Community HealthPathways North Cumbria

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.

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. 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 conditions, 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 culture and sensitivity
   - Stool – ova, cysts, and parasites if appropriate, e.g. overseas travel

- *Clostridium difficile* antigen test (via stoop test), if appropriate
- Faecal calprotectin if patient is younger than 50 years. Before ordering a calprotectin:
  - confirm faecal culture and sensitivity is negative.
  - stop NSAIDs for at least 4 weeks.

Management

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.

Initial management

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
  - faecal calprotectin greater than 250 microgram/g. An acute infection, e.g. campylobacter can cause elevated calprotectin.
- IBD is extremely unlikely if investigations are normal, including a faecal calprotectin 100 microgram/g or less.
- If the faecal calprotectin is:
  - between 100 and 250 microgram/g, repeat the test in 2 weeks. If it remains between 100 and 250 microgram/g on further testing, request non-acute gastroenterology assessment.
  - less than 100 microgram/g, a diagnosis of IBD is unlikely.

- has risen to over 250 microgram/g, request non-acute gastroenterology assessment.

4. If first presentation of inflammatory bowel disease is highly likely, i.e. symptomatic, suspicious bloods, or faecal calprotectin greater than 250 microgram/g (exclude infective cause), request urgent non-acute gastroenterology assessment.
5. If suspected colorectal cancer , request 2 week wait 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 and smoking cessation can significantly improve patient's symptoms.
2. Check medication compliance, side-effects, and drug monitoring. See Medications – Inflammatory Bowel Disease.
3. If starting steroid therapy or if any associated risk factors, e.g. low BMI or smoking, consider using FRAX scoring to assess the patient's risk of osteoporosis.
4. 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 or prolonged (longer than 3 months) 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 .

5. 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:
    - consider seeking gastroenterology advice or advise patient to discuss with their IBD consultant or a specialist nurse
    - signpost the patient to Crohn's and Colitis UK.
  - Before conception, good control of IBD is important.
  - 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 (5 mg) for women taking sulphasalazine or those with malabsorption following small bowel resection.
- When a pregnancy is confirmed, advise the patient to:
  - contact the midwife service as soon as possible.
  - inform their consultant or specialist nurse.

  If you have any concerns about the patient's disease activity or medication, consider seeking gastroenterology advice.

6. If the patient is taking immunosuppression drugs or biologics:
   - set up recalls and add alerts, e.g. Pneumovax, annual influenza vaccinations, and cervical screening if appropriate.

- see NECS Medicines Optimisation – Updated PGDs: Influenza (Seasonal Flu) Vaccines and Shingles (Herpes Zoster) Vaccine for eligibility information for herpes zoster vaccination.

Live vaccines are contraindicated in patients taking immunosuppressants.

7. Advise the patient that if indicated, secondary care will arrange colonoscopic surveillance .

> **Colonoscopic surveillance**
>
> There is increased risk of colon cancer for both ulcerative colitis and Crohn's disease.
>
> - 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 8 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. Surveillance is needed when the patient has a retained rectum after surgery.

8. Manage flare-ups .

> 1. If 2 or more flare-ups:
> - within the past year, request routine non-acute gastroenterology assessment for steroid-sparing treatments. In ulcerative colitis and Crohn's disease, long-term use or recurrent courses of steroids are not appropriate.
> - requiring maximal therapy, request routine non-acute gastroenterology assessment.
> 2. If concerning features (severe flare), seek acute gastroenterology advice or request acute general medicine assessment for intravenous steroids.
> 3. Arrange investigations .
>
> > **Investigations**
> >
> > - Faecal culture and sensitivity and *clostridium difficile (C. diff)* antigen. Relapses may be associated with pathogens or due to *C. diff* after antibiotics.
> > - Blood tests – FBC, CRP, LFTs, urea and electrolytes.
> > - If stool culture is negative and symptoms are not typical of a flare-up, consider sending a faecal calprotectin.
>
> 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. mesalazine 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 for one month, then reduce and stop. 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 colecalciferol with calcium carbonate for bone protection, e.g. Accrete D3 or Evacal D3 one 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 colecalciferol with calcium carbonate for bone protection (e.g. Accrete D3 or Evacal 3D one 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 colecalciferol with calcium carbonate for bone protection (e.g. Accrete D3 or Evacal D3 one tablet twice a day).
   - Alternative regimes may be suggested by the gastroenterology team depending on the patient and their previous treatment. If unsure which regime to use, seek gastroenterelogy advice via Advice and Guidance or IBD specialist nurse.
6. If unsure about the best medication to use, seek gastroenterology advice from an IBD specialist nurse or via Advice and Guidance.

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 250 microgram/g (exclude infective cause), request urgent non-acute gastroenterology assessment.
- If suspected colorectal cancer, request 2 week wait gastroenterology assessment.
- Request non-acute gastroenterology assessment if:
  - 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 flare-ups within the past year, for steroid-sparing treatments.
  - 2 or more flare-ups requiring maximal therapy.
- If on further testing, the faecal calprotectin:
  - remains between 100 and 250 microgram/g, request non-acute gastroenterology assessment.

  - has risen to over 250 microgram/g, request non-acute gastroenterology assessment.
- If concerning features (severe flare), seek acute gastroenterology advice or request acute general medicine assessment.
- Consider seeking gastroenterology advice:
  - if the patient is pregnant and you have concerns about the patient's disease activity or medication.
  - about flare-ups or medication issues, from an IBD specialist nurse or via Advice and Guidance.
- If any concerns in female patients planning a pregnancy, consider seeking gastroenterology advice or advise patient to discuss with their IBD consultant or a specialist nurse.

Information

For health professionals

Education

North Cumbria HealthPathways – Continuing Professional Development

Further information

- British Society of Gastroenterology – BSG Consensus Guidelines on the Management of Inflammatory Bowel Disease in Adults
- North Cumbria University Hospitals – BIS 39: Faecal Calprotectin Algorithm
- Royal College of General Practitioners – Inflammatory Bowel Disease Toolkit

Protocols and procedures

NECS Medicines Optimisation – Cumbria Shared Care Protocols

For patients

Crohn's and Colitis UK:

- About Crohn's and Colitis
- Pregnancy and IBD [includes information on medication and breastfeeding]

© 2023 HealthPathways. All rights reserved. | Terms of Use | View on classic HealthPathways

SEND FEEDBACK

SOURCES

PAGE INFORMATION

Last Updated:	17 August 2022
Last Reviewed:	06 July 2020
Keywords:	crohn crohn's crohns

Topic ID: 682276