

# The art of managing Crohn's disease

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Roy Pounder

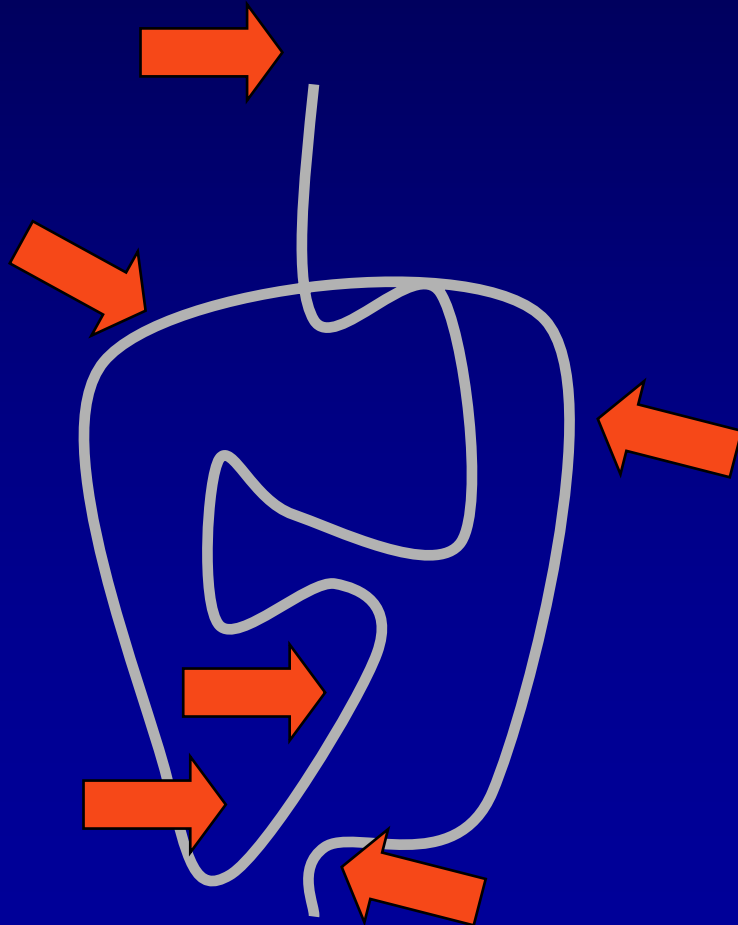
Emeritus Professor of Medicine

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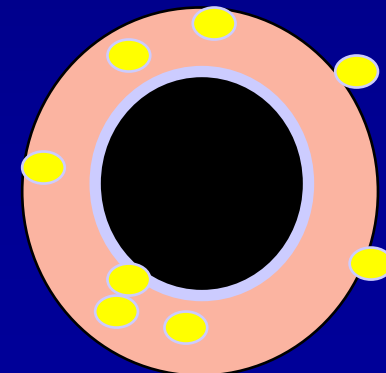
# Clinical features

## *Crohn's disease*

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- *Anywhere - mouth to anus*
- *Patchy disease*
- *Deep inflammation*
- *Granulomas*
- *Post-surgical recurrence*



# Ten steps on the ideal journey

(National Association of Colitis and Crohn's disease)

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1. Awareness of inflammatory bowel disease in primary care.
2. Tests without long delays.
3. Time to talk about the implications of diagnosis.
4. Introduction to the hospital team.
5. Specialist care for emergency admissions.
6. Steroid-free remission.
7. Joint decisions about surgery.
8. Clarity about responsibility for outpatient care.
9. Regular review with a strategic perspective – 'looking beyond the next appointment'.
10. Care for associated conditions.

# The physician's approach to IBD

- Be optimistic
- Be problem orientated
- Be cautious
- Collaborate
- Be available
- Provide confidence through information

# Provide confidence through information

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- Introduce every patient to a patients' group
- Provide an IBD Clinic leaflet, with contacts
- Provide specific leaflets:
  - Azathioprine / MP
  - Ciclosporin
  - Infliximab
  - Having a pouch
  - Travelling abroad
  - Pregnancy
  - Stricture diet
- Provide a 'yellow card'

UNIVERSITY DEPARTMENT OF MEDICINE  
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*INFLAMMATORY BOWEL DISEASE*

If you suffer a relapse of your inflammatory bowel disease you should phone

Professor R E Pounder's and Dr M Hamilton's  
Secretary (0171-830 2243)

who will arrange an urgent appointment.

*This emergency service is ONLY for your bowel condition - you MUST contact your family doctor about all other medical problems.*

Phone from 9.00 am to 5.00 pm (Monday to Friday) and be ready to tell the secretary

- your name
- your hospital number
- a telephone number, if possible
- that you have this YELLOW card

## **GUIDELINES**

# Guidelines for the management of inflammatory bowel disease in adults

M J Carter, A J Lobo, S P L Travis, on behalf of the IBD Section of the British Society of Gastroenterology

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*Gut* 2004;53(Suppl V):v1-v16. doi: 10.1136/gut.2004.043372



## **UK IBD Audit 2006**

### **National Results for the Organisation & Process of IBD Care in the UK**

**Prepared by  
The UK IBD Audit Steering Group  
on behalf of**

- **Association of Coloproctology of Great Britain and Ireland**
- **British Society of Gastroenterology**
- **Clinical Effectiveness & Evaluation Unit,  
Royal College of Physicians of London**
- **National Association for Colitis and Crohn's Disease**

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# Crohn's disease – out-patient care

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- Patients on immunosuppression having 3-monthly blood picture [90%].
- Patients receiving corticosteroids >3m [46%], but on anti-TNF [12%].
- On systemic steroids and bone protection [45%].
- Had bone densitometry within 12m of starting steroids [18%].

# Crohn's disease – in-patient care

- No smoking history [15%].
- Weighed [52%].
- Seen dietician [37%].
- Given DVT prophylaxis [38%].
- Laparoscopic elective surgery [12%].
- Post-resection: no 'protection' from recurrence [49%].

# Crohn's disease – research

- Admitted whilst receiving an investigational drug [ $<1\%$ ].

# Fulminating Crohn's disease

Identify all the problems:

- Inflammation
- Infection
- Malnutrition
- Anaemia
- Surgical issues

# Medical management of IBD

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## *Fulminating disease*

### – Assess the severity

- Serum albumin and CRP
- Fever
- Bowels open > 8x / 24h, especially at night
- Supine X-ray of abdomen [  $\pm$  CT ]
- Stool examinations

# Supine X-ray - fulminating colitis



# Colonic infection

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- *Salmonella sp.*
- *Shigella sp.*
- *Campylobacter jejuni*
- Enterohaemorrhagic *E.coli*
- *Clostridium difficile*
- Amoebiasis
- Tuberculosis

# Fulminating IBD

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## Initial treatment:

- Steroids (? adrenal insufficiency)
- Blood transfusion to 12g/dL
- Parenteral nutrition
- Antibiotics, especially metronidazole and ciprofloxacin
- Heparin / pressure stockings

# Fulminating colitis - antibiotics

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- Evidence-based advice
  - “Not routinely recommended”
- My advice
  - Give metronidazole (*C.difficile*, amoebiasis, and anti-anaerobe)
  - Give ciprofloxacin (*Salmonella*, *Shigella*, *Campylobacter*)

# Colectomy for Crohn's disease

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- May be life-saving.
- Cannot have later pouch.
- New ileostomy – check urinary sodium output before discharge, and in OPD follow-up – must be  $> 50\text{mmol/L}$ .

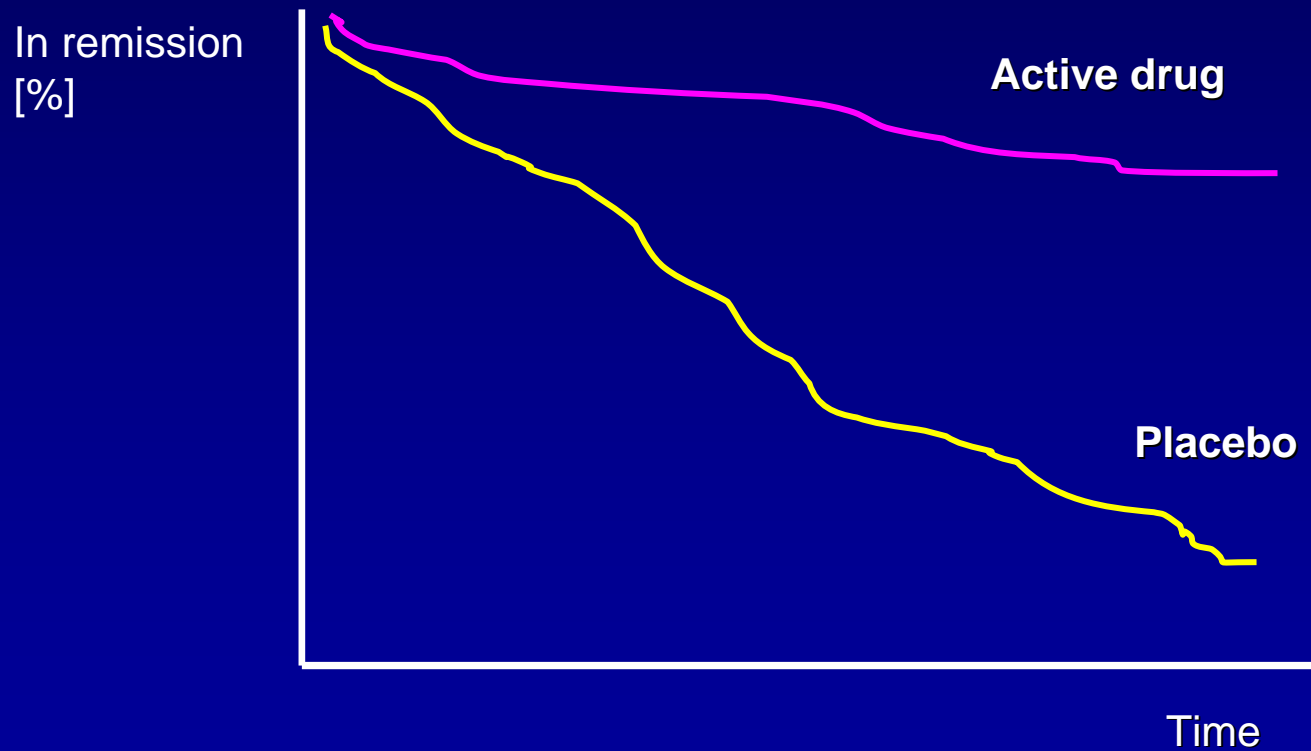
# 3-y mortality after colectomy for Crohn's disease

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- England (1998-2003).
- 23 464 people with hospital stay of more than three days for inflammatory bowel disease, including 5480 who had colectomy.
- Mortality three years after elective colectomy for Crohn's disease (3.3%) was significantly lower than that after either admission without colectomy (10.1%;  $P < 0.001$ ) or emergency colectomy (9.9%;  $P < 0.01$  for Crohn's disease).
- Three or more months after elective colectomy, mortality was similar to that in the general population.

# The case for maintenance treatment

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# Patients with Crohn's disease must not smoke

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“Smoking cessation unequivocally improves the course of Crohn's disease and should be a primary therapeutic aim in smokers with Crohn's disease.”

*Johnson et al, Aliment Pharmacol Ther. 2005;21: 921-31*

# Mesalazine for maintenance

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Oral 5-aminosalicylic acid for maintaining remission in ulcerative colitis

*Sutherland et al, Cochrane Database Syst Rev 2000; 2 :CD000544*

5-ASA in Crohn's disease

*Akobeng AK & Gardener E, Cochrane Database Syst Rev 2005;1:CD003715.*

# Crohn's disease

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- Corticosteroids

Review article: the limitations of corticosteroid therapy in Crohn's disease. Rutgeerts, *Aliment Pharmacol Ther* 2001; 15: 1515-25

- Azathioprine / mercaptopurine

Review article: practical management of inflammatory bowel disease patients taking immunomodulators. Siegal & Sands, *Aliment Pharmacol Ther* 2005;22:1-16.

# Azathioprine and mercaptopurine

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- Myelosuppression
- Nausea & vomiting
- Pancreatitis
- Infections
- *Give written warning to patient*
- Mercaptopurine, not 6-MP

## Review article: infliximab therapy for inflammatory bowel disease – seven years on

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Re-submitted 18 November 2005  
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### SUMMARY

Infliximab, the chimeric monoclonal IgG1 antibody to tumour necrosis factor, is indicated for refractory luminal and fistulizing Crohn's disease and extra-intestinal manifestations of inflammatory bowel disease. Recently, the active ulcerative colitis trials (ACT) studies have shown that infliximab is also efficacious to treat ulcerative colitis resistant to standard therapy. Induction with 5 mg/kg infliximab at weeks 0, 2 and 6 is advocated.

The response to infliximab is improved when concomitant immunosuppressive therapy is given. As the majority of patients will relapse if not retreated, a long-term strategy is necessary. Although episodic therapy can be used, the optimal strategy is systematic maintenance treatment with 5 mg/kg intravenous (i.v.) every 8 weeks. Long-term maintenance therapy with infliximab results in a reduction of the rate of complications, hospitalizations and surgeries associated with Crohn's disease.

Safety problems with the monoclonal antibody infliximab treatment mainly concern the formation of antibodies to infliximab, which may lead to infusion reactions, loss of response and serum sickness-like delayed infusion reactions. Latent tuberculosis needs to be screened for. The rate of other opportunistic infections is slightly increased mainly in patients treated concomitantly with immunosuppression. There is no evidence that malignancy rates in patients treated with antitumour necrosis factor strategies are increased.

*Aliment Pharmacol Ther* 23, 451–463

## Early combined immunosuppression or conventional management in patients with newly diagnosed Crohn's disease

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- 133 patients
- Treatment regimens:
  - infliximab and azathioprine, plus steroids if needed,
  - Escalation: steroids - azathioprine - infliximab

## Early combined immunosuppression or conventional management in patients with newly diagnosed Crohn's disease

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- 133 patients.
- Remission, off steroids, no surgery:
  - infliximab and azathioprine, plus steroids if needed: 60% at 6m, 62% at 12m [AE 31%];
  - escalation steroids - azathioprine - infliximab: 36% at 6m, 42% at 12m [AE 25%].

# What is the cause of IBD?

*Genes*

*Environment*

*Immunity*

*Cytokines*

# Summary

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- *Remember general principles*
  - information and availability
  - problem-orientated.
- *Fulminating IBD* – steroids, antibiotics, immunosuppression, or surgery?
- *Maintenance* – no smoking; mesalazine  $\pm$  azathioprine then infliximab, or *vice versa*?
- *Don't withhold surgery.*

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# Medical management of Crohn's disease

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## *Peri-anal sepsis in Crohn's disease*

- Avoid surgery if at all possible
- Get the whole patient better
- Metronidazole or ciprofloxacin