

CARE GUIDE for *Inflammatory Bowel Disease*

SUGGESTED GUIDELINES	PROCESS	IMPORTANT FINDINGS MEASUREMENTS AND VALUES	INTERVENTION	FOLLOW-UP
Inflammatory Bowel Disease (1,2,3)	<ul style="list-style-type: none"> Differentiate diagnosis IBD includes both Ulcerative Colitis (UC) and Crohn's Disease (CD) UC symptoms – bloody diarrhea, colicky abdominal pain, urgency, tenesmus CD symptoms – abdominal pain, fever, diarrhea and weight loss 	<ul style="list-style-type: none"> UC – diffuse mucosal inflammation limited to the colon. CD – patchy trans-mural inflammation affecting any part of GI tract. Upper and lower endoscopy may confirm diagnosis 	<ul style="list-style-type: none"> Coordinate care with GI specialist Colonoscopy with ileoscopy should be performed. Multiple mucosal biopsies should be taken Capsule endoscopy (intestinal capsule camera) may be useful in the diagnosis of CD (allows a look at the small bowel) 	<ul style="list-style-type: none"> Treatment based on clinical symptoms and findings
Medical Treatment ^(1,3,4)	<ul style="list-style-type: none"> Severity of symptoms varies over time. Treatment needs to address whether symptoms are mild, moderate, severe, and if the condition is fulminant or in remission 	<ul style="list-style-type: none"> Presence and amount of: <ul style="list-style-type: none"> ➤ fever, nausea, vomiting, obstruction, bleeding, adequacy of oral intake, etc. will determine appropriate treatment 	<ul style="list-style-type: none"> For UC: <ul style="list-style-type: none"> ➤ aminosalicylates ➤ corticosteroids ➤ immunomodulators ➤ infliximab For Crohn's: <ul style="list-style-type: none"> ➤ aminosalicylates ➤ corticosteroids 	<ul style="list-style-type: none"> Monitor for complications of immunosuppressant therapy Adjust treatment as needed to achieve the goal of induction and maintenance of remission of

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			<ul style="list-style-type: none"> ➤ antibiotics ➤ immunomodulators ➤ infliximab ➤ adalimumab <p>Avoid NSAIDs</p>	symptoms.
Nutritional Status ^(1,5)	<ul style="list-style-type: none"> • Assess nutritional status 	<ul style="list-style-type: none"> • Assess BMI (body mass index) on diagnosis and periodically • Assess vitamin D levels • Measure B-12 annually in patients with ileal CD 	<ul style="list-style-type: none"> • Refer to dietitian • Address nutritional deficits • Dietary supplements as indicated 	<ul style="list-style-type: none"> • Monitor for improvement in nutritional status
Other Extra-intestinal manifestations ⁽⁹⁾	<ul style="list-style-type: none"> • Identify potential complications early 	<ul style="list-style-type: none"> • Arthritis (25%) <ul style="list-style-type: none"> ➤ peripheral, axial, ankylosing spondylitis • Eye disorders (10%) <ul style="list-style-type: none"> ➤ uveitis, keratopathy, episcleritis, dry eyes, eye disorders related to treatment of IBD • Liver disease (5%) <ul style="list-style-type: none"> ➤ hepatic steatosis, primary sclerosing cholangitis (PSC), gallstones, pancreatitis, chronic active hepatitis (usually B or C), skin disorders • Skin disorders (5%) <ul style="list-style-type: none"> ➤ erythema nodosum, 	<ul style="list-style-type: none"> • Treat or refer to specialist if indicated 	<ul style="list-style-type: none"> • As needed

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		<p>pyoderma gangrenosum, enterocutaneous fistulas, skin tags, anal fissures, aphthous stomatitis, other infrequent disorders related to nutritional deficiencies and/or medications used to treat IBD</p> <ul style="list-style-type: none"> • Bone loss (30% - 60%) • DVT or pulmonary embolism 		
Osteoporosis ⁽⁶⁻⁹⁾	<ul style="list-style-type: none"> • Pts with IBD are at increased risk for osteoporosis. Use of corticosteroids increases the risk for osteoporosis 	<ul style="list-style-type: none"> • DEXA should be ordered for patients who have experienced a vertebral fracture, are postmenopausal, or have been on chronic corticosteroid therapy (>3months) • Diagnostic category based on T scores 	<ul style="list-style-type: none"> • Supplemental calcium and Vit D • Exercise • Smoking cessation • Bisphosphonates • Educate about prevention and treatment goals • Hormone replacement (estrogen or testosterone) 	<ul style="list-style-type: none"> • As needed
Cancer Surveillance ^(1, 2)	<ul style="list-style-type: none"> • Pts with UC and extensive CD have increased risk of colon cancer • Routine colonoscopy is indicated 	<ul style="list-style-type: none"> • Multiple mucosal biopsies (minimally 32 biopsy samples in patients with UC or extensive CD) should be taken on colonoscopy. Pathology findings on biopsy may indicate the need for colectomy. 	<ul style="list-style-type: none"> • Colonoscopy (with biopsies) of entire colon 8 – 10 years after diagnosis and then every 1 – 2 years thereafter 	<ul style="list-style-type: none"> • Findings on colonoscopy may require earlier follow-up

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Cigarette Smoking ^(1, 3)	<ul style="list-style-type: none"> Cigarette smoking exacerbates CD 	<ul style="list-style-type: none"> Patient history 	<ul style="list-style-type: none"> Smoking cessation especially for people with CD 	<ul style="list-style-type: none"> Ongoing support for smoking cessation NOTE: Patients with UC may suffer an exacerbation of symptoms with smoking cessation
Patient Education ^(1, 9)	<ul style="list-style-type: none"> Patient education is an important part of managing IBD. These diseases are not curable, and often affect young patients 		<ul style="list-style-type: none"> Patients may be given educational material or referred to such organizations as the National Crohn's and Colitis Foundation of America http://www.ccfa.org/ 	

Reference List

<p>1. Kornbluth A, Sacher D. Ulcerative Colitis Practice Guidelines in Adults: American College of Gastroenterology, Practice Parameters Committee. American Am J Gastroenterol 2010; 105:501–523; doi: 10.1038/ajg.2009.727; http://www.acg.gi.org/physicians/guidelines/UlcerativeColitis.pdf</p>	<p>6. American Gastroenterological Association medical position statement: guidelines on osteoporosis in gastrointestinal diseases. Gastroenterology. 2003; 124:791-94. [AGA Guideline 2003]</p>
<p>2. Leighton JA, Shen B, Baron TH, Adler DG, Davila R, Egan JV et al. ASGE guideline: endoscopy in the diagnosis and treatment of inflammatory bowel disease. Gastrointest Endosc. 2006; 63:558-65. [Leighton JA, Gastrointest Endosc]</p>	<p>7. Bernstein C, Leslie W. AGA Technical Review on Osteoporosis in Gastrointestinal Disease. Gastroenterology. 2003; 124:795-841. [Bernstein C, Gastroenterology]</p>
<p>3. Lichtenstein G, Hanauer S, Sandborn W and the Practice Parameters Committee of the American College of Gastroenterology. Management of Crohn’s Disease in Adults. Am J Gastroenterol advance online publication, 6 January 2009; doi: 10.1038/ajg.2008.168. http://www.acg.gi.org/physicians/clinicalupdates.asp#guidelines</p>	<p>8. Compston J. Osteoporosis in Inflammatory Bowel Disease. Gut. 2003; 52:63-64. [Compston J, GUT 2003]</p>
<p>4. Lichtenstein GR, Abreu MT, Cohen R, Tremaine W. American Gastroenterological Association Institute medical position statement on corticosteroids, immunomodulators, and infliximab in inflammatory bowel disease. Gastroenterology. 2006; 130:935-39. [Lichenstein GR, AGA Guideline]</p>	<p>9. Crohn’s & Colitis Foundation of America. http://www.ccfa.org/info/about/complications/</p>
<p>5. Carter MJ, Lobo AJ, Travis SP. Guidelines for the management of inflammatory bowel disease in adults. Gut. 2004; 53 Suppl 5:V1-16. [Carter MJ, GUT 2004]</p>	