



IBD: Who Knows Best?

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Crohn's disease (CD), ulcerative colitis (UC), and indeterminate colitis (IC) are diseases characterized by chronic inflammation of the gastrointestinal tract that are classified under the umbrella term of Inflammatory Bowel Diseases (IBD). Though these diseases were historically considered ailments limited to the Western world, a significant increase in their incidence has been observed since the early twenty-first century, particularly in industrialized nations and in emerging economies, primarily driven by the rising incidence of CD [1, 2]. IBD represents a group of immune-mediated chronic disorders affecting individuals of all age groups. The peak onset of IBD occurs during young adulthood, with approximately 20% of cases manifesting before the age of 20. Furthermore, an unfavorable trend toward an earlier age at diagnosis has been noted, with a shift toward early childhood years [3, 4]. Approximately one-quarter of children and adolescents diagnosed with IBD experience onset before the age of 10 and about 4% before the age of 5 [1, 4, 5]. Evidence suggests that the pediatric onset of these diseases is associated with rapid disease progression and more extensive involvement of the intestinal mucosa [5]. The overall impact of these diseases, including the shift toward early childhood onset, imposes a significant burden on both the affected individuals and on society at large [6].

Characteristic features of these diseases include recurrent or persistent inflammatory activity accompanied by increased nutrient malabsorption and elevated nutritional requirements [7]. In children and adolescents, the consequences of these diseases can manifest as nutritional deficiencies, growth and developmental retardation, as well as psychosocial stressors. Greater disease activity during childhood is correlated with negative impacts on stature, weight, and bone density in addition to delayed puberty [8]. Particularly, growth retardation influences the psychosocial

development of affected individuals, with consequent negative self-perception among children and adolescents, which in turn affects their body image [9]. Frequent absences from school and educational activities due to recurrent inflammatory activity further contribute to increased psychosocial burdens among affected children and adolescents [10].

The increasing incidence of new cases in recent years, along with changes in therapy and disease management for IBD, especially in pediatrics, has increased healthcare costs. Evaluating the direct and indirect costs attributable to IBD worldwide is challenging due to country-specific variations in costs and differing healthcare policies [11]. An estimated 2.5–3 million people in Europe alone are affected by IBD, with an estimated direct healthcare cost of approximately €5 bn/year. Approximately 50% of these direct disease costs allocated to medical therapies and 25% to hospital expenses [12]. Given the potential manifestation of IBD at a young age and the chronic nature of these diseases, this will inevitably increase indirect health-economic burdens on societies due to frequent disease-related incapacity for work, disease-induced unemployment, and early disability [11].

Against the backdrop of the individual and societal disease burden associated with diseases within the IBD spectrum, knowledge about these conditions is of utmost importance. In this issue of *Digestive Disease and Sciences*, Vernon-Roberts et al. [13] comprehensively investigated the levels of knowledge regarding inflammatory bowel disease (IBD) among four distinct healthcare professional groups in New Zealand using a self-assessment questionnaire and a 15-question survey tool termed The Inflammatory Bowel Disease Knowledge Inventory Device Version 2 (IBD-KID2). This survey, which has been validated among a variety of medical and non-medical populations, assesses general information, pathogenesis, manifestations, management, treatments, lifestyle, and nutrition that pertains to patients with IBD [14]. IBD-KID2 was used to query members of the nursing, dietitian, pharmacist professions, and medical students regarding their knowledge of IBD. Care was taken to ensure that a sufficiently representative sample from each of the mentioned professional groups was included.

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The results highlight significant gaps in knowledge among healthcare professionals, with variations observed across different professional groups. Notably, the study revealed that nurses, medical students, and pharmacists exhibited the most pronounced deficits in their understanding of IBD. The presence of knowledge disparities between these professional groups was anticipated, as well as the result that medical students in the early preclinical phase of their education demonstrated more substantial knowledge gaps compared with their peers in the later clinical phases.

It is important to contextualize these findings in light of frequent patient interactions and the practical experience gained by healthcare professionals in managing IBD cases. Therefore, the applicability of the study's results may vary depending on the specific healthcare profession and may not be universally generalizable.

These study outcomes provide valuable insights into the specific areas where knowledge deficits exist regarding IBD. These findings should be taken into account when designing continuing education programs and training initiatives for healthcare professionals.

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