Crohn's disease compared with the general population.[2-6] There is a diverse range of reasons for osteoporosis being more common in patients with Crohn's disease, including: avoidance of calcium-rich dairy foods, in the belief it may worsen their disease; impaired calcium absorption from the gastrointestinal tract; and the use of corticosteroids which directly cause osteoporosis.[7] Worryingly, osteoporosis in patients with Crohn's disease leads to hip fracture with increased post-fracture mortality, particularly in women.[3] At present there appear to be no published guidelines as to when and how frequently osteoporosis should be screened for in patients with Crohn's disease, although even patients in durable remission from their Crohn's disease still remain at an increased risk for developing osteoporosis.[5]

Screening for osteoporosis needs to be considered, and repeated at timely intervals, as per RACGP recommendations, by assessment of bone mineral density (BMD) using dual energy x-ray absorptiometry (DXA) scanning on at least two skeletal sites, including the lumbar spine and hip, unless these sites are unsuitable (e.g. hip prosthesis).[8]

Patients requiring antiresorptive therapy for management of their osteoporosis, specifically bisphosphonates and denosumab, may be at increased risk for medication-related osteonecrosis of the jaw (MRONJ), particularly when this is used continuously for more than five years and with invasive dental procedures, namely dental extractions. Concurrent use of TNF-α inhibitors for Crohn's disease may further increase the risk of MRONJ.[9] The risk of MRONJ with the newer osteoanabolic agent romosozumab is not yet clear. Teriparatide shows promise in the management of MRONJ.[10] Therefore, reinforcement of good oral hygiene and review by the patient's dentist on commencing bone-modifying agents would represent good clinical practice.[11]

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COMPETING INTERESTS: Associate Professor Schifter: None.
Associate Professor Girgis has received an honorarium from Gedeon Richter.

REPLY: We would like to thank Associate Professor Schifter and Associate Professor Girgis for their response to our article 'Crohn's disease: an overview and update on medical and dietary therapies'.[1]

Their response highlighting the importance of osteoporosis screening and management in patients with Crohn's disease is well received. Our article's purpose was to provide an update on medical and dietary therapies and discussed associated preventive health measures to these therapies. Our article is not comprehensive on all preventive measures, with osteoporosis being an important additional consideration in patients with Crohn's disease.

It has been recognised that osteoporosis screening and management is inconsistent in real world inflammatory bowel disease (IBD) populations, highlighting the need of all healthcare workers involved with IBD patient care to be mindful of bone health.[2] There are numerous published guidelines on IBD and bone health; however, they are unlikely to be known to the non-gastroenterologist or IBD community.[3-5] A clinician-friendly flow diagram detailing clinical scenarios for which to arrange DXA scans in patients commencing or recommencing corticosteroids, as well as patients on long-term corticosteroid therapy, is included in *British Society of Gastroenterology (BSG) consensus guidelines on the management of IBD in adults* – see Figure 5.[3] Key scenarios for BMD screening are: patients who commence corticosteroids with prolonged use (beyond three months) or recurrent corticosteroid use; patients older than 40 years of age who have a high score using the Fracture Risk Assessment Tool (FRAX); and patients under 40 years of age who have multiple risk factors for osteoporosis.

The European Crohn's and Colitis Organisation's *ECCO Guidelines on extraintestinal manifestations in inflammatory bowel disease* recommend that DXA scans be performed for patients with IBD who are at high risk of osteoporosis.[4] Risk factors specifically for low BMD in patients with IBD include Crohn's disease, corticosteroid use, low BMI, malnutrition, malabsorption (particularly important in small bowel disease), reduced physical activity, and genetic factors.[6] In addition, general osteoporotic risk factors such as smoking and advanced age are important considerations.[7] Therefore, Crohn's patients with multiple risk factors would benefit from BMD screening with DXA scans. Patients with recurrent flares or extensive small bowel disease and patients who never achieve remission or have restrictive eating behaviours will likely have more than one of these risk factors and are certainly worth considering for osteoporosis screening.

We acknowledge that data and recommendations guiding when to repeat DXA scans in the IBD population are sparse.[3-5] The American College of Gastroenterology (ACG) conditionally recommend periodic BMD screening; they refer to using general osteoporosis screening guidelines.[5] The BSG guidelines recommend that patients on long-term corticosteroid therapy undergo a repeat DXA scan one year later – this should then be repeated at one-year intervals if BMD is observed to be declining or at two- to three-year intervals if BMD is stable.[3] For patients not on long-term corticosteroid therapy, the BSG guidelines recommend considering a repeat DXA scan in three to five years' time, based on risk factors. In clinical practice, we recommend collaborative management with a physician who has a special interest in bone health for patients who have persistent risk factors for osteoporosis or who have demonstrated osteopenia or osteoporosis on their DXA scan.

Prevention is better than cure. Encouraging a nutritious diet, with adequate calcium intake, regular exercise and supplementation of vitamin D in high-risk populations, particularly over the winter months, is important during interactions with Crohn's patients.[3] Notably, this advice is not merely important for BMD but also for overall general health and wellbeing.

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