Introduction and Guest Background

Welcome back. We're continuing a conversation on Reversing Crohn's and Colitis. I'm your host, Sinclair Kennally, and today I am joined by the wonderful Dr. Colin Brown,, who's an MD who graduated from Duke University with a degree in history in 1994.

And after spending several years in the financial services industry, he went to Temple University School of Medicine and graduated in 2003. He completed his internal medicine residency at Boston Medical Center and his fellowship in gastroenterology and hepatology from the University of Alabama, Birmingham in 2010, where he also received a masters in Public Health.

Since 2010, he has been with the same gastroenterology practice, Middlesex Monmouth Gastroenterology, which in 2017 became part of Allied Digestive Health, an integrated network of over 200 providers dedicated to providing digestive health care.

One of the things that, in talking with Dr. Colin, you know, has become immediately apparent is that, we are dealing with such an epidemic with chronic diseases today.

And while the data is available to us and the clinicians are caring, we're talking in sort of an echo chamber right to each other. And so I love your mission, Dr. Colin, of bringing this out to the public and inviting everybody in to take it a step further in managing their own health.

So welcome and thanks so much for tackling this topic with me today. thank you Sinclair. I'm looking forward to, to a great conversation with you. Wonderful.

So can you just briefly define for folks what is Crohn's disease and what is ulcerative Colitis? What's the difference between the two? Sure. So both Crohn's disease and ulcerative Colitis are two disease types in a in a broader category of what's called inflammatory bowel disease.

the two diseases are similar yet different in some key ways. Ulcerative colitis.

Crohn's Disease vs. Ulcerative Colitis

as the name implies, it's basically limited to the colon though, it's a disease that goes from the rectum and can travel, what we would call proximately, up the colon to, the to where the colon meets the small intestine.

It does not involve the small intestine. it's usually in a confluent manner, which means it starts in the rectum and then can travel, basically, so sequentially, uninterrupted and, and has some pathologic features.

It has, superficial inflammation, which can lead to bleeding and ulceration. Crohn's disease, on the other hand, can involve any part of the digestive tract, really from the esophagus.

All the way down to the colon. unlike ulcerative colitis, it can actually be a little bit more penetrating. it can be, associated with more fibrosis and scarring and in some ways, bowel obstruction.

the two diseases are similar in the sense that they're both considered autoimmune diseases. what happens is that our own bodies, generate, an immune response to what we see as, a foreign invader or something, hostile to our body.

And unfortunately, our, immune system. Then, like many autoimmune diseases, looks at our body as the enemy, and, it triggers an inflammatory cascade and leads to, a variety of complications, which we can get into.

But hopefully that gives you a good overview of some of the similarities and differences between the two. Yeah. Talk to me more about the the science of the inflammatory cascade.

What would somebody be experiencing in their symptoms that they could tell versus what you would see on let's. Sure. So it's funny, there's there is a variety of, of symptoms that patients experience.

But there are certainly, main categories that you see over and over again. And ulcerative Colitis, one of the main things you'll see is, diarrhea. and often it's associated with blood and mucus.

And people will go anywhere from 3 to 4 times a day to, upwards of 10 to 12 times a day. And in a bad flares, even more, Crohn's disease is, is a little bit more variegated with its, presentation.

Crohn's disease can certainly, present with diarrhea, and it can certainly present with bleeding. However, because of the penetrating nature of the disease and because it can be associated with scarring and strictures, some people have constipation and abdominal pain and bloating and, are unable to have a bowel movement.

And, some people, have more pain. they don't feel like eating. They're anorexic. so there's a variety of symptoms that can be associated with Crohn's disease.

It's a little bit more of a masquerade or, ulcerative colitis tends to be a little bit more straightforward. But the one thing about ulcerative colitis, which is interesting, is some people will say, oh, I feel constipated.

And it's like, well, how can you be constipated when you have a disease that causes diarrhea? And it's because the inflammation in the rectum just gives out, in this constant sense that you have to go to the bathroom even though nothing is there.

Yeah. It's, it's a symptom called Nesmith's. but it's interesting when it does come up, sometimes when patients. Yeah. I appreciate you pointing that out, because that's a very frustrating symptom for.

Folks as it is. Yes. To want to be able to go and not to be able to go is very frustrating. And to be afraid to go because it can be so uncomfortable when you're at that part of tender tissue is being overused.

Yeah. Absolutely. Let's, let's unpack that a little bit for folks. The difference too between irritable bowel irritable bowel disease versus irritable bowel syndrome.

Because people are using these words interchangeably. And we know that's not actually accurate. So yeah.

Symptoms and the Inflammatory Cascade

So what I like to do is when a patient comes to me with symptoms, I try not to get caught up in the nomenclature because the nomenclature, as you pointed out, Sinclair, can be very confusing, will have irritable bowel syndrome to have it.

Do I, do I have colitis? You know, what is my disease process? Help me understand the doctor. And so when a patient comes to me with symptoms and I don't know what they have, and I haven't done any testing yet, the first thing I try to tell them is, listen, what we're trying to do is distinguish between having a functional disease and having that structural disease.

So a structural disease is something that, shows up on a colonoscopy or an endoscopy or a Cat scan, you know, something that has tangible, alteration to the structure of the colon or the small bowel, things that we can diagnose, things that we can biopsy.

Functional disease, of which irritable bowel syndrome is a subset of is basically that patients experience a variety of symptoms similar to what we talked about.

Usually not so much the bleeding, but pretty much anything else in that gamut. and when you do all the testing and you do the colonoscopy, you do the endoscopy, you do the the Cat scan, you do the lab work, nothing really shows up.

And so you're left with patients that have symptoms, and their symptoms are completely real and they're completely valid. But you don't have the structural findings to, to match it up and say, okay, well, this is what you have.

And here you need to be on these medications. It's a little bit more, art and science. but that's one of the main ways that I try to approach, a problem when a patient comes to the office.

So I'm really glad you're bringing the attention to the treatment room, because so often we inherit people in our practice that feel like they weren't listened to by their GI's, and they were told, we'll just keep an eye on this, and there's nothing that can be done.

What should, someone be asking in their doctor's office if they're experiencing these types of symptoms? Well, I think that's a good that's a good question.

And I think when it comes to treating functional disease, the whole treatment really is oriented around, number one, treating the symptoms that are in front of us.

And number two, if we can find a reversible cause or identify potential reason for their symptoms, then we try to go ahead and treat it. And when somebody comes in with a functional problem I try to break it down again.

Okay. Your labs are normal, your Cat scans normal. We may have done a colonoscopy. That's normal. but you're still experiencing these symptoms. You know, what are some possible etiologies of this?

And, I think one of the things that's come to light, especially over the last decade, is that our gut microbiome, is that you? Source of how our symptoms, how our intestines function.

And, you know, there there are FDA approved regimens that include a course of antibiotics, which I've used personally and I found to be effective, not in every patient, but in certainly a subset of patients.

And, you know, we can treat we can treat them with that, and other, potential cause of their symptoms, is, food and how they digest food. And I know this is something that you, are very well versed on.

IBD vs. IBS and Functional Disease

Probably much better than I am. But, you know, there are some diets which, which I've used and have and have discussed with patients. And I think you're probably familiar with what's called the low Fodmap diet.

I won't, I won't, I won't spell out the acronym because it's, it's a little bit complicated, but basically they're foods that are high. Any sugar and sugar alcohols?

that are not necessarily unhealthy but can be difficult for some patients to digest and break down. And when that happens, you know, they're left with symptoms like bloating, diarrhea.

And it's it's difficult because, you know, listen, we patients eat in a variety of different, scenarios, foods not always consistent. anybody who's done Weight Watchers knows that keeping track of what you eat is, like, near impossible.

So, it's just trying to get my. My goal in this scenario is not to have somebody rework their diet, but just somewhat be a little bit more food oriented with their symptoms.

Hey, today I'm feeling really bloated. I'm having some diarrhea. What did I eat in the last 12 hours? So eat anything unusual? Is there anything that I ate that's on this list of high Fodmap foods?

Okay, maybe there's something there. So that's that's the approach with diet that I take. And the last is well, not the last. But the other big one is, certainly stress.

I think we all know that, the gut and, the, neurologic system in our brain, and especially our emotional system are, very strongly connected. It's no accident that we say things like, I feel this in my gut, the same neurotransmitters and, stress hormones that generate certain strong emotions, you know, have receptors on there on your digestive tract.

And, when patients have stress, have been carrying stress, have new stressors or even stressors that have been maybe buried and have, maybe been inadequately dealt with over the years.

they can sometimes bubble to the surface and cause a variety of symptoms, not just the digestive tract, but obviously that's where they come to my office.

Yeah, that's it's a really important point. Like, we cannot skip our awareness of this. It's it's so obvious the data is there. We've got to be talking about it with a more nuanced conversation at this point.

Absolutely, absolutely. I really appreciate you bring it the food piece, too, because I can't tell you how many guys have told, or we've heard stories, you know, because we can hear it.

People, of course, from other clinics. How many guys have said, yeah, food doesn't really matter. Don't stress about the food piece. It's like, well, okay, but if we know that certain foods have, you know, greater fermentation, you know, potential in the gut and you have, you know, an imbalance in the gut bacteria and you feel worse after you eat them.

Maybe we should look at that. Listen, I think when you when you don't have a clear diagnostic path to getting somebody better, you know, you do look at you try to just widen your scope of vision and look at different factors that might be playing a role in their symptoms and listen, I mean, it's, you know, diet is one of the things that I can tell, just experientially when patients say, listen, I noticed when I was eating XYZ foods, I was having these issues, I change my diet, I feel so much better.

And that's happened, you know, not a handful of times in the in the 14 years that I've been doing. So while, you know, you do have to walk a line, you know what?

You don't want people to be crazy about diet, right? If they don't have to be, you know, because sometimes people can take dietary advice and run with it to an extent where I think sometimes causes more stress.

And, and potentially more symptoms.

Diet, Microbiome, and Stress Triggers

so you want to do a balance, but you want to try to be pragmatic about it and just say it's really more of a, of a sense of being aware, you know, just being aware of what you're eating, being aware of what you're taking in and being aware of how that may affect your symptoms.

there's not always a correlation. You know, obviously I've had patients that will say, I eat, you know, this meal Wednesday I was fine. And then I eat this meal Saturday.

And and, you know, now I feel like I'm nine months pregnant. And that's frustrating. And I hey, I don't know always how to how to navigate that, but, but if you can sort of bring patients back to saying, okay, you know, let's see if there's anything else that triggers you or, you know, maybe there's something else going on.

And, you know, it's really about keeping the conversation alive and letting them know you're invested in their and their symptoms. Absolutely. And of course, we got to acknowledge the confluence of factors with conditions, right. Like how full is your stress bucket when you eat that meal.

Yeah. Yeah. That's right, that's right. Yeah I love that. This is I always tell people that I'm not the food police because I don't want you to be afraid of your food.

I understand how dysregulated that can be. You know, orthorexia is real. I got down to three foods, and I was very, very afraid of food. And if you're nervous, systems aren't having a response as you're looking at that food, thinking about that food, how well is that going to go down right now?

It's interesting. I always think of, I went to this lecture about celiac disease and I won't mention any names, but, we, you know, there was definitely somebody who is very, well known in the world of celiac disease.

And this is something that comes up with my patients a lot. And they ask me, you know, is there a safe level? Right. And I actually ask the question, I ask this, you know, very well known, academic, is there you know, you know, it's what was Ralph Nader's book?

You know, it's, you can't go for whatever it is. You can't go above 55, you know, like, there's no that was unsafe at any speed, that's unsafe at any speed.

So it's gluten unsafe at any speed. Yeah. And, he basically he basically sort of, echoed what you were just saying, which is that the people that are the most, preservative and maniacal about just making sure that any molecule of gluten ever touches their palate actually have worse outcomes than people who are actually gluten free and are seriously gluten free. But if some escape, you know, they they understand it's not the end of the world, which it's not.

And I think there is something to that. I do, too, especially for conditions that are autoimmune in nature. We have to acknowledge the nervous systems role in this.

Yeah. So in the GI world, you know, we're having a rapidly evolving conversation. And you know there's new data coming out all the time about these conditions.

Like you acknowledged just a minute ago, how how short the history is. studying the microbiome really, as we understand it today. Right. 100%. What are some of the, myths that still persist in your mind in gastroenterology?

You know, that we're still struggling to catch up, even though the data has come out to refute them. Well, that's a that's a really good question, Sinclair.

I mean, I think I, you know, I interact with myths, and, and different systems of belief all the time. I think one of the I think one of them, you know, does go back to, you know, making sure there's one 100% correct way to eat, which, as I think you you imply, there's not.

I think that just having more of a, more of an approach of awareness, is, is probably the optimal way of going about things. you know, I think with, as, as also far as myths go, with respect to structural diseases, I think, you know, you want to make sure that people do, understand that these diseases, while they can sometimes spontaneously, get better.

And I've certainly seen people get better with very minimal, therapies, which I always, you know, I'm happy about and welcome, that a lot of times these things just don't get better on their own.

and even if you are doing better, you do need to check in because there are some things that can sort of go under the radar and then come back and cause, larger problems, you know, and that being, you know, structuring, you know, potential obstruction.

And in the worst case scenario, malignancy. So those are just things that you want to be aware of. whenever you're treating a disease that just because your symptoms are better and your symptoms are extremely important, but you want to make sure that while the symptoms are better, the inflammatory pathways, the way the, the, the lining of the intestines look match up with that, because because if they don't, you just have to be aware of that.

And you may want to tweak your therapeutic approach I agree. Yeah, absolutely. That's a really great point to make. Do you think that, well, I'll ask this differently.

What are your the most interesting advances you've seen in the last two years in Gastroenterol as we're expanding our, our view of these diseases? Yeah. No, that's a great question.

you know, as you know, medical research, it's stochastic, you know, you'll have no, you'll have no movement in an area. And then all of a sudden, you know, everything spikes.

And, you know, we're talking about Crohn's and colitis, the, the, the types of, therapies that are in our armamentarium. today, 2024, you know, you go back even five years ago, we didn't have nearly, the amount of effective therapies, and there's really been an amazing push, with our understanding of immunology, to, you know, find target, therapies that, can create a lot of efficacy and hopefully, over the long run, create minimal side effects, for patients.

So I think that's, you know, that's been an amazing area.

Myths, Disease Monitoring, and New Advances

I think one of the amazing areas that we're going to see, coming up is, you know, how we deal with, fatty liver disease. I know that's a little bit off topic for this, but as we know, it's an epidemic in this country.

And, you know, it's going to lead to a significant amount of morbidity as the population ages. and I think trying to find ways that we can, hijack, you know, our, our metabolic system in a positive way, to limit, fibrosis and scarring of the liver is going to be, real important for our future, for the, you know, for a future health and digestive disease.

I absolutely those you those are some of the things I've seen on the on the therapeutic realm. I've also seen, you know, refreshingly, I think, kind of what we were talking about before, a an appreciation for the mind body, connection and how important it is, when you're dealing with digestive disease, you know, how things like some of the softer, quote unquote, softer elements of patient care, but addressing, you know, their emotions, their stressors, you know, how important that is in taking care of the patient and getting them to, you know, to their symptoms under control.

Yeah, that's excellent point. So when you get somebody in your treatment room that is a new patient and they've been suffering for quite some time with say ulcerative colitis and they're clearly under distress, you know, and this is impacting their quality of life.

They're willing to do something about it. What are your favorite go to tools that you start with. Well I think first again we have to we want to make sure, that their symptoms are matching up with some degree of inflammatory activity.

because as we know, as symptoms, a lot of times can be independent of inflammatory activity. And if that's the case, you don't want to focus on the symptoms, not the inflammation.

So often, especially if I haven't, seen the patient in a long time and they're new to me, or these symptoms are relatively recent. You know, I will recommend some kind of, and this topic evaluation, like a colonoscopy.

And that way I just see for myself how bad the inflammation is, is the ulceration, you know, how extensive it is. Is it? Because that gives me a mental picture of how I can, best address this needs over the long run?

So that's number one. You know, number two, you know, you want to get the patient, in some kind of clinical remission is as soon as possible because, you know, while diseases like diabetes, heart disease, and even some other autoimmune diseases, you, you know, you may have them, but whenever you go about your daily life, you don't know if you you don't know what your blood pressure is necessarily.

You don't know that your blood sugar may be 180. You'll know if it's 680, but you won't know if it's 180. with GI

disease, you can't ignore it, right?

I mean, we live our lives so much. So much for our digestive tract. So, you know, these symptoms really do affect people's body lives. They affect how many they affect how they commute.

They affect how they work. you know, to have many teachers as patients, it's more fine for them to have the go back and forth to the bathroom. So it's really about getting their symptoms under control.

It's really having an understanding for how serious their symptoms, impact the quality of life. And so you want to, you know, do something in the short term and not my favorite drugs, but certainly they work quickly are steroids.

and while, at least for the short term, while we're trying to, to see where the dust settles, you know, get them and get their symptoms a little bit better just so they can function with the understanding that this is not a long term, solution, but it it is kind of a band aid, but it's important to put that Band-Aid on.

And then after that, what you want to do is also have a, have a conversation with the patient about what how they see their treat because, there's so many different therapeutic options and we are getting to I'm not so much a genomic medicine doctor.

Like I can say, let me see your 23 and me report and I'll give you the best, you know, IBD medication. But what I can do is say, okay, are you interested in going on a biologic?

Because that means once you get on one of these advanced therapies, you're probably not going to be able to come off. So how important is that to you?

Is it important to to have an oral pill or are you okay having an infusion pill? what's your risk tolerance as far as potential side effects? so having these types of different conversations at least helps me gauge where the patient, is mentally and how we can best approach is, the therapy for that person, you know, again, as a over the, over the horizon.

Because when you're looking to start one of these therapies, the idea is that you're not giving this therapy for a short period of time. It is a commitment for both me.

But definitely the patient. Yeah, I really appreciate that. I think that our, patients and clients do best whatever practitioner you're seeing, where they are actively enrolled in the decisions in their capsule.

Yeah, they have to take responsibility for their outcomes. Well, I think they they feel better about it usually. I mean, some patients are very old school and just say, you're the doctor, tell me what you want.

And okay, I mean, that's fine. I try to steer them in a different direction.

Treatment Strategy and Shared Decision-Making

But for the most part, especially with patients who are younger, they appreciate that, they want to be part of the decision making process. And it's it's shared.

It's a shared decision making model because they're the ones with at the end of the day, they're the ones with the disease. They're the ones that are showing up for the therapy.

They're the ones that are experiencing the side effects. I'm just trying to figure out how the best got to how to best treat them and discuss with them their options.

some of that. What do you think? we haven't covered yet. That's really important for a patient to understand while they're out there searching for tools right now.

That's why they're listening to this interview and they're on the hunt for, like, how can they sort for the best practitioner for themselves? Or, you know, what have we not covered for them that would really support them on their path?

Well, I mean, I think it's it's challenging because we deal with so much information. I mean, we're information overload, right? So how do you separate the signal from the noise?

I think the best thing you can do is, when when you have, an initial consultation with the gastroenterologist, you know, first of all, hopefully shame is not in the building.

I know where it's it's, It's embarrassing to bring up some of these issues, but I tell them all the time, you know, people say, oh, this is gross. I listen, this is this is what I chose to do.

I don't have to be here, but I'm here and your job is to tell me what your symptoms are. And, so really, you know, the person you go to chose gastroenterology as a profession.

He or she knows what they're getting into. So, there's no shame with with bringing up the symptoms that you have. I think the other thing is just and and patients, I think could do this, you know, do themselves a service, write down some of the questions that you want answered.

because, listen, it's it's, as you know, it's sometimes hard to get an appointment. It's, you know, you wait 6 to 8 weeks, sometimes even longer, to get in with somebody.

So when you're there, maximize your interface. You know, it's one thing to look something up on Google, but it's another thing to talk to somebody who's seen patients under a long, you know, over a lot of different ages, a lot, a lot of different points in their life, different demographics, who can kind of who at least have a feel of where you might be in the greater, you know, body of knowledge that the physician has accumulated over over the years?

and take advantage of the humanness of that interaction. You know, these are two humans talking to each other about trying to, to solve a health care problem and so show up with questions.

You know, certainly it's you want to be respectful. You don't want to, you know, say, well, Google told me this. Why are you saying that? I mean, that's you know, that's not helpful, but I think, you know, having, you know, having some idea of what you want answered is important.

You know, it may be not the most important thing at the end of the day, but it's certainly important right then and there in the room. So that would be that would be some of the advice I would give.

Yeah. It's a beautiful way to frame that taking. You're taking your real advantage of your role in your own care is a really important piece to this. Yeah.

Tell me more about Allied Digestive Health and the. Yeah, I mean, this is an organization you've been with for a long time, right? Sure. So I, I just have health is an organization.

it started off in new Jersey, now includes, over 200, providers. So these are gastroenterologists, these are anesthesiologists, these are nurse practitioners and physician assistants, along with, other specialists such as nutritionists, to to meet the digestive needs of our community.

You know, my community is in Monmouth County, new Jersey. basically. What what, us joining this organization has done for us, it's helped make me a better physician because it's expanded my world.

The people that I talk to, I now have, a network of gastroenterologists, that are in my peer group that I regularly communicate with, discuss cases with, discuss some of the, the challenges of running a practice and also, a patient care of navigating new technologies, of what you have, of navigating what are the best therapeutic for patients in certain situations.

So I think that's the best benefit, that Allied Digestive has done is it's brought a variety of practitioners, to a lesser extent, were practicing in their own 5 to 6 person group bubbles and brought them together.

And I think by bringing together they've made they've made the, the practice stronger, made the organization stronger. And it's allowed us to do some pretty interesting things.

Patient Advocacy and Preparing for Appointments

together, we were able to put together an educational conference for the first time this past February, which I was fortunate enough to be, one of the program directors for which really focused on, treating patients over the course of their, over the course of their lifetimes, basically taking a community view to, management of chronic disease, long term health problems. So, that's basically Allied Digestive in a nutshell.

Nice of that. What a great way to introduce this, this topic. Yeah. This is, such an important and also amorphous conversation that people are having.

And I know, like you said, it's very frustrating and exhausting to be the patient on this journey. So I really appreciate you boiling it down and simplifying the approach for our audience.

Is there anything you want to share that's more on the advanced side of things that people feel like? I've explored all the different approaches. You know, I went on steroids, I went off stories that went on avionics went off, and I got, you know, tell me more.

What what is a stone unturned for somebody who's been way down this path for years that might provide them some hope to explore today? Well, I think, you know, I would take solace in the fact that there's definitely a lot of research, that's and still going on in this disease.

you know, one of the things that I am involved with in our clinical trials, so I do get a bird's eye look at some of the upcoming therapies, and there's a lot of investment and looking, to find therapies that are working, for patients, with multiple different, problems, you know, inflammatory bowel disease is tough, even in the best studies.

You know, we're still talking 50 to 60% remission. So there's a whole, you know, so there's a whole, cohort of people, almost half a population. And the best the studies are not necessarily achieving clinical remission.

Allied Digestive Health and Clinical Trials

So it is frustrating, but just take solace in the fact that there's very smart people that are looking in a variety of different ways to, to get therapies for people who are suffering and, you know, clinical trials are a way to do that.

And there's ways that you can look up yourself if you are interested in clinical trials. Dot gov, and search different trials to reach out to, people who are running clinical trials because it may be, a potential avenue, for, for somebody who's gone through three or 4 or 5 therapies.

Nothing's worked. so I would say that I would just take solace that there's a, there is a lot of investment, a lot of a lot of smart people doing a lot to try to try to get people relief because we know that there are gaps in, in symptom relief.

Yeah, absolutely. That's a beautiful message of hope. Thanks for acknowledging the problem and helping us tackle it. Where can people find you and where can they find Allied Digestive Health?

Well, I guess I don't really have much of a social media presence, but, we do have, Allied Digestive Health does have a website. and certainly there are some resources in there.

Links, about patient that are patient, oriented about a variety of different disease conditions. And certainly if you're in, in New York and New Jersey area, and you're looking to find a gastroenterologist, there's a list of, we have a

wonderful, wonderful roster of physicians, from all over new Jersey, Long Island, the New York metro area and upstate New York, some really phenomenal people.

So I think, you know, just going to, Allied Digestive Health and, kind of in going through the website on that end, may, may open some doors for you. Thanks so much for your help today.

You're welcome. My pleasure.