ECCO CONSENSUS ON MANAGEMENT OF INFLAMMATORY BOWEL DISEASE IN LOW AND MIDDLE INCOME COUNTRIES

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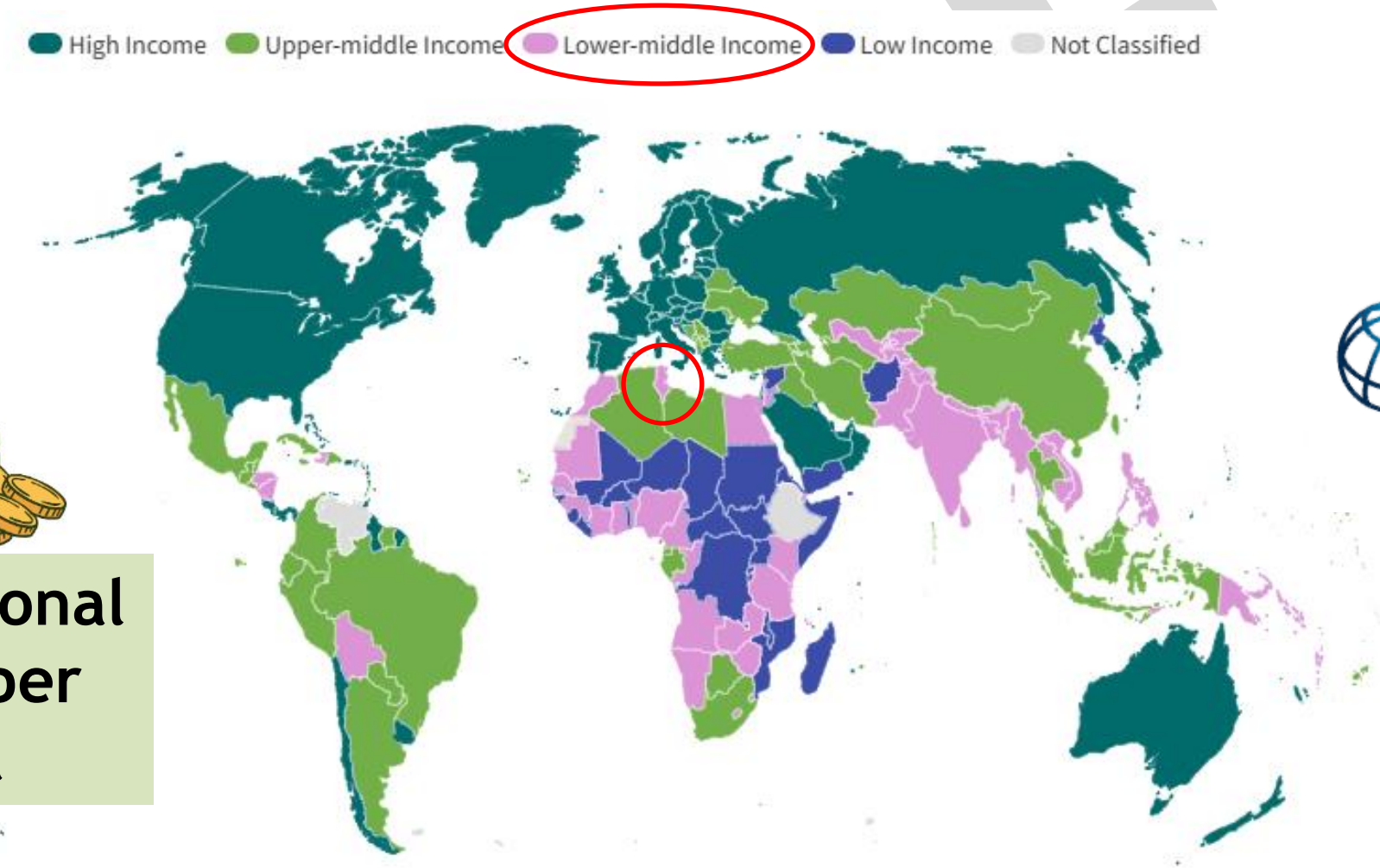
Introduction

IBD in low-and middle-income countries (LMICs)

- Incidence / prevalence : ↑ rapidly (Urbanization / lifestyle changes)
- Accurate diagnosis: remains difficult (limited resources)
- Management particularly challenging

ECCO consensus (2025) ➔ **Evidence-based guidance for IBD care in LMICs**

Low- and middle-income countries (LMICs)



Gross national income per capita

THE WORLD BANK

ECCO consensus on management of Inflammatory Bowel Disease in low-and middle-income countries

Epidemiology

Diagnosis

Medical treatment

Surgical treatment

Epidemiology

- IBD incidence in LMICs is probably increasing
- Regional differences in IBD hospitalization rates and mortality
- Targeting modifiable risk factors could help ↓ IBD

Epidemiology

Modifiable risk factors

High total fat intake

Antibiotic use

Contaminated water

Air pollution

Smoking

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Epidemiology

Diagnosis

Medical treatment

Surgical treatment

Diagnosis

Infections

- Should be considered when <u>diagnosing</u> IBD / <u>each disease relapse</u>

Overlapping symptoms !

- Tuberculosis, amoebiasis, Salmonella, Yersinia, C.difficile …
- Detailed patient history: recent travel, antibiotics

- Misdiagnosis 

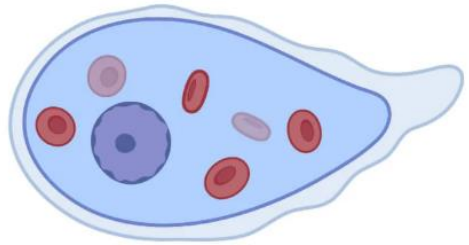
➔ Can aggravate the condition

Diagnosis

Infections

- Entamoeba histolytica :
  - **Stool PCR : Gold standard**
  - Stool microscopy
  - Serology

↓sensitivity and specificity



Empirical anti amoeba therapy may be considered based on clinical suspicion in areas with limited diagnostic tools, particularly in endemic regions

low prevalence 0,5 %

Siala et al, 2016

Diagnosis

Infections

Crohn's Disease

Tuberculosis

Overlapping clinical, radiological, endoscopic and histopathological features

Intermediate endemicity

Misdiagnosis

↓

Delayed / inappropriate treatment

↓

Serious complications

Diagnosis

Crohn's Disease

Tuberculin skin test

Limited availability

Quantiferon

Not distinguish active and latent TB

Tuberculosis

Sensitivity 64.7%
Specificity 73.3%
PPV= 73.3% (vaccination)
NPV= 64.71% (IS therapy)

Sensitivity= 81%
Specificity =85%
PPV= 87%
NPV= 87%

Diagnosis

Infections

Crohn's Disease

Tuberculosis

Multifaceted approach: improve diagnostic accuracy++

No single test that can clearly differentiate between TB and CD

Clinical, immunological, molecular, endoscopic, radiological, histopathological, and microbiological assessments

Diagnosis

Crohn's Disease

THE CHALLENGE

Tuberculosis

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Diagnostic uncertainty
TB-endemic regions

Consider diagnostic trial of ATT (EL3)

2 months

Colonoscopy

Response

Drug-resistant TB

Diagnosis

Endoscopy

- Issues related to endoscopy access

- Colonoscopy: Limited availability

Faulty equipment

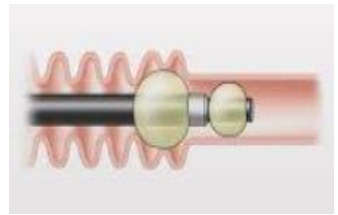
➔ Long waiting lists

Diagnosis

Endoscopy

Advanced endoscopy: rarely available

- Endoscopic balloon dilation
- High-definition white light endoscopy
- Small-bowel endoscopy: video capsule endoscopy and device-assisted enteroscopy (DAE)



Centres caring for patients with small-bowel CD should have access to one form of DAE

Diagnosis

- Perianal CD: **physical examination**

  often used alone in LMICs

- **Endoanal ultrasound: low-cost alternative to pelvic MRI**

  (performed by trained specialists)

➔ Education on use of endoanal US

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Epidemiology

Diagnosis

Medical treatment

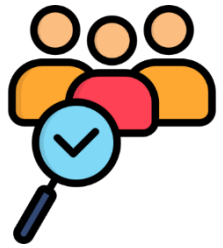
Surgical treatment

Medical treatment

Screening for active or latent tuberculosis

- Before starting biologic therapies ++

  Immunosuppressive therapy



- ↑ risk reactivating latent TB ➔ severe complications

Medical treatment

Vaccination

Statement 13

Vaccinations against infectious diseases should be administered, preferably prior to starting immunosuppressive therapy in LMICs [EL3]. However, the cost of vaccines, their availability, and local infection prevalence are particular considerations in LMICs [EL5].

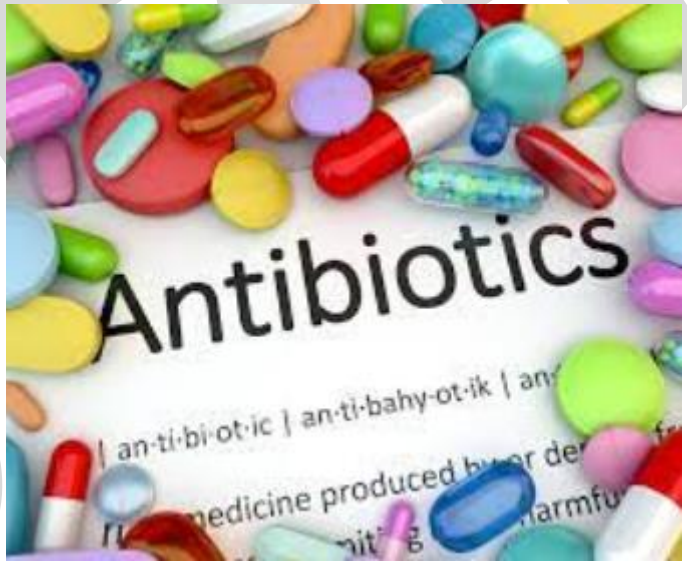
- Serological response to vaccination
- **Hepatitis B:** loss of protection can occur in the long term
  ➔ monitoring anti-HBs titres **every 2 years**
- Booster dose ➔ restore anti-HBs titres **> 100 mIU/mL**
  (anti-TNF agents ++)

RECOMMENDED

Medical treatment

Evidence for use of empiric antibiotics during IBD flares

Not available



Do not improve outcome

Medical treatment

Complementary and alternative medicine

Chinese herbal medicine

Curcumin

Coconut water

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Efficacy ??
Safety??

Indigo naturalis

Medical treatment

Nutrition

Malnutrition:

↑ complications: ↑ surgery /hospitalization rates

↓ quality of life

Dietary therapies++ (if expertise/ therapies available)

May be beneficial:
Influence
- ✓ Disease course
- ✓ Quality of life

↓ inflammation

Cost <<< specific diets

Medical treatment

Thiopurines

- Wide use LMICs >>> HICs
- Affordability and availability >>> biologics
- Most common treatment after corticosteroids for CD in LMICs
- Thiopurine Monitoring : limited availability

✓ TPMT and NUDT15 testing

✓ Thiopurine metabolite testing

Regular monitoring blood count / Liver function

↑Mean corpuscular volume (MCV)
↓ lymphocyte count

Medical treatment

5 ASA

- Frequently used in LMICs
- No evidence to support use for CD

➔ **Should be avoided**

Advanced therapies

- Limited Access
- Cost, cold-chain storage manufacturing infrastructure…

➔Should be improved

- Cost-effective biosimilars may help ↓ costs

Medical treatment

Monitoring Therapeutic Response

- Magnetic resonance enterography
- Ileocolonoscopy

limited availability

- **Non-invasive modalities ++**
  - ✓Routine tests (CRP, Mean platelet volume)
  - ✓Faecal biomarkers (FC)
  - ✓Intestinal ultrasound

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Epidemiology

Diagnosis

Medical treatment

Surgical treatment

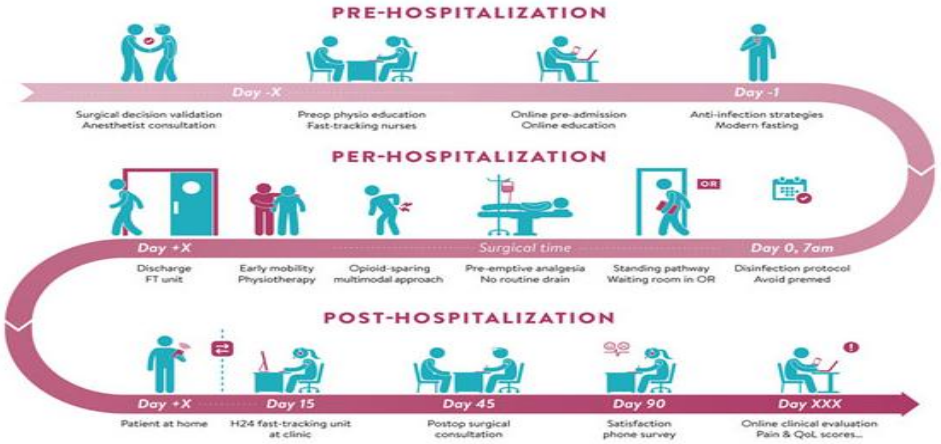
Surgical treatment

- Emergent surgery ++ (delayed diagnosis)
  ➔ **Poor outcome**

- **Surgical-site infection:** the most frequent complication in LMICs
- Multifactorial: pre-existing malnutrition

Delayed surgery

Surgical treatment



ECCO

Adoption of Enhanced Recovery After Surgery [ERAS] programs remain a challenge in LMICs [EL4].

Wider adoption of ERAS programs could significantly improve postoperative outcomes, especially in settings with limited resources and high postoperative morbidity rates [EL5].

Investment to implement ERAS programs in LMICs

➔ Economically beneficial: ↑postoperative outcomes
↓costs

Surgical treatment

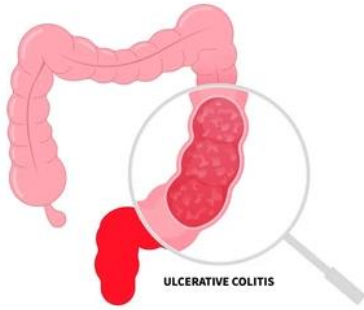
Length of resected and remaining bowel segments

Rarely reported

Structured and standardized reporting of the length of resected and remaining bowel segments during CD surgery in LMICs is a simple yet very useful improvement

Surgical treatment

Refractory severe UC



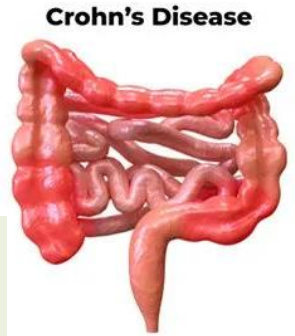
Non-response to intensive medical therapy

limited access to advanced therapy and intensive care

Early surgical intervention

Improve outcomes
↓ mortality

Surgical treatment



- **Ileocolonic resection** could be considered a viable **first-line treatment** for CD, particularly in areas with a **high prevalence of Tuberculosis**.

Conclusion : ECCO 2025 Consensus on IBD in LMICs

*Take home message

- IBD is increasingly frequent in LMICs, with diagnosis often delayed.
- Infections (Tuberculosis++) :major diagnostic challenge
- Limited access to endoscopy and advanced therapies

  → more complicated forms and surgery.
- Education and early referral from primary care: improve outcome
- **Locally adapted guidelines and IBD registries:** essential to optimize care and understand disease burden.

THANK YOU!