Inflammatory Bowel Disease (IBD)

See also Medications – Inflammatory Bowel Disease.

Red flags

- Fever
- Tachycardia
- Hypotension
- Significant abdominal pain – toxic megacolon, perforation, bowel obstruction, abscess

Background

About inflammatory bowel disease (IBD)

About inflammatory bowel disease (IBD)

Inflammatory bowel disease (IBD) includes Crohn's disease (CD), ulcerative colitis (UC), and inflammatory bowel disease unclassified (IBDU). All are characterised by inflammation of the gut mucosa with symptoms including diarrhoea, rectal bleeding, abdominal pain, and weight loss.

- The location and type of inflammation distinguishes CD from UC:
    - UC affects the colon only with continuous mucosal inflammation extending proximally from the anus.
    - CD can affect any part of the gastrointestinal tract from the mouth to the anus, but most commonly the terminal ileum. It causes transmural inflammation and can be patchy.
    - IBDU is when the large bowel is inflamed but there are no distinctive features to distinguish between UC and CD.
- Peak incidence is between 15 and 35 years but may occur at any age.
- Diagnosis is made through clinical assessment, endoscopy, and biopsy, with radiological investigations as required.

Assessment

1. Consider inflammatory bowel disease or colorectal cancer if:
    - diarrhoea with urgency, rectal bleeding, abdominal pain, and weight loss.
    - nocturnal symptoms such as diarrhoea or abdominal pain which wake the patient. Functional diarrhoea (e.g. irritable bowel syndrome) usually stops at night.
2. History – ask about:
    - family history, drugs, smoking, travel.

      Family history, drugs, smoking, travel

      - Family history of IBD, colorectal cancer, coeliac disease, autoimmune disease.
      - Drugs, especially nonsteroidal anti-inflammatory drugs (NSAIDs) (e.g. NSAID enteropathy), antibiotics, laxatives.
      - Smoking – check the timing relative to IBD symptoms as there is a paradoxical relationship between smoking and IBD:
          - Smoking increases the risk of developing Crohn's disease.
          - Smoking reduces the risk of ulcerative colitis. Smoking cessation can precipitate ulcerative colitis.
      - Travel history.
    - extra-intestinal manifestations of IBD.

      Extra-intestinal manifestations of IBD

      - Skin, e.g. erythema nodosum, pyoderma gangrenosum
      - Arthropathy
      - Eye, e.g. episcleritis, iritis
      - Mouth ulcers
      - Night sweats
      - Primary sclerosing cholangitis (PSC)
3. Perform examination:
    - Check temperature, pulse, and blood pressure
    - Examine abdomen for tenderness, distension, and masses
    - Examine rectum for blood, masses, and perianal disease, e.g. abscesses, fistula, fissures
4. Arrange initial investigations.

   Initial investigations

   - FBC, CRP, LFTs, urea and electrolytes

- Ferritin, B12
- Anti-tissue transglutaminase antibodies and IgA (coeliac serology)
- Faecal microbial screen (molecular enterics)
- Stool – ova, cysts, and parasites if appropriate, e.g. overseas travel
- *Clostridium difficile* PCR
- Faecal calprotectin if patient younger than 50 years and faecal infective screen is negative

Management

Practice point

Never use methotrexate in pregnancy

Methotrexate is teratogenic and absolutely contraindicated in pregnancy.

Treatment involves inducing remission and then maintaining it with drugs or surgery in association with a gastroenterologist and specialist nurse, depending on the IBD severity and medications.

First presentation

1. If concerning features, request acute general medicine assessment.

   Concerning features

   Bowels open more than 6 times a day and one of:

   - Fever
   - Tachycardia
   - Hypotension

2. If severe abdominal pain (possible toxic megacolon, perforation, bowel obstruction, abscess), request acute general surgery assessment.
3. Otherwise, review once blood and faecal results are back.

   Blood and faecal results

   - IBD is suggested if:
     - bloods show anaemia, leucocytosis, thrombocytosis, or
     - increased CRP or ESR, or
     - faecal calprotectin greater than 150 microgram/g. An acute infection, e.g. campylobacter can cause elevated calprotectin. Confirm faecal infective screen is negative before making request.

- IBD is extremely unlikely if investigations are normal, including a faecal calprotectin 150 microgram/g or less.

4. If first presentation of inflammatory bowel disease is highly likely, i.e. symptomatic, suspicious bloods, or faecal calprotectin greater than 150 microgram/g (exclude infective cause), request urgent gastroenterology assessment for colonoscopy.
5. If colorectal cancer may be a cause of the symptoms, request non-acute gastroenterology assessment.
6. Always ensure that the patient has a diagnosis before starting treatment, e.g. steroids.

Ongoing management

1. Advise smoking cessation as smoking significantly worsens the course of Crohn's disease.
2. Check medication compliance, side-effects, and drug monitoring. See Medications – Inflammatory Bowel Disease.
3. Address specific issues:
    - Nutrition

      Nutrition

      - In active Crohn's disease, under-nutrition, protein deficiency, and specific deficiencies in vitamins, minerals, and trace elements are common.
      - As under-nutrition has a negative impact on clinical course, rate of postoperative complications, and mortality:
          - encourage a healthy balanced diet.
          - consider and treat any nutritional deficiencies, e.g. iron, vitamin B12, vitamin D. Less common are vitamin K, zinc, and folate deficiencies.
    - Monitor fragility fracture risk as there is a risk of osteoporosis with repeated courses of steroids (prednisolone or budesonide) or low vitamin D levels.
    - Risk of opportunistic infections

      Risk of opportunistic infections

      There is a possibility of varicella and other infections due to immunosuppression – increased by immunomodulators, steroids, and biologics, especially if on more than one medication. Advise patients to present early if they become unwell.

    - Confidence and self-image. Be aware that depression is more frequent in IBD due to factors such as the impact on the patient's quality of life.
    - Extra-intestinal manifestations of IBD.
4. For young women with IBD, provide advice and management on contraception, fertility, pre-conception planning, and pregnancy.

   Advice and management

- Discuss contraception:
    - Combined oral contraceptive pill (COC) absorption may be reduced if there is small bowel involvement in Crohn's disease. Large bowel involvement does not affect absorption.
    - Do not use COC in patients prone to severe hospitalised exacerbations, as their risk of venous thromboembolism (VTE) is increased.
    - IBD increases the risk of osteoporosis, and the effect of Depo-Provera on bone density may be additive. Alternative progestogen-only contraceptives that do not affect bone density may therefore be better.
    - For more information see Sexual and Reproductive Health for Individuals with Inflammatory Bowel Disease.
- Fertility:
    - There is no difference in fertility with ulcerative colitis unless patients have had pouch surgery.
    - In IBD, the main factor in fertility relates to good disease control i.e., the better the disease control, the more likely to get pregnant.
- Pre-conception planning.
    - If planning a pregnancy:
        - advise patient to discuss with an IBD consultant or a specialist nurse.
        - request non-acute gastroenterology assessment.
    - Before conception, good control of IBD is important.
    - Contact the Welsh Medicines Information Centre if further advice is needed.
    - Methotrexate is teratogenic and is absolutely contraindicated in pregnancy. Advise both women and men to delay a pregnancy for at least 6 months after stopping the drug. Continue contraception for at least 6 months after stopping methotrexate.
    - Consider using a higher dose of folic acid dose (5 mg) for women taking sulphasalazine or those with malabsorption following small bowel resection.
- When a pregnancy is confirmed:
    - Request non-acute obstetric assessment and non-acute gastroenterology assessment.
    - In clinic, the gastroenterologist will discuss medication risks and benefits in pregnancy and while breastfeeding.
    - Contact the Welsh Medicines Information Centre if further advice is needed.

5. If on immunosuppression drugs or biologics:
    - set up recalls and add alerts, e.g. Pneumovax, annual influenza vaccinations, and cervical screening if appropriate.

- see relevant shared care protocols for eligibility information for herpes zoster vaccination.

6. If indicated, secondary care will arrange regular screening for colon cancer.

Regular screening for colon cancer

There is increased risk of colon cancer for both ulcerative colitis and Crohn's colitis.

- The main risk is related to the duration, extent, and activity of the disease rather than if it is ulcerative colitis or Crohn's colitis.
- A family history of colorectal cancer and concomitant primary sclerosing cholangitis add to the risk for colorectal cancer.
- A baseline colonoscopy is offered at about 10 years after the onset of the disease.
- Further surveillance colonoscopies are advised at intervals of 1 to 5 years depending upon the extent and degree of inflammation and the coexistence of other risk factors.
- Surveillance is not necessary when disease activity is limited to the rectum or the sigmoid colon.

7. Manage flare-ups.

1. Request non-acute gastroenterology assessment for steroid-sparing treatments if 2 or more flares within the past year. In ulcerative colitis and Crohn's disease, long-term use or recurrent courses of steroids are not appropriate.
2. If concerning features (severe flare), seek acute gastroenterology advice or request acute general medicine assessment for intravenous steroids.
3. Arrange investigations.

Investigations

- Faecal microbial (molecular enterics) and *clostridium difficile (C. diff)* PCR. Relapses may be associated with pathogens or due to *C. diff* after antibiotics.
- Blood tests – FBC, ESR, CRP, LFTs, urea and electrolytes.

4. In ulcerative colitis, optimise 5-Aminosalicylate (5-ASA).

- Increase oral 5-ASA to maximum dose, e.g. Octasa 2.4 g to 4.8 g per day (over 2.4 g per day as divided dose only).
- Start rectal 5-ASA enema or suppository if tolerated, e.g. Asacol foam 1 g enema at bedtime. Can be difficult to hold but encourage patient to persist. Can use suppository in the morning and enema at bedtime.
- 5-ASA enemas are more effective than steroid enemas. If patient does not respond or is intolerant to 5-ASA enema, use steroid enema, e.g. hydrocortisone 100 mg (Colifoam), budesonide 2 mg (Budenofalk).
- Use 5-ASA suppositories for proctitis, e.g. Salofalk 1 g per day.

- If successful in controlling symptoms, continue topical treatment until a few days after symptoms settle. Continue oral 5-ASA at the higher dose for 4 to 6 weeks, then reduce to a maintenance dose unless evidence of ongoing active disease.
- If on maximal 5-ASA or limited response after 2 weeks, start oral prednisolone 40 mg once a day, reducing by 5 mg per week, with bone protection, e.g. Accrete D3 1 tablet twice a day.

5. If Crohn's disease, start steroids and request non-acute gastroenterology assessment to consider starting an immunomodulator or biologic, or changing the current medications:
    - Oral prednisolone 40 mg once a day, reducing by 5 mg per week, with bone protection (e.g. Accrete D3 1 tablet twice a day) for ileal or colonic Crohn's disease.
    - Budesonide 9 mg per day for 8 weeks, reducing gradually over 2 weeks following treatment, as an alternative to prednisolone for ileal and proximal colonic Crohn's disease, with bone protection (e.g. Accrete D3 1 tablet twice a day).
6. If unsure about the best medication to use, seek gastroenterology advice from an IBD specialist nurse or request non-acute gastroenterology assessment.

Request

- If any concerning features, request acute general medicine assessment.
- If severe abdominal pain (possible toxic megacolon, perforation, bowel obstruction, abscess), request acute general surgery assessment.
- If first presentation of inflammatory bowel disease is highly likely, i.e. symptomatic, suspicious bloods, or faecal calprotectin greater than 150 microgram/g (exclude infective cause), request urgent gastroenterology assessment for colonoscopy.
- Request non-acute gastroenterology assessment if:
    - colorectal cancer may be a cause of the symptoms
    - a flare-up of Crohn's disease requiring steroids and for consideration of starting an immunomodulator or biologic, or changing the current medications
    - 2 or more flares within the past year, especially if steroids are used.
    - pregnancy is planned.
- If pregnancy has been confirmed, request non-acute obstetric assessment and non-acute gastroenterology assessment.
- Consider seeking gastroenterology advice from an IBD specialist nurse or requesting non-acute gastroenterology assessment about flare-ups or medication issues.

Information

For health professionals

Further information

- British Society of Gastroenterology – Guidelines for the Management of Hereditary Colorectal Cancer from the British Society of Gastroenterology (BSG)/Association of Coloproctology of Great Britain and Ireland (ACPGBI)/United Kingdom Cancer Genetics Group (UKCGG)
- Crohn's and Colitis UK – Healthcare Professionals
- European Crohn's and Colitis Organisation – Inflammatory Bowel Diseases: Published ECCO Guidelines
- Royal College of General Practitioners – Inflammatory Bowel Disease Toolkit
- Welsh Medicines Information Centre – Shared Care Protocols

For patients

Crohn's and Colitis UK – About Inflammatory Bowel Disease

SEND FEEDBACK

SOURCES

PAGE INFORMATION

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