Inflammatory Bowel Disease: What the primary care physician may need to know

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Scope

• 1700 patients 650 CD 1050UC
  – 100 admissions per year
  – 100 new cases per year
  – 2000 outpatient appointments
  – 800 IBD specialist nurse contacts
  – 85 patients on biologic treatment and rising
  – 10 resectional and reconstructive surgeries
  – 45 perianal disease surgery
  – 40% of our young pts are not working regularly

The Service

• IBD Service
  – 1 IBD nurse specialist
  – 5 gastroenterologists
  – 2 colorectal surgeons
  – 2 radiologists
  – 1 histopathologist
  – Cognitive behavioural therapist
  – Enhanced recovery nurse
  – 2 stoma nurses
  – Dietician

• IBD Multidisciplinary clinic
• IBD multidisciplinary meeting
• IBD nurse clinic and telephone contact
• General gastroenterology clinics
Ulcerative colitis

- Presents at any age
- Can involve any length of the colon but almost always involves rectum
- Extra-intestinal manifestations in 5-10%
  - Arthralgia
  - Iritis
  - Ank Spond
  - Primary sclerosing cholangitis
  - Skin-EN, pyoderma
What the primary care physician needs to know UC: diagnosis

• Diagnosis straightforward
• Diarrhoea = 3 or more loose bowel motions per day 6 or more days per week
• Typical presentation with bloody diarrhoea
  – No need to do faecal calprotectin
• Not all cases have bloody diarrhoea
• Suspect if diarrhoea lasting more than one week
• Short time from symptom onset to diagnosis
• Always do stool culture especially if Hx of foreign travel
UC: what the GP needs to know: common treatments and important side-effects

• Mesalazines
  – Interstitial nephritis
  – diarrhoea

• Prednisolone
  – Long-term use hypertension, oesteoporosis, diabetes
  – Short and long-term
    • Infection- VZ, other bacterial and viral infections especially at doses >20mg per day

• Thiopurines (Azathiaprine, mercaptopurine)
  – Low WCC, headaches, nausea, rashes, abdo pain incl pancreatitis, abn LFTs
  – Skin cancer (not melanoma)
  – Viral infections
  – Non-Hodgkins lymphoma
    • Young EBV neg males and older males >55
  – Cervical cancer

• Anti-TNFs
  – Bacterial infection esp pulmonary including TB
  – No clear relation to cancer risk
Managing of UC flares in general practice: severity of flare and risk profile dictate Rx

• **Severity(acutely)**
  – >6x bloody bowel motions per day with any evidence of systemic toxicity (p>90, fever >37.5, p>90, CRP >20, alb<35)
  – Moderate 4-6 bloody bowels no toxicity
  – Mild <4 bloody bowels

• **High risk(increased chance of developing severe colitis or needing colectomy):**
  – Extensive colitis(involving TV colon and beyond)
  – Previous course of steroids within past 12 months
  – Young age of onset <18
  – On immunomodulators

• **Low risk**
  – L sided disease
  – More extensive disease not requiring steroid treatment for 1-2 years
  – Pts on immunomodulators stable for 2 years

• **Management of mild/moderate acute flares in low risk patients in primary care**
  – **Initial treatment:**
    • If on 5 ASA increase dose to maximum 4.8g/day Asacol,
    • If L sided disease add 5ASA enema once a day or 5ASA supp or if on maintenance rectal Rx add maximum strength oral 5ASA
    • If no response within 2 weeks or already on max dose 5ASA start Prednisolone 40mg per day 8/52 tapering + Adcal D3 + Ranitidine 300mg nocte
  – **Reassess after 2/52:** response=improvement remission= 3 or fewer bloodless BO/day
    • Response continue maximal therapy for 8/52 and then maintenance
    • If no response refer to hospital IBD help line
    • If given steroids remission is expected by 2 weeks-if not refer hospital
    • Full improvement with enemas or 5ASA may take longer and effect generally maximal after one month. If not in remission after one month

• **High risk patients and severe flares in previously low risk patients or any flare in patient on immunomodulators**
  • refer to hospital IBD help line
Annual review of UC in General Practice: scope of this currently under discussion

- Low risk UC as defined (currently being discussed):
  - L sided disease
  - More extensive disease not requiring steroid treatment for 1-2 years
  - Pts on immunomodulators stable for 2 years
- Annual blood tests
  - FBC: If drop in Hb refer back- could reflect disease activity and/or need for parental iron
  - U&E : If rise in creatinine > 20% above baseline refer for renal opinion, repeat for lesser degrees(5ASA interstitial nephritis)
  - LFTs: If an increase refer back(Sclerosing cholangitis)
  - Haematinics B12(ileal Crohn’s), ferritin.
- Annual immunisations:
  - Flu and pneumococcus
- Cervical screening for patients on immunomodulators
- Screening colonoscopy
  - Scheduled by hospital-after 10 years and then 1-5 yrly depending on findings
- Refer back to hospital if: pregnancy, suspected extra-intestinal manifestations, any other concerns. IBD helpline first port of call
- For pts on immunomodulators refer back to hospital at age 55 for consideration of stopping
- For shared care of patients on immunomodulators see Shared Care Pathway
Crohn’s disease

- Tends towards younger people affecting any part of the gut, terminal ileum and caecum most commonly
- Increasingly being diagnosed in older people related to obesity
- Severe younger onset from associated with low BMI high risk for surgery
- 25-30% will have perianal disease
- 20% will develop other internal fistulas or intra-abdominal collections
- Extra-intestinal manifestations similar to UC but less common
Crohn’s disease classification

- **Age at onset**
  - <18
  - 18-40
  - 40+

- **Disease behaviour**
  - Inflammatory
  - Stenosing
  - Fistulating

- **Location**
  - Ileal (only if associated with stricturing or fist)
  - Ileocolonic (only if associated with stricturing or fist)
  - Colonic
  - Upper GI

- **Perianal disease**

- **Approx 20-30% of pts run a benign course**
- **60-70% have significant risk of complications (strictures, fistulas**
- **30% of pts ‘cured’ by surgery**
CD diagnosis: what the GP needs to know

• From symptom onset to diagnosis up to 2 years
• May be pain (typically RIF), +/- diarrhoea, episodes of acute bowel obstruction
• Associated features – perianal abscess, mouth ulcers, weight loss
• Faecal calprotectin useful but less sensitive than in UC
• CRP also useful
• US provides no reassurance
Primary care role in management
more limited but a subgroup with

- Patients suitable for primary care FU
  - Mild colonic Crohn’s
  - Pts stable for >2yrs
  - Pts stable on immunomodulators for > 2yrs
  - Older age of onset >40

- Annual vaccinations
- Rapid referral back for new symptoms
- FBC, U&E, LFT B12, folate, ferritin
- If on immunomodulators consider opinion re continuing after age 55
- Cervical cancer screening for pts on immunomodulators
- Screening colonoscopy will be organised by hospital
Questions?
The IBD Nurse Specialist Service