Use of IBD Endoscopic Scoring Systems in Practice

Jill K. J. Gaidos MD, FACG[1]; Badr Al-Bawardy MD[1]; Francis A. Farraye MD, MACG[2]; Miguel Regueiro MD[3]

1. Yale University School of Medicine Section of Digestive Diseases, New Haven, CT.
2. Division of Gastroenterology and Hepatology, Mayo Clinic, Jacksonville, FL.
3. Department of Gastroenterology, Hepatology & Nutrition, Cleveland Clinic, Cleveland, OH.

BACKGROUND

- Inflammatory bowel disease (IBD) treatment targets include endoscopic healing based on standardized endoscopic scoring systems.
- The rates and ease of use of these scoring systems in practice have not been well described.
- Aims: We aimed to assess the rates and potential barriers to using IBD endoscopic scoring systems in practice from IBD Live attendees.

METHODS

•IBD Live is a weekly international case-based conference

•We created a web-based survey on the frequency and ease of use of various IBD endoscopic scores.

•This survey was emailed to the IBD Live listserv in March 2022 with a second email sent 14 days later.

•We included only respondents who are currently performing endoscopy and those who completed questions on at least 1 endoscopic scoring system.

•Continuous variables were analyzed using an unpaired student's t-test. Categorical variables were analyzed using a Pearson's chi-square test.

•This study was approved by the Yale IRB.

RESULTS

- There were 65 responses out of 170 (38.2% response rate).
- Eleven responses were excluded (4 with no response on the use of endoscopy scores, 7 were not performing endoscopy).
- Of the respondents, 72.2% are from the US, 70.4% are adult gastroenterologists, 53.9% in academic practice, and 40.7% in practice for ≥ 15 years.
- Of the endoscopy scores used ≥ 50% of the time, 74.1% were using the Mayo Endoscopic Sub-score (MES), 72.3% using the Rutgeert's Score, 61.2% using the Simple Endoscopic Score for Crohn's Disease, and 28.6% using the Pouchitis Disease Activity Index.

RESULTS (cont)

- Attending IBD Live ≥ monthly (p=0.028), attending an IBD conference ≥ every 2 years (p=0.020), and having the scoring system incorporated into the endoscopy documentation software (p=0.002) were associated with more consistent use of the MES.
- Attending IBD Live ≥ monthly (p=0.026), having an IBD volume of ≥ 50% (p=0.011), and attending an IBD conference ≥ every 2 years (p=0.004) was associated with more frequent use of the Rutgeert's score.
- There were no factors that increased the use of other endoscopic scores.

Table 1: Respondent Demographics

Variable	N (%)
Practice Location:	
USA	39 (72.2)
Asia	7 (12.9)
Europe	4 (7.4)
Other	4 (7.5)
Specialty:	
Adult Gastroenterologist	38 (70.4)
Surgery	10 (18.5)
Pediatric Gastroenterologist	5 (9.3)
Other	1 (1.9)
Practice Location:	
Academic	32 (59.3)
Private Practice	13 (24.1)
Other	9 (16.6)
Years in Practice:	
Less than 5 years	15 (27.8)
5- less than 10 years	8 (14.8)
10-15 years	9 (16.7)
More than 15 years	22 (40.7)
Percent of Practice Focused on IBD:	
Up to 50%	28 (51.9)
50% or more	26 (48.1)
Attends an IBD Conference ≥ 2 years:	
Yes	50 (92.6)
No	4 (7.4)
IBD Live Attendance:	
At least monthly	36 (66.6)
Less than monthly	18 (33.3)

Table 2: Use of Endoscopy Scoring ≥ 50% of the Time

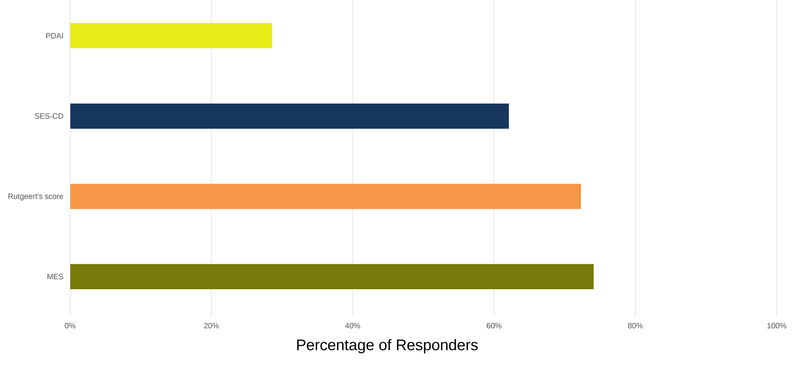

Table 3: Factors Associated with the Use of Endoscopy Scoring

Use of Mayo UC Endoscopic Sub-Score	≥50% of the time (n=40), n (%)	<50% of the time (n=14), n (%)	p-value
Endoscopic Score Built into Software	27 (67.5)	3 (21.4)	**0.002**
Attend IBD Conference ≥ every 2 Years	39 (97.5)	11 (78.6)	**0.020**
Attend IBD Live:			**0.028**
At least monthly	30 (75)	6 (42.9)	
Less than monthly	10 (25)	8 (57.1)	
Number of years in GI practice:			0.55
< 10 years	18 (45)	5 (35.7)	
≥ 10 years	22 (55)	9 (64.3)	
Specialty:			**0.012**
Adult GI	32 (84.2)	6 (15.8)	
Pediatric GI	4 (80)	1 (20)	
Colorectal surgery	4 (40)	6 (60)	
Other	0	1 (100)	
Use of the Rutgeert's Score	**≥50% of the time (n=34), n (%)**	**<50% of the time (n=13), n (%)**	**p-value**
Endoscopic Score Built into Software	17 (50)	3 (23.1)	0.45
Attend IBD Conference ≥ Every 2 Years	34 (100)	10 (76.9)	**0.004**
IBD patient volume ≥50%	22 (64.7)	3 (23.1)	**0.011**
Attend IBD Live:			**0.026**
At least monthly	27 (79.4)	6 (46.2)	
Less than monthly	7 (20.6)	7 (53.9)	
Number of years in GI practice:			0.51
< 10 years	14 (41.2)	4 (30.8)	
≥ 10 years	20 (58.8)	9 (69.2)	
Specialty:			0.19
Adult GI	27 (79.4)	7 (53.9)	
Pediatric GI	3 (8.8)	2 (15.4)	
Colorectal surgery	4 (11.8)	4 (30.8)	
Use of the Simple Endoscopic Score for Crohn's Disease	**≥50% of the time (n=30), n (%)**	**<50% of the time (n=19), n (%)**	**p-value**
Endoscopic Score Built into Software	18 (60)	6 (31.6)	0.09
Attend IBD Conference ≥ Every 2 Years	29 (96.7)	16 (84.2)	0.12
IBD patient volume ≥50%	17 (56.7)	8 (42.1)	0.32
Attend IBD Live:			0.16
At least monthly	23 (76.7)	11 (57.9)	
Less than monthly	7 (23.3)	8 (42.1)	
Number of years in GI practice:			0.10
< 10 years	15 (50)	5 (26.3)	
≥ 10 years	15 (50)	14 (73.7)	
Specialty			0.25
Adult GI	24 (68.6)	11 (31.4)	
Pediatric GI	2 (40)	3 (60)	
Colorectal surgery	4 (44.4)	5 (55.6)	

CONCLUSIONS

• The MES and the Rutgeert's score are more commonly used with much lower rates of use of endoscopic scores for Crohn's disease and pouchitis.

•The use of these endoscopy scores is more common among those who regularly attend IBD conferences, have higher volume IBD practices and have these scoring systems incorporated into endoscopy software.

•Further evaluation of ways to improve utilization of endoscopic scoring for Crohn's disease and pouchitis are needed.