

Obesity and IBD



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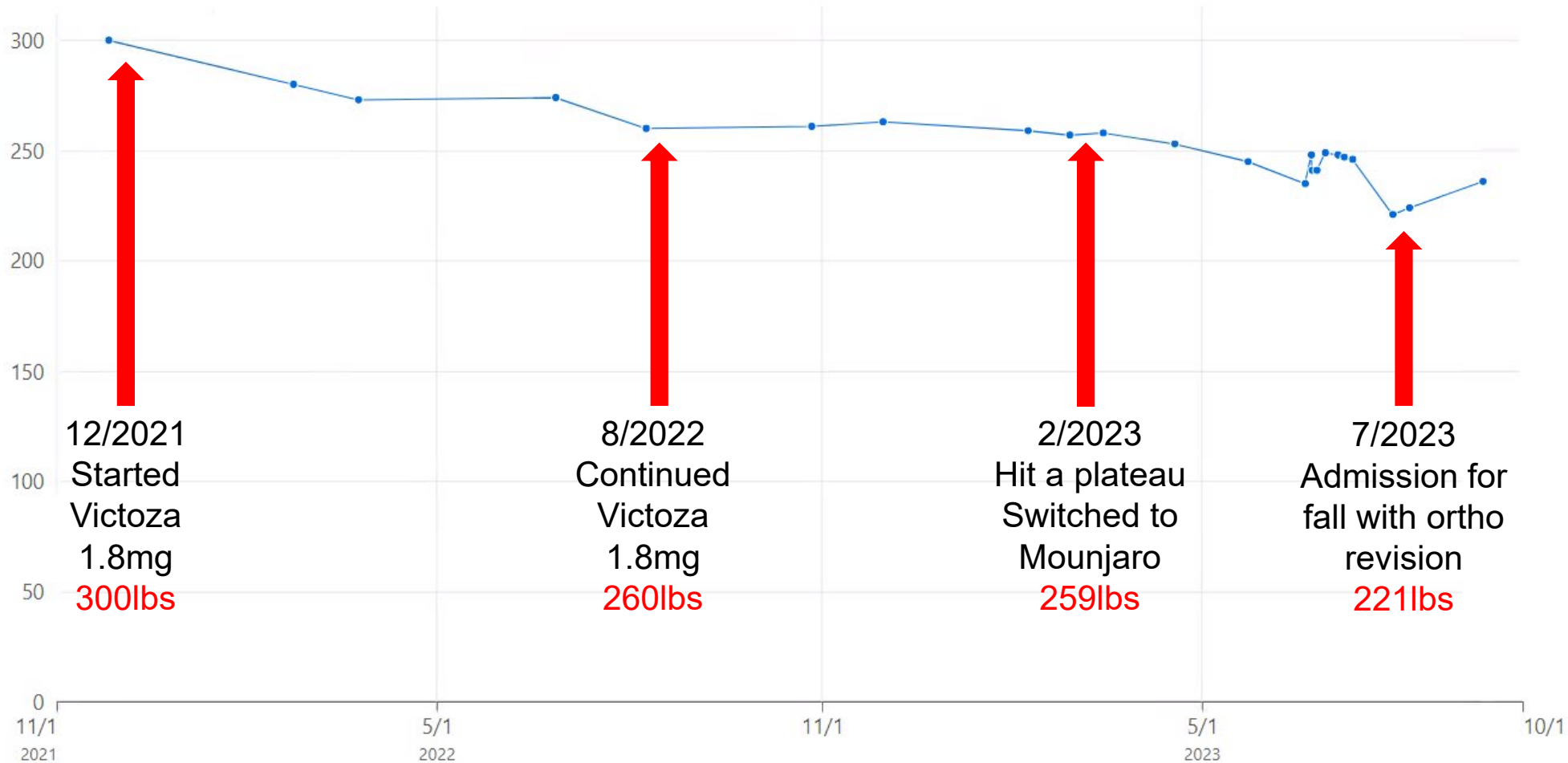
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Objectives

- Discuss the benefit of treating obesity in patients with IBD
- Review the safety and efficacy of GLP1 receptor agonists in IBD patients
- Review the current recommendations for aspiration risk in endoscopy
- Consider the role of gastric ultrasound in assessing stomach contents pre-procedurally

CASE

- 65-year-old man with colonic and perianal CD controlled on Adalimumab and MTX
 - Recent increase of Adalimumab from 40 to 80 weekly, not at goal
 - Stopping MTX due to worsening fatty liver disease
 - Untreated DM2 (a1c 6.6) and obesity (current BMI 44, max 47)
- Referred for treatment of obesity



Follow-up

- Lost 80 pounds
- Became therapeutic on adalimumab at level needed for perianal Crohn's disease
- Never needed another immunomodulator



AMERICAN BOARD
of OBESITY MEDICINE

Obesity as a Disease

- 2004: Medicare removed language saying obesity was not a disease
 - Part D continued to exclude “weight loss medications”
- 2012: First ABOM examination was offered
- 2013: AMA declared obesity a disease



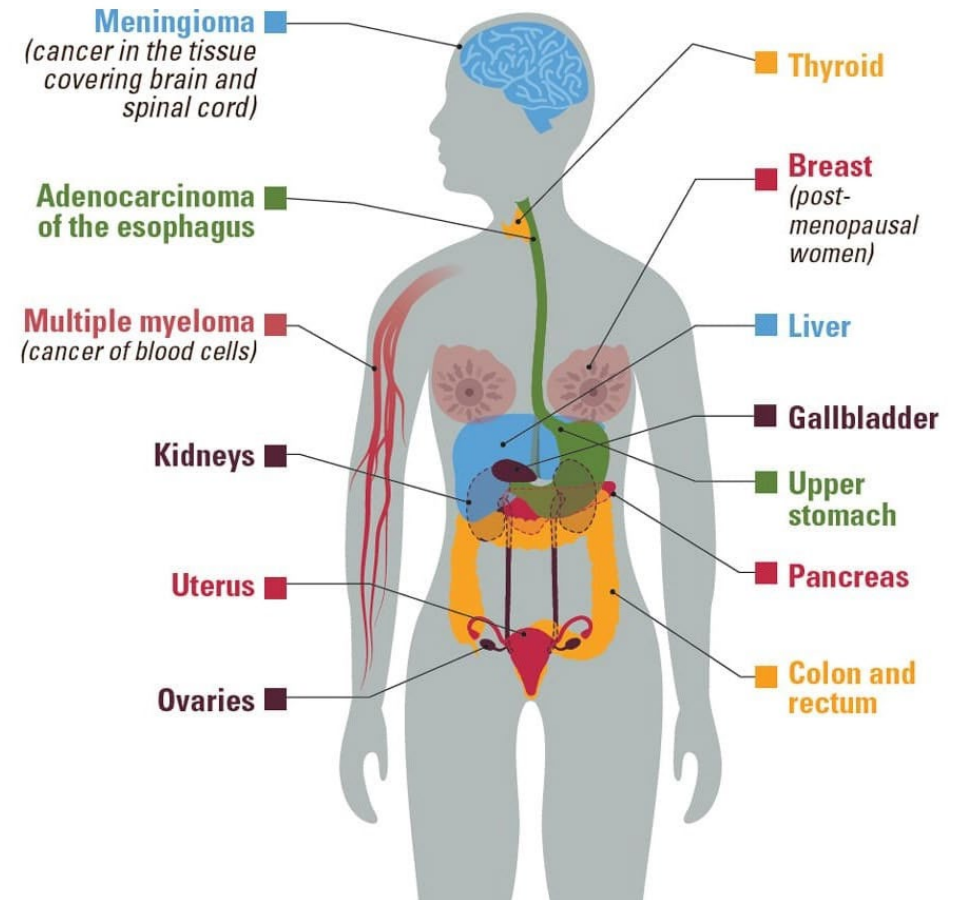
DIPLOMATES BY SPECIALTY (TOP 10)

Internal Medicine	3029
Family Medicine	2449
Pediatrics	613
Endocrinology	522
Surgery	352
OB/GYN	292
Gastroenterology	245
Psychiatry	161
Emergency Medicine	137
Cardiology	56

The Role of Gastroenterology

- Cancers (6 of 13 are GI)
- Bariatric Endoscopy
- Surgical Complications
- MASLD
- Inflammatory Bowel Disease
- GERD
- Motility
- IBS
- Microbiome
- Eating Disorders
- Nutrition
- Endoscopic Risk of Aspiration

13 cancers are associated with overweight and obesity



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Original Research Article - Clinical



Effectiveness and Safety of Semaglutide for Weight Loss in Patients With Inflammatory Bowel Disease and Obesity

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Study Design

- Retrospective review of 47,424 patients with IBD and obesity
- 150 patients on semaglutide
- TBW change in pounds between 6-15 months
- Propensity score matching

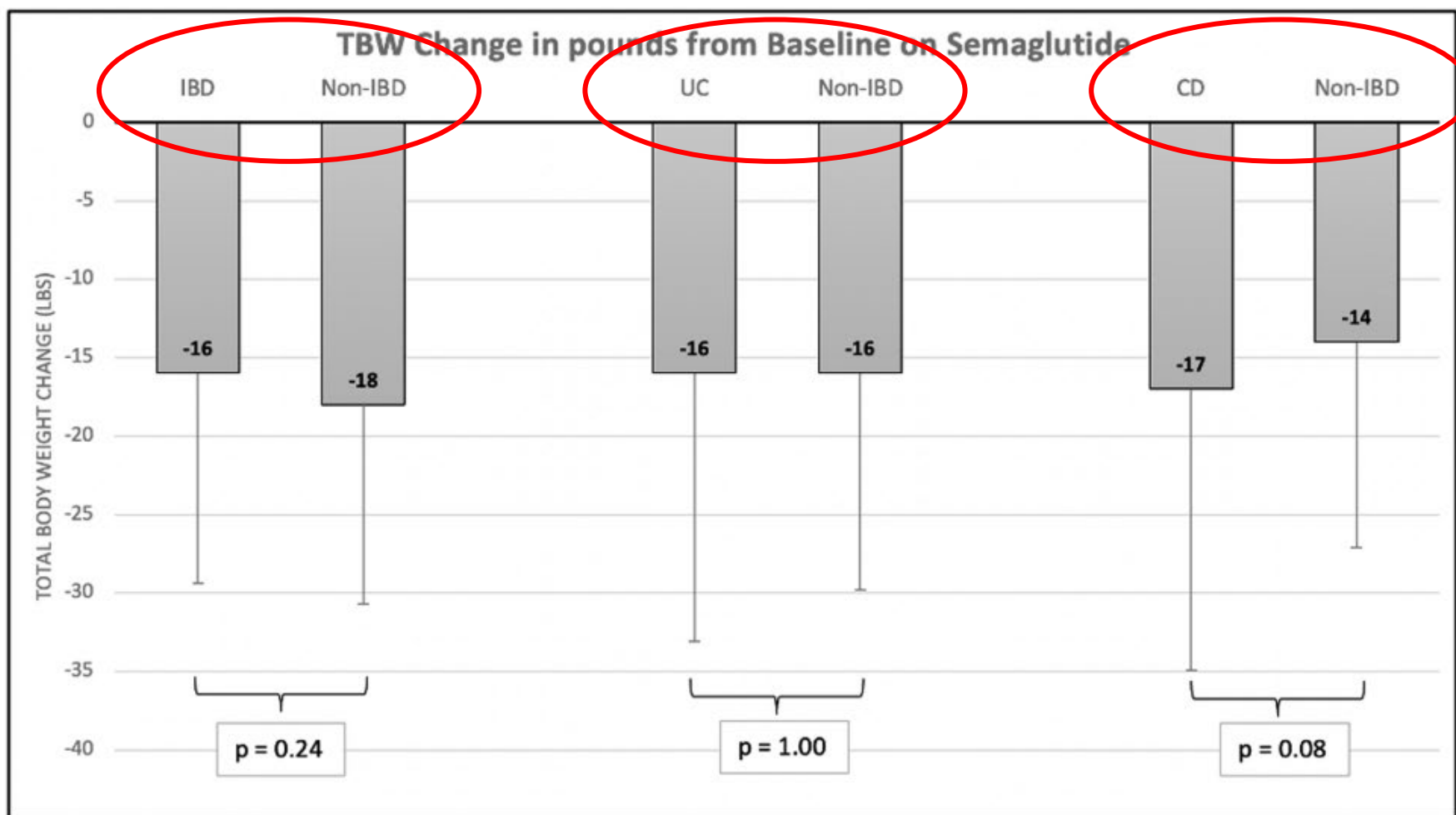


Figure 1. Bar graph representing total body weight (TBW) change between the inflammatory bowel disease (IBD) and non-IBD cohort after initiation of semaglutide. CD, Crohn's disease; UC, ulcerative colitis.

Table 5. Risk of IBD-specific adverse outcomes within 1 year in patients in the IBD semaglutide cohort compared with IBD cohort without semaglutide after propensity score matching.

Outcome	Cohort	Participants	aOR (95% CI)	P value
Oral steroid use	IBD semaglutide	38 (26.7)	0.81 (0.48-1.36)	.43
	IBD control	44 (30.9)	—	—
Intravenous steroids	IBD semaglutide	10 (7)	0.69 (0.29-1.61)	.39
	IBD control	14 (9.8)	—	—
New advanced therapy initiation	IBD semaglutide	10 (10.3) ^a	1.03 (0.41-2.60)	.94
	IBD control	10 (10) ^a	—	—
IBD-related surgery	IBD semaglutide	0 (0)	—	—
	IBD control	10 (5.9) ^a	—	—
Any-cause hospitalization	IBD semaglutide	17 (11.9)	0.35 (0.19-0.67)	.001
	IBD control	39 (27.4)	—	—
Any-cause ED visit	IBD semaglutide	31 (21.8)	0.92 (0.52-1.61)	.77
	IBD control	33 (23.2)	—	—

Values are n (%).

Abbreviations: aOR, adjusted odds ratio; CI, confidence interval; ED, emergency department; IBD, inflammatory bowel disease.

^aTriNetX database obfuscates patient counts between 1 and <10 to protect patient confidentiality.

Results

- Similar efficacy in IBD vs non-IBD
- No increased risk of IBD-specific adverse events

Disease Modifying Effects

- Lower rates of hospitalizations
- Lower rates of surgeries
- Lower rates of complications

Efficacy and Safety of GLP-1 Agonists on Metabolic Parameters in Non-Diabetic Patients With Inflammatory Bowel Disease. St-Pierre J, Klein J, Choi NK, et al. Digestive Diseases and Sciences. 2024;69(12):4437-4445.
doi:10.1007/s10620-024-08720-2.

Non-Metabolic Mechanisms

- Anti-inflammatory actions
- Immunomodulatory actions
- Gut barrier-enhancing actions
- Could contribute to improve IBD control
- Supported by preclinical/early clinical data

Efficacy and Safety of GLP-1 Agonists on Metabolic Parameters in Non-Diabetic Patients With Inflammatory Bowel Disease. St-Pierre J, Klein J, Choi NK, et al. Digestive Diseases and Sciences. 2024;69(12):4437-4445. doi:10.1007/s10620-024-08720-2.

Endoscopic Considerations

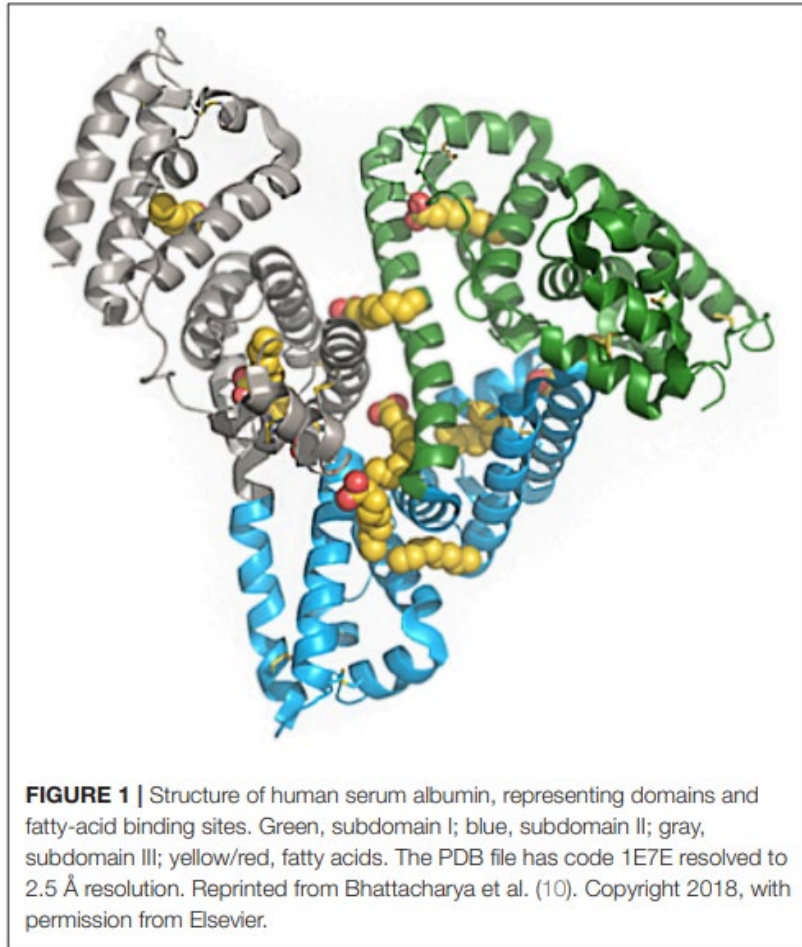
Aspiration During Anesthesia

- Rare, but associated with high morbidity/mortality
- Reported 5% of closed claims
- 50% of airway-related deaths in anesthesia

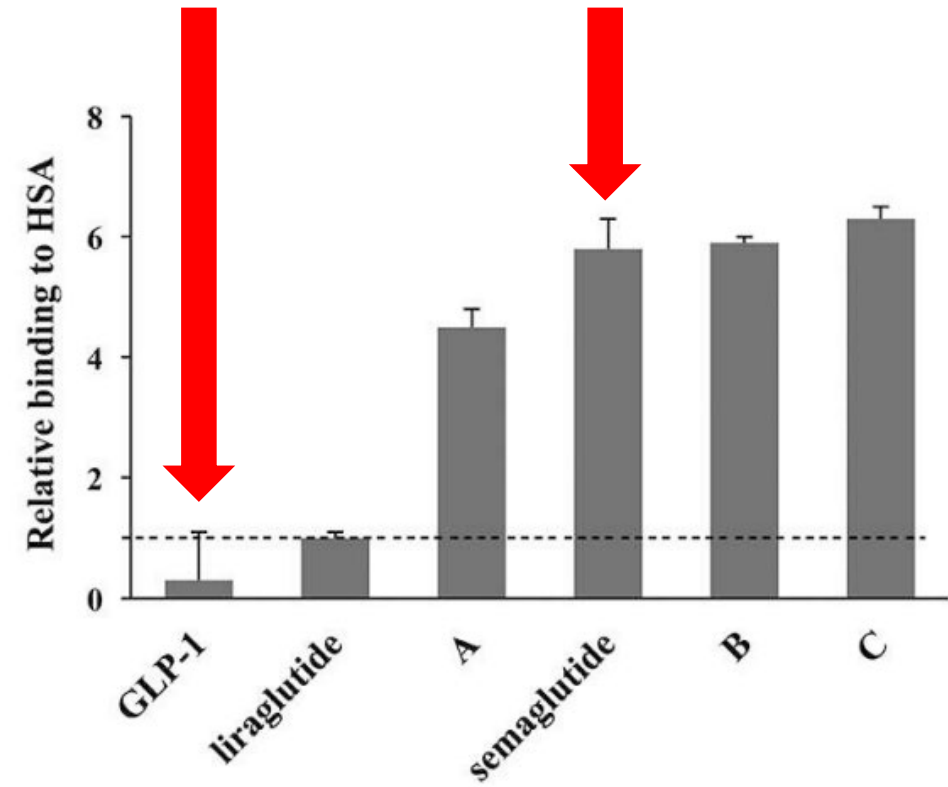
Table 2: Risk Factors for Aspiration.

Esophageal Pathology • Achalasia • Previous esophagectomy (e.g., Ivor Lewis) • Tracheoesophageal Fistula	High risk for ileus/bowel dysmotility • Acute pancreatitis • Recent intra-abdominal surgery • Inpatient receiving opioids/prolonged bedrest
Intra-abdominal Obstruction • Gastric outlet, small bowel, colonis	Emergency Case
Known, suspected, or induced gastroparesis (longstanding diabetes, neuromuscular disorders, medication—e.g., GLP-1 agonist)	Case with prolonged duration or complexity
Pregnancy	Active GI Bleed

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B



Half-Life of Semaglutide as an Example

- Half-life = 160 hours = approximately 1 week
 - 5 half-lives 97% clearance (5 weeks)
 - 9 half-lives 99% clearance (9 weeks or 2 months)
- But when does gastric emptying return to normal?

Why Not Hold GLP1s Longer Than a Week

- Coverage restrictions
- Titration challenges
- Hyperglycemia perioperatively

POSITION STATEMENT



American Society for
Gastrointestinal Endoscopy

American Society for Gastrointestinal Endoscopy position statement on periendoscopic management of patients on glucagon-like peptide-1 receptor agonists and sodium-glucose cotransporter-2 inhibitors



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Sharaiha Reem Z, et al. American Society for Gastrointestinal Endoscopy position statement on periendoscopic management of patients on glucagon-like peptide-1 receptor agonists and sodium-glucose cotransporter-2 inhibitors. *Gastrointestinal Endoscopy*, Volume 101, Issue 2, 285 - 294

Summary of Recommendations

Statement 1. The ASGE recommends immediate preprocedure evaluation for GI symptoms (severe nausea, vomiting, regurgitation when lying supine, abdominal bloating, abdominal distention, and abdominal pain) suggestive of possible delayed gastric emptying for all patients on GLP-1 RAs.

Statement 2. The ASGE recommends a detailed discussion regarding possible risk of aspiration with all patients on GLP-1 RAs undergoing endoscopic evaluation.

Statement 3. The ASGE suggests a liquid diet 24 hours before endoscopic procedure for all patients on GLP-1 RAs.

Statement 4. The ASGE recommends against delaying required diagnostic or therapeutic urgent or emergent endoscopy for hospitalized patients who are on GLP-1RAs.

Statement 5. The ASGE suggests obtaining an anesthesia consult for hospitalized patients who are on GLP-1RA medication requiring urgent or emergent endoscopy.

- A. If a patient has symptoms suggestive of delayed gastric emptying, the ASGE suggests using aspiration, “full stomach” precautions (general anesthesia with a rapid sequence induction and intubation with cuffed endotracheal tube), or avoid deep sedation.
- B. If a patient does not have symptoms suggestive of delayed gastric emptying, point of care gastric US, when available, may be used to determine the gastric volume.

Statement 6. The ASGE recommends against delaying time-sensitive **outpatient** diagnostic or therapeutic endoscopy for patients who are on GLP-1RAs.

Statement 7. The ASGE suggests anesthesia consultation for patients who are on GLP-1RAs requiring time sensitive outpatient endoscopy.

Statement 8. The ASGE suggests holding GLP-1RAs 24 hours before the procedure for patients who are on daily dosing of GLP-1RAs and require outpatient time-sensitive endoscopy.

Statement 9. The ASGE suggests holding GLP-1RAs before **elective** endoscopy procedures for patients who are on GLP-1RAs as follows:

A. For patients who are on daily dosing, the ASGE suggests holding GLP-1RAs at least 24 hours before the procedure.

B. For patients who are on weekly dosing, the ASGE suggests holding GLP-1RAs at least 7 days before the procedure.

C. The ASGE suggests moderate sedation or anesthesia directed sedation for patients who have stopped GLP-1RAs at the recommended time interval and have no symptoms suggestive of delayed gastric emptying.

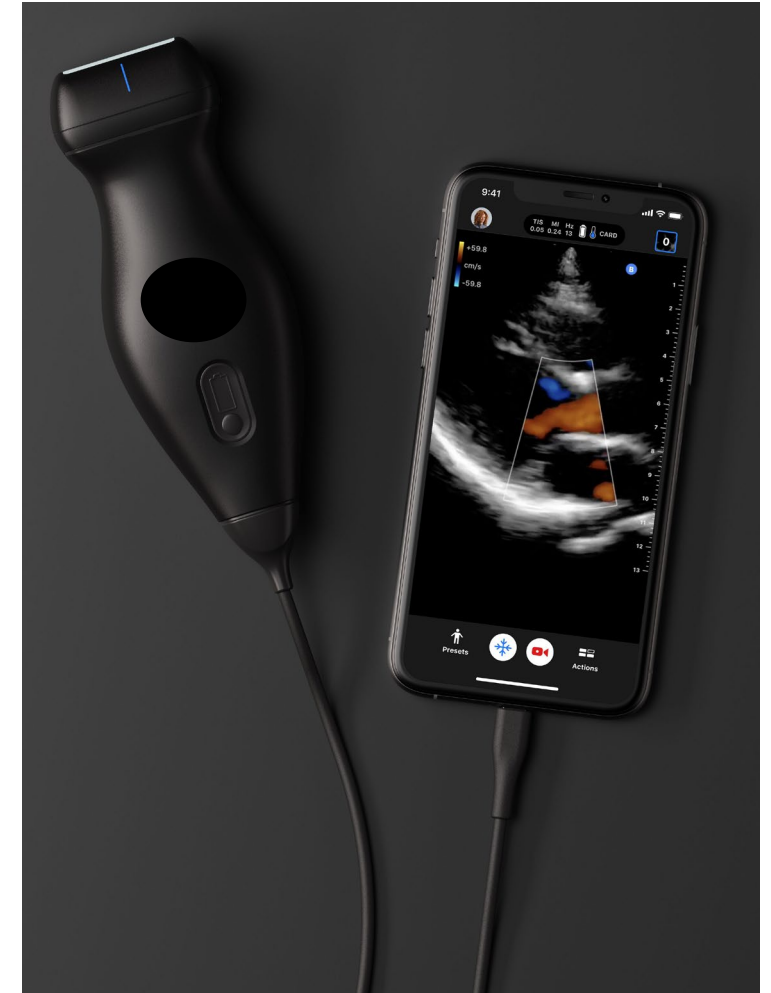
D. The ASGE suggests anesthesia consultation and multidisciplinary discussion for patients who either did not stop GLP-1RAs at the recommended time interval or have symptoms suggestive of delayed gastric emptying despite holding medication appropriately.

Statement 10. The ASGE suggests consideration for bridging the antidiabetic therapy for patients who will be stopping GLP-1RAs 1 week before elective endoscopy.

Statement 11. The ASGE suggests holding SGLT-2 inhibitors 3 to 4 days before elective endoscopy procedures. The ASGE suggests either rescheduling the procedure or obtaining a basic metabolic panel before the procedure to evaluate for anion gap acidosis for patients who did not hold the medication as per the recommendation.

Background on Gastric Ultrasound

- Not new, used in IR regularly
- Easy to use and learn
- www.gastricultrasound.org is a great resource
- Hand-held options are available



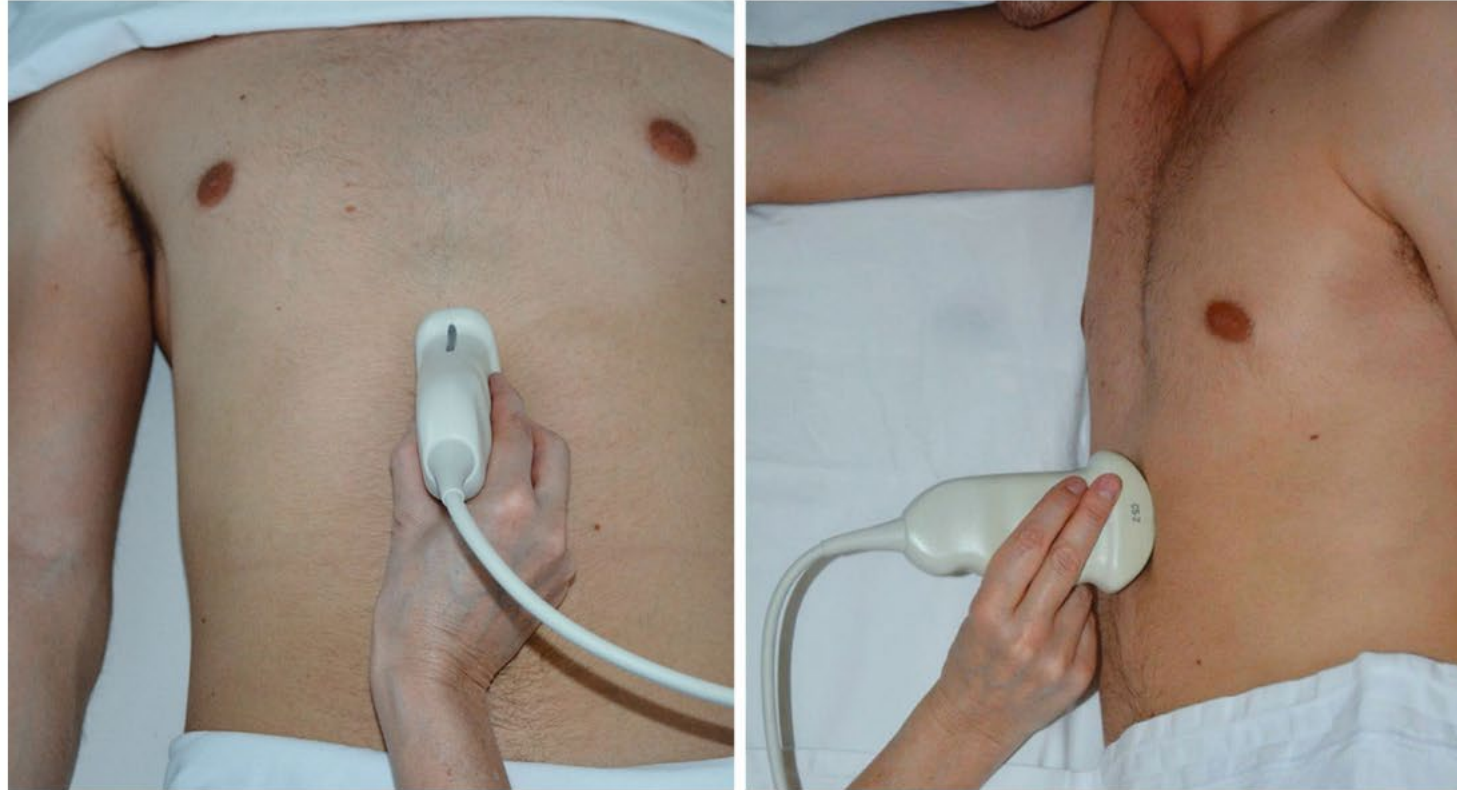


Fig. 1 “Gastric point-of-care ultrasound (POCUS) scanning of patient in the supine (left image) and right lateral decubitus position (right image) using a curved array low-frequency abdominal probe (2-5 MHz). Used with permission from gastricultrasound.org

Fig. 2 Upper abdominal sonographic image showing an empty stomach antrum. A = antrum; Ao = aorta; D = diaphragm; L = liver; P = pancreas; R = rectus abdominis muscle; Sma = superior mesenteric artery. Used with permission from gastricultrasound.org

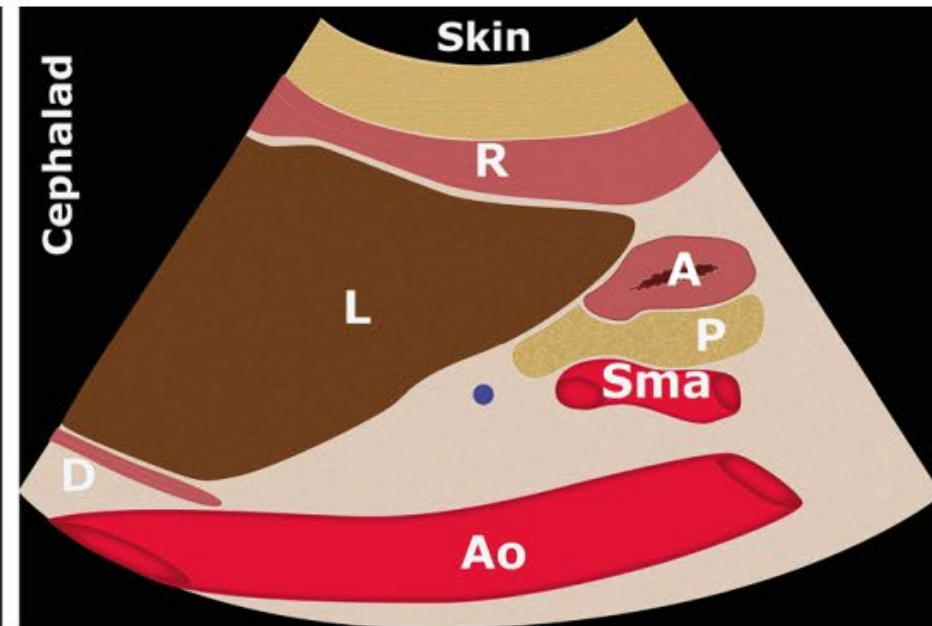
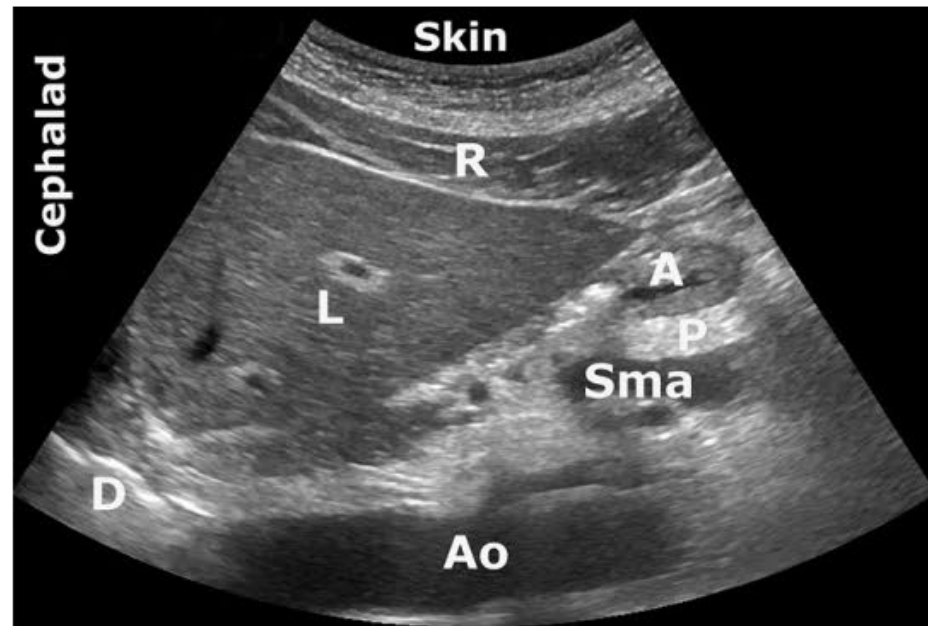


Fig. 3 Sonographic image of the stomach showing solid gastric contents with a “frosted glass” appearance. A = antrum; Ao = aorta; L = liver; R = rectus abdominis muscle. Used with permission from gastricultrasound.org

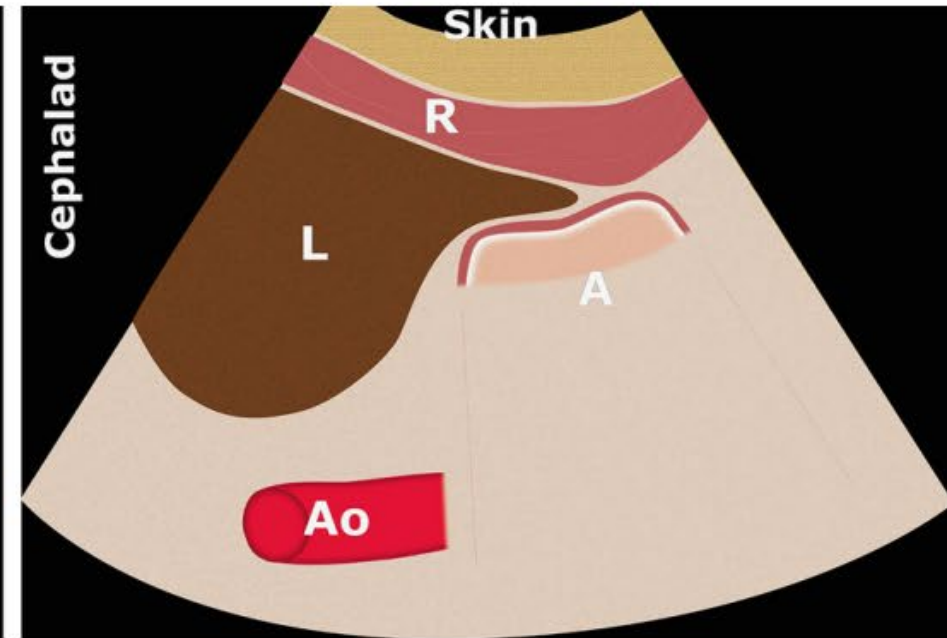
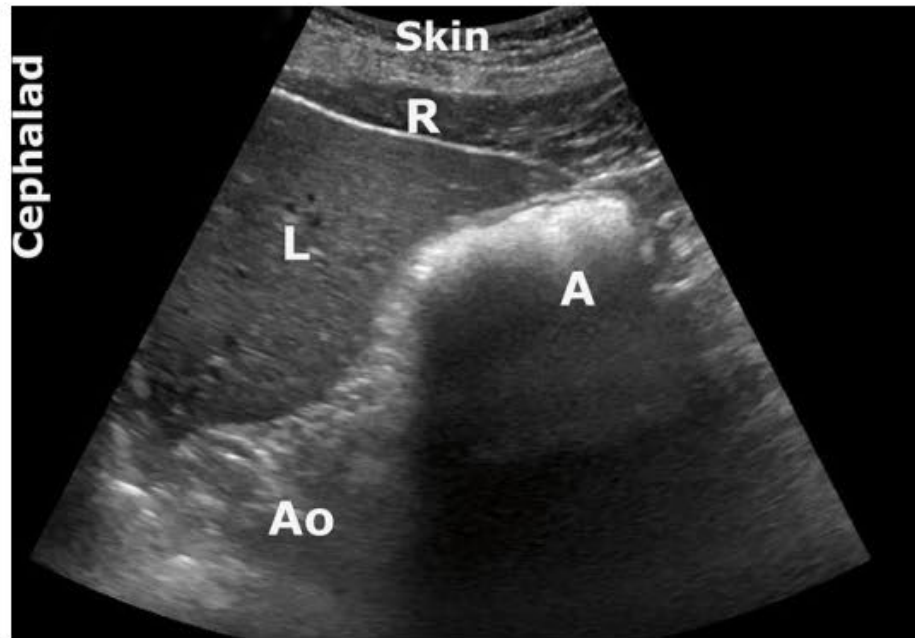


Fig. 4 Sonographic image of the stomach showing “late stage” solid gastric contents. A = antrum; Ao = aorta; L = liver; P = pancreas; R = rectus abdominis muscle; S = spine; Sma = superior mesenteric artery. Used with permission from gastricultrasound.org

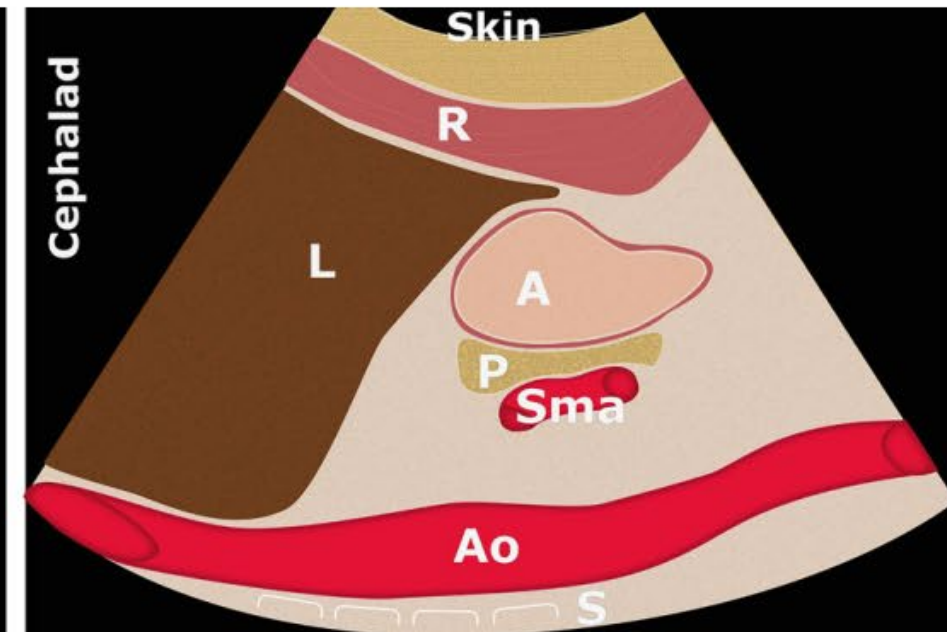


Fig. 5 Sonographic image of the stomach showing clear fluid gastric contents. A = antrum; Ao = aorta; D = diaphragm; L = liver; P = pancreas; R = rectus abdominis muscle; Sma = superior mesenteric artery. Used with permission from gastricultrasound.org

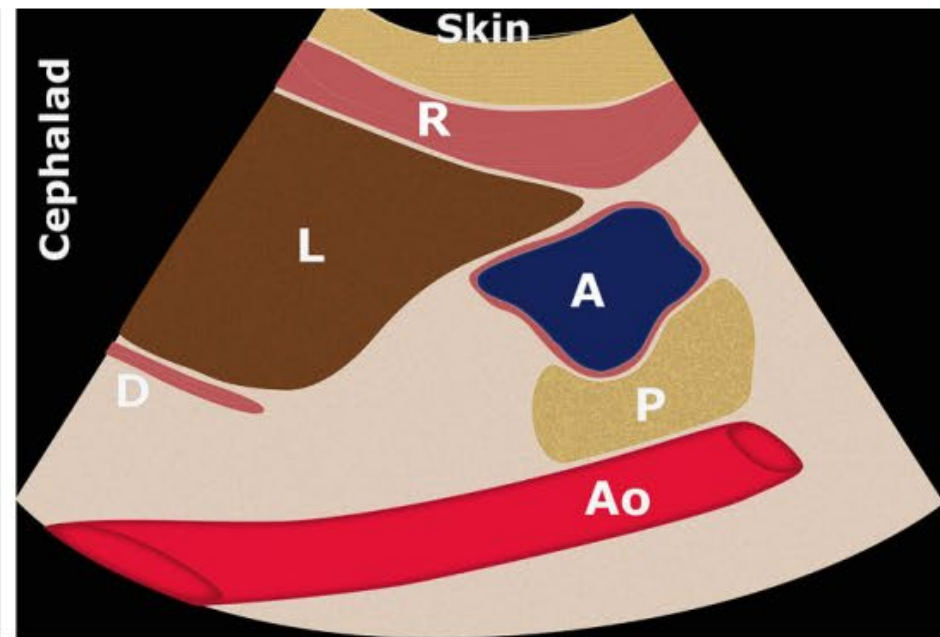
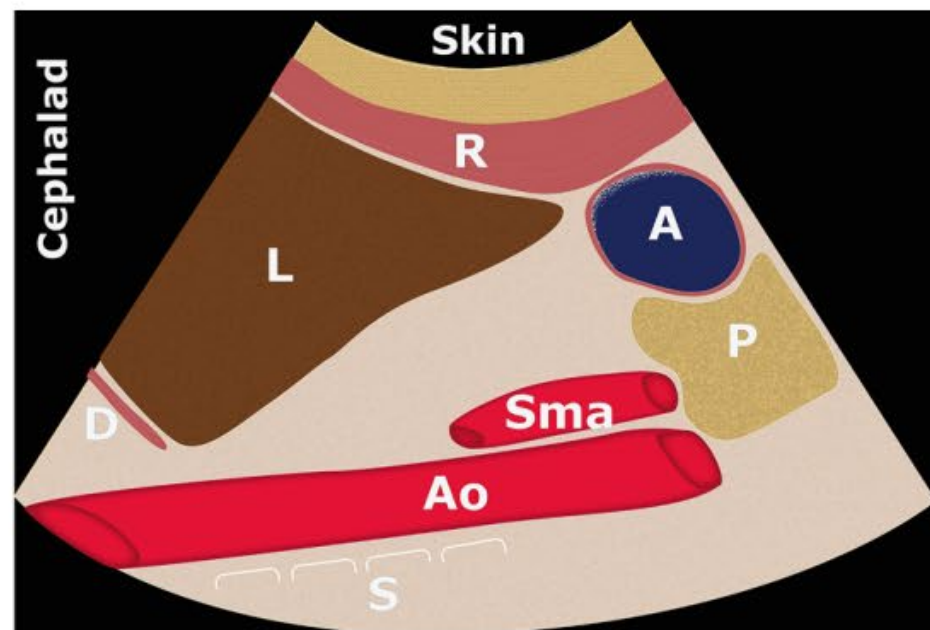
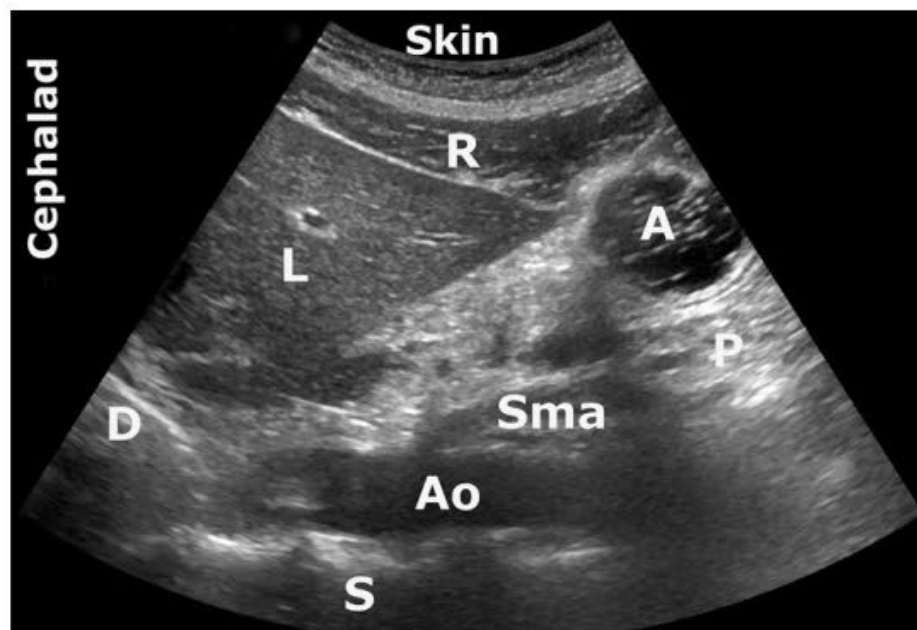


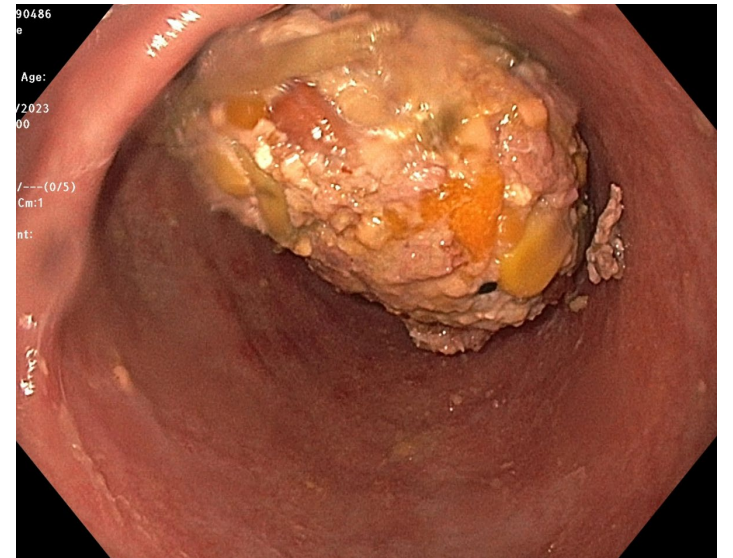
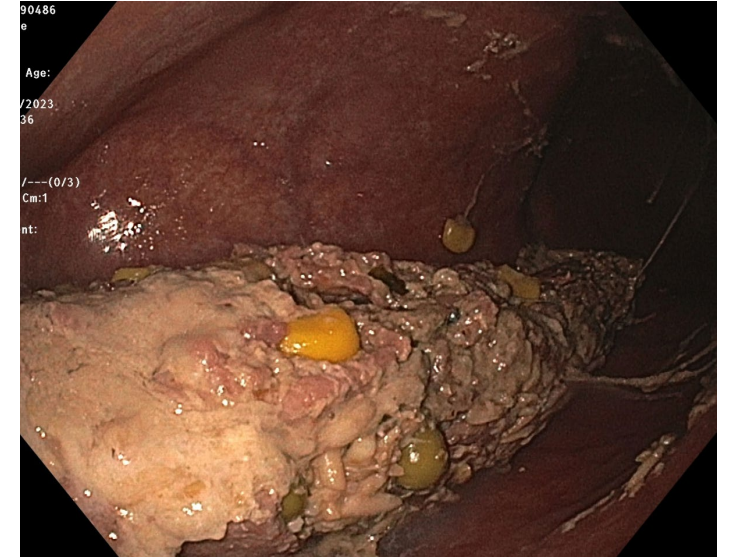
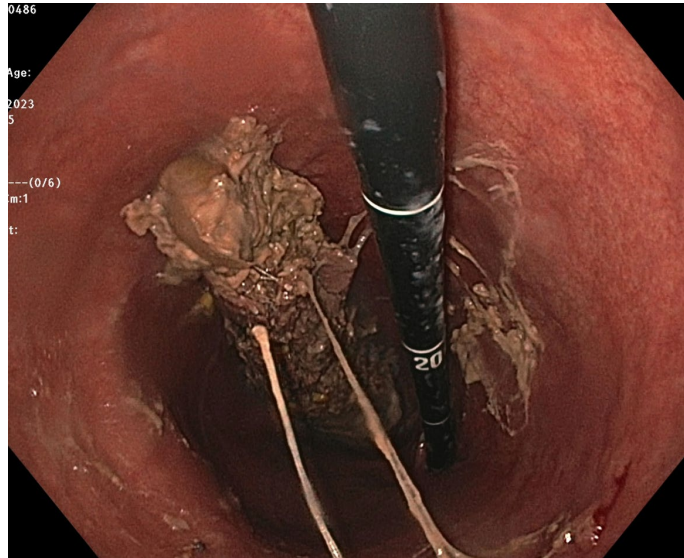
Fig. 6 Sonographic image showing the “starry night appearance” of the stomach represented by clear fluid mixed with gas bubbles. A = antrum; Ao = aorta; D = diaphragm; L = liver; P = pancreas; R = rectus abdominis muscle; S = spine; Sma = superior mesenteric artery. Used with permission from gastricultrasound.org



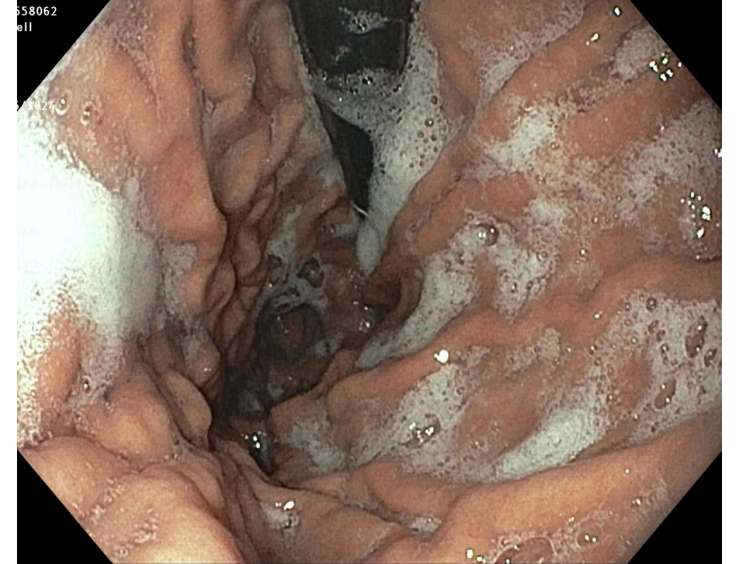
BMI 56



Full stomach



Shadowing



Conclusion

- There is benefit to treating obesity in patients with IBD including improving clinical outcomes in IBD
- GLP1 receptor agonists are safe and effective in IBD patients
- There are recommendations to mitigate aspiration risk in endoscopy for patients on GLP1 receptor agonists
- Gastric ultrasound is a useful tool to assess stomach contents pre-procedurally

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