

Editorial Policies and Skills to Solving Diagnostic Delay in Inflammatory Bowel Disease

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Editorial

Developing a reliable diagnostic marker will allow patients previously diagnosed as indeterminate colitis (IC) and/or ulcerative colitis (UC), but in reality were Crohn's colitis (CC) cases and received inappropriate surgical intervention, to receive recommended appropriate therapies [1]. Colonic inflammatory bowel disease (IBD), "The Colitides" patients are to date still seriously under-diagnosed or diagnosed with serious delay [2-4]. Diagnostic delay (DD) duration has not changed over the last 60 years although the number of IBD patients with a longer DD significantly decreased. Older age at diagnosis and a complicated disease at Crohn's colitis (CC) diagnosis are risk factors for longer DD [1-4]. Even with a combination of recommended state-of-the-art diagnostic system modalities a substantial number of IBD patients cannot be diagnosed and are labeled as indeterminate colitis (IC) when no definitive clinical, endoscopy, radiologic, and histopathologic evaluations can be made [5-7]. Most IC and CC patients are presumed ulcerative colitis (UC) and are pouch operated (restorative proctocolectomy and ileal pouch-anal anastomosis) subsequently are found to develop a recurrent de novo Crohn's disease in the ileal pouch. This is a serious complication that may hinder the restoration of intestinal continuity [8-10]. In an attempt to solving the DD challenges we attempted to understand molecular fingerprint differences between the colitides [11,12]. We are now able to report aberrant expression of Paneth cell specific Human α -Defensin 5 (HD5) levels distinctively delineate the colitides [13]. Among patients with IC, Paneth cell specific HD5 is a reliable differentiator with a positive predictive value of 96% [13]. These studies are the first to show that HD5 is a potential and reliable molecular candidate biomarker to differentiate CC from UC and reclassify IC into CC or UC phenotype. This finding is a trustable lead to developing a specific and more reliable diagnostic tool in IBD. The tool should eliminate the uncertain misleading IC diagnosis, and enable

appropriate conservative medical measures and surgical care for IC classified patients. The possibility of exploiting HD5 as a potential therapeutic target for CC needs to be illuminated.

Worldwide, the course of IBD patients appears to be evolving [14]. Rates of disease onset have increased for both Crohn's disease and ulcerative colitis. Its incidence and prevalence in developing countries is steadily rising and has been attributed to the rapid modernization and Westernization of the population. There is a need to reconcile the most appropriate treatment for these patient populations from the perspectives of both disease presentation and cost. In the West, biological agents are the fastest-growing segment of the prescription drug market. In patients with Crohn's disease, the need for biologic therapy has increased while surgery rates have decreased. More recent cases of IBD, especially in woman patients with Crohn's disease, appear to be more challenging. Timely and accurate diagnosis of IBD phenotype is indeed economical [1,14].

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