Southern Health and Social Care Trust

IBD

Dr Andrew Murdock
Consultant Gastroenterologist

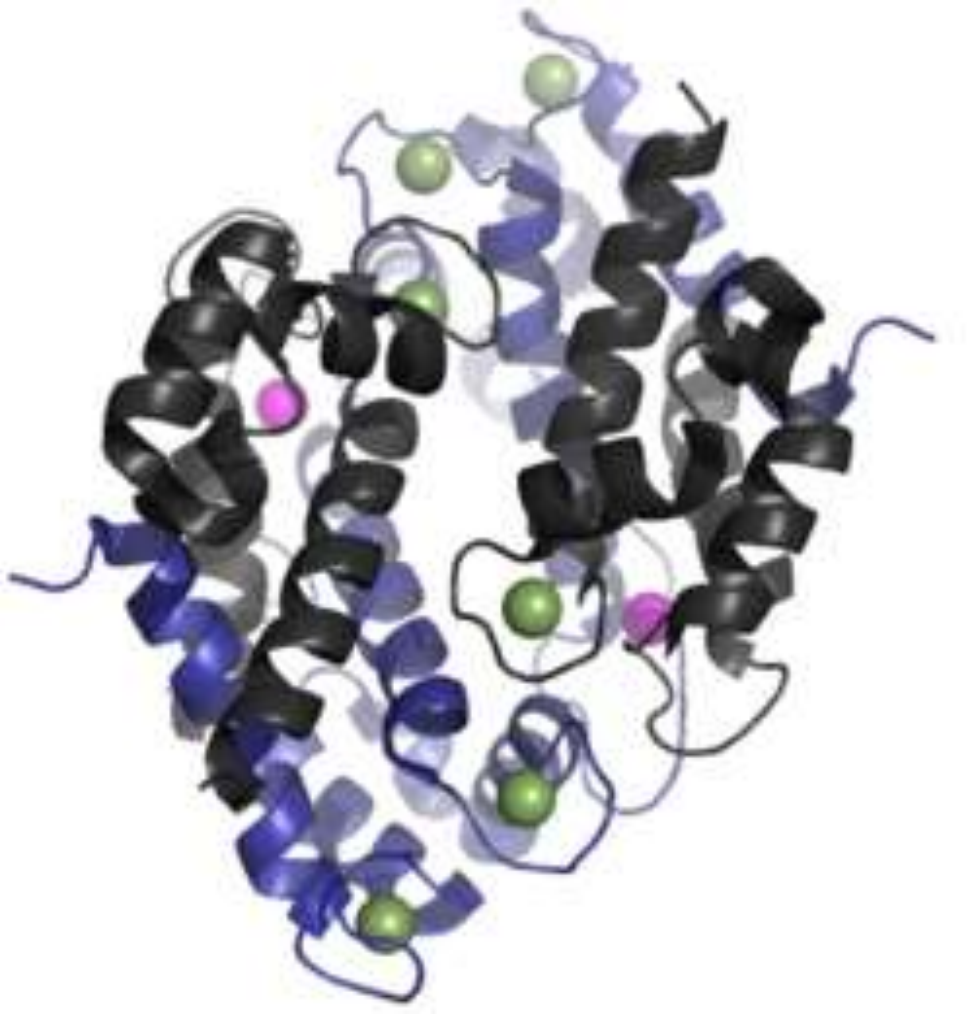


Agenda


• Faecal Calprotectin
• Pathways
• Flare management
• Questions

Calprotectin

- Ca & Zn binding protein of the S-100 protein
- Mainly found within neutrophils
- Presence of Calprotectin in faeces is a consequence of neutrophil migration into the gastrointestinal tissue due to an inflammatory process.



FC has high sensitivity and lower specificity in identifying mucosal inflammation,

CRP has the opposite characteristics: it has higher specificity but low sensitivity



- **Recommendations**
- Faecal calprotectin testing is recommended as an option to support clinicians with the differential diagnosis of IBD or IBS in adults with recent onset lower gastrointestinal symptoms for whom specialist assessment is being considered, if:
- cancer is not suspected, having considered the risk factors (for example, age) described in the NICE guideline on suspected cancer **and**
- appropriate quality assurance processes and locally agreed care pathways are in place for the testing.

- Age is important – calprotectin is used in Lothian for patients under 50 with new lower GI symptom

FC elevation – inflammation specific not disease specific

- Coeliac disease
- Infective colitis
- Diverticulitis
- Cirrhosis
- Pancreatic exocrine insufficiency
- Microscopic colitis
- Colonic adenomas & colorectal cancer
- Peptic ulcer disease
- Acute appendicitis
- PPI use
- NSAID use
- Cystic Fibrosis
- Smoking
- Higher BMI

A policeman sees a drunk man searching for something under a streetlight and asks what the drunk has lost.

He says he lost his keys and they both look under the streetlight together.

After a few minutes the policeman asks if he is sure he lost them here, and the drunk replies, no, and that he lost them in the park.

The policeman asks why he is searching here, and the drunk replies, "this is where the light is"



Original article

Unrestricted faecal calprotectin testing performs poorly in the diagnosis of inflammatory bowel disease in patients in primary care

Samantha Conroy [1], Melissa F Hale [1], Simon S Cross [2], Kirsty Swallow [3], Reena H Sidhu [1], Ravishankar Sargur [3], Alan J Lobo [1]

Correspondence to Profosser Alan J Lobo, Gastroenterology Unit, P Floor Royal Hallamshire Hospital, Sheffield S10 2JF, UK; alan.lobo@sth.nhs.uk

BMJ Learning | Take the Test

Conclusions FC testing in primary care has low sensitivity and specificity with poor PPV for diagnosing IBD. Its use needs to be directed to those with a higher pretest probability of disease. Local services and laboratories should advise general practitioners accordingly.

Question	Answer
Referred-To DEP	ST CAH GASTROENTEROLOGY
Provisional diagnosis (reason for referral)	Provisional Diagnosis: ongoing raised faceal calproectin
Additional information	Additional Information: Dear Colleague, Thank you for seeing this 59 year old lady. In may this year she developed diarrhoea for 3 weeks and bowels were moving 4 times a day associated with some abdomen cramping before bowel moved. Her abdomen exam was
	NAD and PR showed piles. Her bowel screening showed camplyobacter at the time. Her symptoms all resolved at the end of may and she has felt well since. However her faceal calprotectin in may was 753 and june was 233 and july was 49.1 and august was 67.5.
	It was repeated numerous times as was felt to be faised secondary ro campylobacter infection but as has all resolved now for 2 months and reading remains raised at 67.5 i would be grateful for your advice

Referred-To DEP	ST CAH GASTROENTEROLOGY
Provisional diagnosis (reason for referral)	Provisional Diagnosis: ?IBD
Additional information	Additional Information: 70 year old lady. - Has previously been referred to GI by A&E and on waiting list for OGD. - Complaining of reflux, nausea, epigastric discomfort, headaches. - Sometimes nausea 2/52 intermittently. No vomit. - 2/52 bowels either
	loose or constipated. - BO - ''Scanty bits''. BO - 5-6 times today. Loose. Taking laxatives when constipated. - No mucus in stools. - No dysphagia. - No change in appetite or weight. - E+D. - Tongue is sore. Got nystatin for it. - Exam by colleague: abdo
	soft - tender epigastric area and over sternal area on palpation, nil pain on deep inspiration, abdo minimal tenderness LLQ, no guarding. chest clear. mouth - tongue red/describes white coating that she has removed with toothbrush - still very
	sensitive. - Faecal calprotectin - 71 - 10/7/26. - Repeated and Faecal calprotectin - 237 - 28/07/2026. - I would appreciate investigation into this. - Many thanks - - -

Referred-To DEP	ST CAH GASTROENTEROLOGY
Provisional diagnosis (reason for referral)	Provisional Diagnosis: weight loss, abdominal discomfort & raised faecal calprotectin
Additional information	Additional Information: feels full of wind with crampy tummey , bo x 3 times every morning longterm. feels this upset is since omeprazole was changed to esomeprazole. - Nil of note on examination. - Has lost 3-4 kg since Feb-normal QFIT & coeliac screen, normal Hb. - Raised faecal calprotectin x 2 now; 245 now 123

Question	Answer
Referred-To DEP	ST CAH GASTROENTEROLOGY
Provisional diagnosis (reason for referral)	Provisional Diagnosis: Liver cirrhosis, Bowel symptoms, raised calprotectin
Additional information	Additional Information: Dear Colleague - Would it be possible for this man to be seen at clinic and advice given re further management of his liver condition and bowel symptoms? - He was originally referred in Sept 2025 due to anaemia/bowel symptoms. Sept 2025 Colonoscopy- diverticular disease- OGD- varices and gastritis- he has a known history of fatty liver and I note his fibroscan results are in keeping with likely cirrhosis. - He had a CT abdomen during inpatient admission with fall in Dec 2025 - this showed thickening and fat stranding of the ascending colon ? infection ?inflammation. - He is currently c/o worsening loose motions, faecal urgency and occasional incontinence. - Calprotectin has been slightly elevated x 2 (58, rpt 81)- Q fit negative Hb N CRP N. - We would appreciate advice re further management of his symptoms and optimisation of his liver issues.

FC monitoring IBD remission

UC Pragmatic approach

FC <100 µg/g likely in endoscopic remission,

FC 100–200 µg/g intermediate probability of endoscopic remission

FC >200 µg/g to have a low likelihood of endoscopic remission

FC >200 µg/g should trigger a discussion about lower gastrointestinal endoscopy

FC 100–200 µg/g in an otherwise well patient, should prompt a test within a reasonable time frame

Reliable indicator of remission in Crohn's disease,

There is considerable disagreement in the cut-off values in Crohn's disease,

May be dependent on disease location.

Changes in an individual's faecal calprotectin over time may be more meaningful than absolute numbers.

PRIMARY CARE DIAGNOSTIC PATHWAY FOR LOWER GASTROINTESTINAL (GI) SYMPTOMS IN ADULTS (NOT FOR ACUTELY UNWELL PATIENTS)

Click the pointer for hyperlinks

FOR USE BY PRIMARY CARE TEAMS. APRIL 2024.

RED FLAG COLORECTAL CANCER SYMPTOMS

A FIT in primary care to support asessment of colorectal cancer may be needed.

Follow country cancer pathway:
England, Scotland, Wales, Northern Ireland

RED FLAG OVARIAN CANCER SYMPTOMS

CA125 blood test in primary care will support need for an ovarian cancer referral.

Follow country cancer pathway:
England, Scotland, Wales, Northern Ireland

SCAN ME

COMMON SYMPTOMS OF LOWER GI CONDITIONS

- Change in bowel habit, for example, frequency, urgency, faecal incontinence, tenesmus
- Abdominal pain, cramping, bloating, excessive wind
- Rectal bleeding
- Weight loss
- Mucus in stools/fatty stools

Symptoms may also include:

- Reduced appetite
- Nausea with or without vomiting
- Symptoms made worse with eating
- Persistent mouth ulcers
- Ongoing fatigue

COULD IT BE SELF LIMITING?

Consider duration of symptoms and history.

If less than two weeks duration consider, for example, recent travel, changes in diet, alcohol, medications, infection causing gastroenteritis, menstrual symptoms, possibility of haemorrhoids and fissures.

Consider if stool test necessary to exclude infection. See also INVESTIGATIONS.

If cancer is not being considered

The main forms of IBD are Crohn's Disease and Ulcerative Colitis. More rarely, Microscopic Colitis.

COULD IT BE INFLAMMATORY BOWEL DISEASE (IBD)?

IBD often presents with diarrhoea, abdominal pain, rectal bleeding or weight loss, but may also present with common symptoms in the box above.

Presents at any age but mainly 18-35, with a second peak in 65+. Family history increases risk.

POTENTIAL DISTINGUISHING SYMPTOMS:

Nocturnal defecation, fevers, recurrent/persistent anal abscesses, extra intestinal manifestations in joints, skin, eyes or perianal area. Microscopic colitis, mainly in women 50+, presents as isolated watery diarrhoea.

COULD IT BE COELIAC DISEASE?

Coeliac disease occurs in 1 in 100 people and is undiagnosed in two thirds of cases. It can present in non-specific ways, including the common symptoms in the box above. Family history increases risk (first degree relative 1 in 10 risk).

More likely with Down's/Turner syndromes or history of autoimmune conditions e.g. type 1 diabetes, thyroid disease. Associated with iron deficiency anaemia or B12 or folate deficiency.

POTENTIAL DISTINGUISHING SYMPTOMS:

Dermatitis herpetiformis, tooth enamel problems, reduced bone mineral density, unexplained subfertility or repeated miscarriages, neurological problems such as unexplained ataxia or peripheral neuropathy.

COULD IT BE IRRITABLE BOWEL SYNDROME (IBS)?

IBS is a longstanding illness with frequent abdominal discomfort and bowel symptoms that cannot be explained by any other disease. It is uncommon for people over 50 to present with IBS for the first time. Extraintestinal features are common including: lethargy, nausea, back pain, headache or bladder symptoms.

GI PRESENTATION:

- Abdominal pain or discomfort (present for at least 6 months) and relieved by defecation or associated with altered bowel frequency or stool form.
- Altered stool passage (straining, urgency, incomplete evacuation).
- Abdominal bloating (more common in women than men).
- Passage of mucus.

Based on history and appropriate clinical examination, consider which primary care lower GI investigations are needed to support the clinical assessment of your patient.

POSSIBLE PRIMARY CARE LOWER GI INVESTIGATIONS

BASELINE BLOOD TESTS:

- **Full Blood Count and Ferritin:** looking for anaemia or infection or systemic inflammation.
- **C-reactive protein:** tests for inflammation and autoimmune disease.
- **Coeliac screen:** advise patient not to eliminate or reduce gluten from their diet.
- **Thyroid Function Tests:** to exclude hyperthyroidism as a cause of diarrhoea and hypothyroidism as a cause of constipation.
- **Renal and Liver Function Tests** including albumin and calcium.

STOOL TESTS:

- **Stool sample to test for infection.** If not already excluded, use to eliminate infective causes. Consider also parasites and if specific tests need to be requested e.g. *C. difficile*.
- **Faecal calprotectin** and/or **Faecal Immunochemical Test** (FIT) to support diagnosis or exclusion of IBD, request according to local pathway guidance.

[No Title]

To avoid the patient making multiple trips aim to do all necessary tests at the same time.

A negative bowel cancer screening programme FIT does not mean a patient who presents with symptoms does not have colorectal cancer. Symptomatic thresholds for a positive result are lower than the thresholds used in national bowel cancer screening programmes.

- Coeliac screen positive. REFER to secondary care for diagnosis. If secondary care confirms Coeliac diagnosis, treat with a gluten free diet with dietetic support (as per National/local guidance).
- Coeliac screen negative. See pink dotted border box below and SAFETY NETTING.

Encourage the patient to take gluten in their diet until secondary care confirms diagnosis to avoid false negative.

- Once faecal calprotectin or FIT results are available, refer to local pathway guidance for the appropriate action.
- If faecal calprotectin and FIT are normal for your reference range, see pink dotted border box below and SAFETY NETTING.

Exact thresholds for faecal calprotectin and FIT may vary and should be based on local assays and audit data

- After alternative conditions considered and if baseline tests suggest, make a positive diagnosis of IBS and treat in primary care. SEE SAFETY NETTING.

Woman aged 50 or over with new IBS symptoms in the previous 12 months should be tested for ovarian cancer.

SAFETY NETTING

- **if symptoms persist or symptoms change – reassess (even if tests were negative) and consider referral**
- referrals should be based on clinical need
- if severe symptoms – urgent GI referral may still be needed

IF SYMPTOMS SUGGEST, CONSIDER:

- upper GI cancer e.g. pancreatic or gastric cancer, or cancers of other systems
- non-site specific cancer pathway referral for persistent concerning symptoms
- negative or normal stool tests and ongoing symptoms – could still be IBD or cancer
- false negative Coeliac screen – too little gluten in diet, IgA deficiency (test for total IgA and IgG based serology)
- severe IBS symptoms may need a GI referral to optimise treatment
- conditions of other systems, e.g. gynaecological, liver, renal
- HIV screening for chronic diarrhoea

COULD IT BE ANOTHER LOWER GI CONDITION?

Other conditions may also cause similar symptoms to IBS but not respond to symptomatic, supportive treatment. Multiple lower GI conditions are possible at the same time.

- **microscopic colitis**, if persistent loose watery diarrhoea (exclude by biopsy, faecal calprotectin can be normal)
- **bile acid malabsorption**, common after cholecystectomy
- **diverticulitis**
- **small bowel bacterial overgrowth**
- **pancreatic insufficiency**, often causes weight loss, test for faecal elastase

For more information, visit www.whatsupwithmygut.org.uk

CROHN'S & COLITIS UK · coeliac uk live well gluten free · GUTS UK! · ibsnetwork · cicra · The Association of Coloproctology of Great Britain and Ireland · bsg · BSPGHAN · RCGP Royal College of General Practitioners

NICaN Lower GI Suspected Cancer Pathway (June 2024)

Patient with signs or symptoms of possible colorectal cancer

Rectal Bleeding
- New onset, persistent and unexplained

Change in Bowel Habit
- Persistent change in bowel habit especially towards looser stools (more than 4 weeks)

Mass
- Abdominal mass
- Ano-rectal mass/ulcer

Anaemia without other likely cause
- Iron deficiency anaemia OR microcytic anaemia. (Consider prescribing oral iron).

Other
- Abdominal pain and weight loss

(Consider Upper GI referral if necessary; best investigations are usually CT CAP & OGD if/when available)

Investigations / Examination

qFIT (symptomatic test c/o GP) is only for patients with signs & symptoms of colorectal cancer & it should not be sent in their absence

ESSENTIAL investigations / examination:
- **qFIT ***
- **Full Blood Count**
- **Ferritin**
- **U+E**
- **Digital Rectal Examination**

Recommended investigation: Coeliac profile (if IDA, weight loss or diarrhoea).

*If patient is unable to complete qFIT, please make clear why on referral.
If patient does not return qFIT when requested please reassess with safety netting.

qFIT used when no signs or symptoms

If qFIT is sent in the absence of signs or symptoms & result >10 µg Hb/g, the referral will only be processed if it is >120 µg Hb/g in patients aged 60 to 74 years (screening parameters). Outside these parameters the referral will not be triaged red flag & the GP will be asked to discuss with and/or reassess the patient.

Symptoms after normal screening test

qFIT should be offered to newly symptomatic patients [illegible] person has a negative qFIT result through NI [No Title] cer Screening (screening test has different threshold) https://www.nidirect.gov.uk/bowel-screening

Symptomatic high-risk features

Does this symptomatic patient have any of the following high-risk features?
- qFIT ≥10 µg Hb/g faeces
- Ano-Rectal mass / ulcer
- Abdominal mass
- Iron deficiency anaemia OR microcytic anaemia

No

No high-risk features

Patients with a qFIT result <10 µg Hb/g, no anaemia and no mass, are highly unlikely to have significant bowel pathology. Referral on an urgent or routine basis may occasionally be warranted.

Continue to manage patient's lower gastrointestinal symptoms as clinically indicated. For more advice & guidance please see NICaN webpage.

Patients with new, persistent and unexplained rectal bleeding should have a qFIT. If the result is <10 µg Hb/g consider urgent referral or safety netting.

Yes

Red Flag Referral

Red flag referral to your local trust via CCG.

Please ensure blood, qFIT test & DRExam results are attached on the INITIAL SINGLE REFERRAL to facilitate optimal triage outcome, which may result in your patient being sent direct to test.

Please consider and document fitness for investigation if referring.

Ongoing Concern

Patients with lower GI symptoms who can't be managed suitably via general practice should be considered for referral to Gastroenterology.

If there is significant clinician concern after two qFIT results <10 µg Hb/g, two months apart, red-flag referral will be appropriate.

DIAGNOSING IBD

RCGP LEARNING

KEY FEATURES

Demographic	Main gastrointestinal symptoms	Other common symptoms
• Mainly teens/twenties for ulcerative colitis (UC)/Crohn's • Microscopic colitis mainly women 50+ • Can be any age • Family history ^risk, especially Crohn's	• Diarrhoea • Abdominal pain • Rectal bleeding • Aphthous (mouth) ulcers • Bloating • Constipation	• Delayed growth (children) • Weight loss • Lethargy • Fevers • Night sweats

WORKUP

Investigations	Refer for suspected cancer (NICE)
• FBC • Ferritin/Iron studies • ESR/CRP • Coeliac screen • Faecal immunochemical test (FIT) • Faecal calprotectin • Faecal microscopy & culture	Offer FIT test to guide referral for suspected cancer to adults:(NICE) • With an abdominal mass. • With a change in bowel habit. • With iron deficiency anaemia. • Aged 40 and over with unexplained weight loss and abdominal pain • Aged under 50 with rectal bleeding and unexplained abdominal pain or weight loss • Aged 50 and over with unexplained rectal bleeding, abdominal pain or weight loss • Aged 60 and over with anaemia even in the absence of iron deficiency. refer for suspected colorectal cancer if the FIT test is 10mcgHb/g of faeces or more.

NEXT STEPS

Differentials	Increased suspicion of IBD	Extra-intestinal manifestations
• Irritable bowel syndrome (IBS) – can co-exist • Colorectal cancer • Coeliac disease • Endometriosis • Ovarian cancer	• Unexplained fever • Weight loss • Anaemia • Family history of IBD • Extra-intestinal manifestations	• Present in nearly half of patients • May manifest before bowel symptoms • Inflammatory arthritis • Erythema nodosum • Pyoderma gangrenosum • Primary sclerosing cholangitis • Eye: uveitis/iritis/episcleritis

Clinical Features

Flare features	Assessment	Acute illness
• Mild: BO 1-3x/day ± blood and no systemic symptoms • Moderate: BO 4-6x/day with blood and no systemic symptoms • Severe: BO >6x/day with blood, fever, tachycardia, low BP	• Check pulse, temperature, BP • Abdominal examination – masses, peritonitis • Blood tests: FBC, U&E, ESR, CRP • Stool: faecal calprotectin ± stool culture (don't wait for result before treating) • Seek advice from IBD team	• Risk of rapid decompensation • Acute severe colitis: BO >6x/day with blood plus one or more of: fever >37.8°C, pulse >90bpm, Hb <105 g/L or CRP >30 mg/L – admit to medical team as risk of sepsis or acute kidney injury • Abdominal mass – abscess potential in Crohn's disease – acute surgical referral

Initial Treatment

UC: left sided/pancolitis	UC: proctitis	Crohn's disease
• Increase oral mesalazine to maxiumum dose (varies by brand) • Also offer rectal mesalazine • Consider locally acting oral agents (Cortiment 9mg od for up to 8/52 or Clipper 5mg od for 28 days) • If no response consider oral prednisolone 40mg od for 7 days then reduce by 5mg/week over 8 weeks (total 252 tablets)	• Rectal therapy: mesalazine (Salofalk suppository 1g nocte, Octasa 1g suppository nocte, or Pentasa 1g suppository nocte)	• Risk of severe systemic illness and abscesses more common. Do not initiate or change treatment in primary care unless specified on the personal care plan • Discuss with local IBD team • Enteral nutrition may be first line in children (specialist decision)

[No Title]

CROHN'S & COLITIS UK

Ulcerative Colitis Flare Pathway

1

Pathway for adults with known uncomplicated Ulcerative Colitis who may be having a flare

Remember to inform the patient's IBD team that they are having a flare

Exclusions: age under 16, have a stoma or fistula, have had surgery, or on biological therapy

Y → These patients should have access to an IBD specialist – please contact their team before making any medication changes

N

Ask about triggers. Check adherence to medication (consider once daily dosing for maintenance therapy). Stop NSAIDs, avoid opiates and seek advice for pain relief from the IBD team if needed. Consider self-care for functional symptoms once inflammation has been excluded. See rcgp.org.uk/ibd and signpost to crohnsandcolitis.org.uk.

Tests: stool culture (including Clostridium difficile testing), U&E, FBC, ESR/CRP, faecal calprotectin. Consider self-care for mild symptoms including dietary advice and reducing stress. Seek advice from the IBD helpline, IBD team or on-call gastroenterologist if results are significantly abnormal.

Acute severe colitis:
> 6 bloody stools per day and systemic toxicity with at least one of: Visible blood in stool; Pyrexia (temperature greater than 37.8C); Pulse rate greater than 90bpm; Anaemia (Hb <105g/L); CRP >30mg/L

Y → Discuss with on-call gastroenterologist/ medical team as may need admission

N

Pancolitis or left-sided/extensive disease

Maximise oral 5-ASA (mesalazine):

Pentasa 4g, Mezavant XL 4.8g, Octasa 4.8g, Asacol 4.8g, Salofalk 3g. Consider half maximum doses for patients who have mild disease and who are not currently taking an oral 5-ASA, or who are on a lower maintenance dose.

Offer rectal therapy:

especially if incomplete response to oral 5-ASA

Mesalazine Salofalk foam enema 2g nocte, Pentasa liquid enema 1g nocte, or Salofalk liquid enema 2g nocte. Consider locally acting oral agents if 5-ASAs not tolerated or not effective Oral Cortiment (Budesonide MMX) 9mg od for up to 8 weeks or Clipper (Beclamethasone) 5mg od for 28 days.

Visit the NICE website for further info on doses:

bnf.nice.org.uk/drug/budesonide.html#indicationsAndDoses

bnf.nice.org.uk/drug/mesalazine.html#indicationsAndDoses

Proctitis:

Mesalazine Salofalk suppository 1g nocte, Octasa 1g suppository nocte, Pentasa 1g suppository nocte

Assess response after two weeks

Please see page two

CROHN'S & COLITIS UK

Ulcerative Colitis Flare Pathway

2

Pathway for adults with known uncomplicated Ulcerative Colitis who may be having a flare

(continued flow from Pancolitis/extensive disease and proctitis or left sided disease pathways)

Assess response after two weeks

Deteriorating → May need admission. Discuss with on-call Gastro team.

No better

Oral prednisolone 40mg od for 7 days then 35mg od for 7 days. Reducing by 5mg each week over 8 weeks = 252 x 5mg prednisolone tablets in total.
Remember GI and bone protection where required. Counsel re: side effects.

Inform the IBD team when oral steroids are given. Patients should not have more one course of steroids in a year without considering escalating steroid-sparing agents.

crohnsandcolitis.org.uk/steroids

Assess response after two weeks

Deteriorating → May need admission. Discuss with on-call Gastro team.

Seek advice from the IBD team via the IBD hotline: crohnsandcolitis.org.uk/ibdnurse

No better

Improving

Improving

Continue treatment for 8 weeks then continue dose required to prevent further relapse.

Encourage lifetime compliance

crohnsandcolitis.org.uk/aminosalicylates

Complete course of steroids but continue other IBD medication. Remember to inform the IBD team of this course of steroids.

For more information on supporting patients with Crohn's or Colitis, see the RCGP and Crohn's & Colitis UK IBD toolkit:

www.rcgp.org.uk/ibd

Endorsed by: bsg, RCGP Royal College of General Practitioners, PCSG

Produced with support from: Garfield Weston Foundation, Peter Sowerby Foundation, James Tudor Foundation

November 2022

Inflammatory Bowel Disease Pathway, Ulcerative Colitis – Management of Flare (Primary Care)

1) Assess Disease Activity

The treatment of Ulcerative Colitis is stratified by the extent of inflammation and severity.
Extent is divided into proctitis (restricted to the rectum), left-sided colitis and extensive colitis (beyond the splenic flexure at colonoscopy).

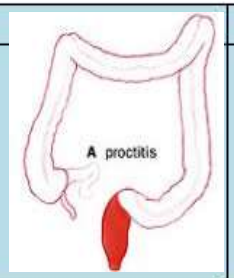
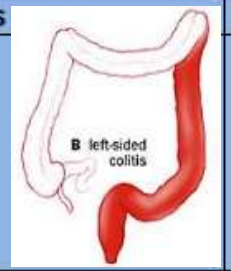
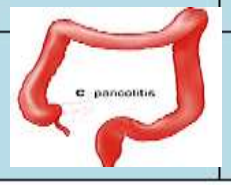
2) Please Do Following Investigations:

i) Stool cultures, incl C. diff and OCP if travel history
ii) Blood tests FBC, U&E, LFT, Ca^{2+}, Alb, CRP
iii) Faecal test: Calprotectin or FIT as per local protocol

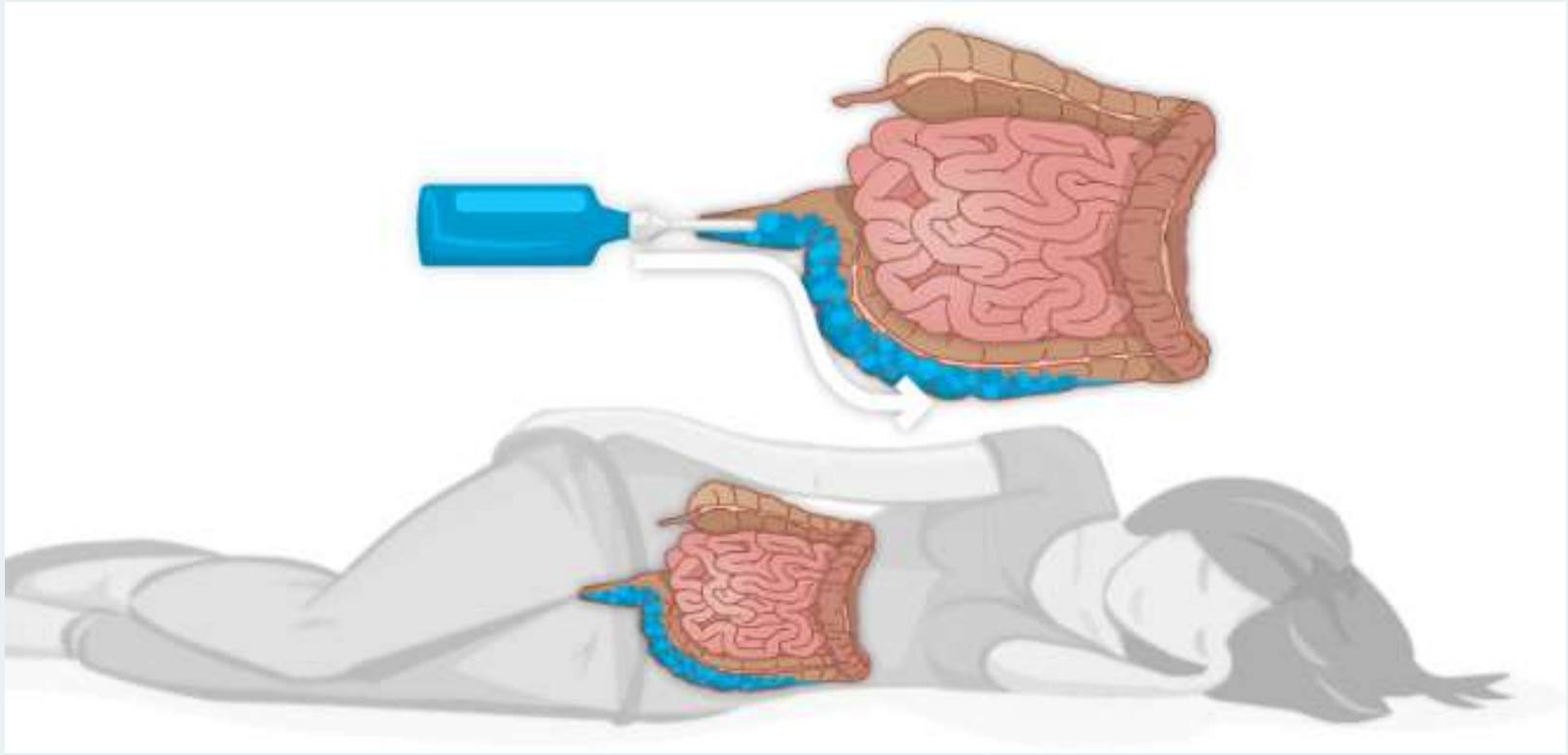
Assessment of disease activity in ulcerative colitis

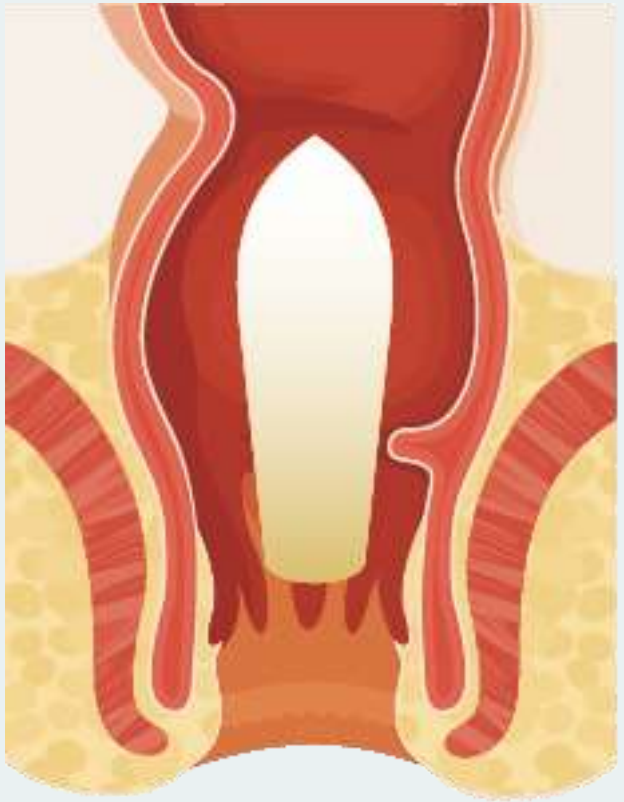
	Bloody stools/day	Systemic disturbance (Pulse 90, temp 37, Hb 10.5, ESR/CRP >30)
Mild	<4 per day	No
Moderate	4-5 per day	No
Severe	6 or over	Yes

3) Treatment

Proctitis 	**Mild/moderate disease**			**Severe disease**
	Mesalazine suppositories 1 g nocte, steroid suppository if Mesalazine intolerant If no response after 2 weeks, add oral Mesalazine 2.4 g od If deterioration, consider Prednisolone 40 mg od for 1 week, then reduce by 5 mg per week to 0 Engage with local IBD Service at early stage			Admit to hospital
Left-sided Colitis 	**Mild disease**		**Moderate disease**	**Severe disease**
	Give oral Mesalazine 2.4 g od OR Mesalazine liquid enema 2 g nocte, steroid enema if Mesalazine intolerant If no response, give both oral Mesalazine 2.4 g od AND Mesalazine liquid enema 2 g nocte If still no response, add Prednisolone 40 mg od for 1 week, then reduce dose by 5 mg per week to 0 Engage with local IBD Service at early stage		Give Mesalazine liquid enema 2 g nocte AND oral Mesalazine 2.4 g od If no response, add Prednisolone 40 mg od for 1 week, then reduce dose by 5 mg per week to 0 Engage with local IBD Service at early stage	Admit to hospital
Extensive Colitis 	**Mild/moderate disease**			**Severe disease**
	Give Mesalazine liquid enema 2 g nocte AND oral Mesalazine 2.4 g od If no response, add Prednisolone 40 mg od for 1 week, then reduce by 5 mg per week to 0. Engage with local IBD Service at early stage			Admit to hospital

Suppository Vs Enema





5-ASA Adherence in UC

Increased risk of relapse with failure to take 5 ASA's

- Adherent = **89%** chance of maintaining remission vs. **39%** in non-adherent patients
- Up to **60%** of patients in remission are non-adherent and take less than **70%** of their 5ASA's

5-ASA's reduce risk of CRC by up to 75%

- **31%** of patients who didn't adhere to 5-ASA's developed **CRC** vs. **3%** who continued with long-term treatment

Remember Co-Trimoxazole treatment for patients on triple Immunosuppressant's (960mg OD Mon/Wed/Fri)

Inflammatory Bowel Disease Pathway, Crohn's Disease – Management of Flare (Primary Care)

The treatment of Crohn's Disease is defined by extent, severity and behaviour.
Extent is subdivided into colonic, small bowel or both, with or without perianal or upper GI disease.
Severity of inflammation can be difficult to define in Crohn's Disease:
- clinically defined as stool frequency, abdominal pain and wellbeing but symptoms may be a poor indicator of gut inflammation
- A commonly used index is Harvey-Bradshaw index (see right)

Please Do Following Investigations:
1) Stool cultures, incl C.diff and OCP if travel history.
2) Blood tests FBC, U&E, LFT, Ca^{2+}/Alb, CRP
3) Faecal test: Calprotectin or FIT

No of liquid stools/day	General Wellbeing	Abdominal Pain	Abdominal Mass	Complications Add 1 point for each
	Very well = 0	None = 0	None = 0	Arthalgia
	Slightly below par = 1	Mild = 1	Dubious = 1	Uveitis
	Poor = 2	Moderate = 2	Dubious = 2	Erythema nodosum
	Very poor = 3	Severe = 3	Definite & tender = 3	Aphthous ulcers
	Terrible = 4			Pyoderma gangrenosum
				Anal fissure
				New fistula
				Abscess

The values from each column are totalled to give a score. This is categorised as follows:
Remission <5; Mild disease 5-7; Moderate 8-16; Severe >16. An online calculator is available at: http://www.e-guide.ecco-ibd.eu/resource/hb-index . Faecal testing is a very useful and objective marker that should be used as well as symptoms to define disease activity.
Behaviour – have strictures or fistulas formed as complications of the condition

Colonic Crohn's Disease	Mild disease	Moderate disease	Severe disease
	Consider giving no treatment If faecal testing is normal, consider concurrent IBS Repeat faecal testing at 3 months	Prednisolone 40 mg od for 1 week, then reduce by 5 mg/week to 0 Budesonide 9 mg od for 6 weeks is an alternative for Prednisolone intolerant patients with inflammation in right and transverse colon Engage local IBD Service at early stage	Admit to hospital
Ileo-Colonic Crohn's Disease	**Mild disease**	**Moderate disease**	**Severe disease**
	Consider giving no treatment If faecal testing is normal, consider concurrent IBS If previous ileal resection consider bile salt malabsorption and give Cholestryamine 4 g bd. Repeat faecal testing at 3 months	Budesonide 9 mg od for 6 weeks then 6 mg od for 1 week, then 3 mg od for 1 week, then stop. If no response, Prednisolone 40 mg od for 1 week, then reduce by 5 mg per week to 0. Polymeric diet is an alternative to steroids. Engage local IBD Service at early stage	Admit to hospital
Extensive Small Bowel Disease	**Mild disease**	**Moderate disease**	**Severe disease**
	Low residue diet. Consider giving no treatment. If faecal testing is normal, consider concurrent IBS Repeat faecal testing at 3 months Engage local IBD Service for advice at early stage	Polymeric diet: discuss with secondary care and refer to dietitian. Budesonide 9 mg od for 6 weeks, then 6 mg od for 1 week, then 3 mg od for 1 week, then stop. If no response, Prednisolone 40 mg od for 1 week, then reduce by 5 mg per week to 0. Polymeric diet is an alternative to steroids. Engage local IBD Service at early stage	Admit to hospital
Perianal Disease		**Active perianal disease with no abscess**	**Active perianal disease with abscess**
	Assess temperature, inspect perineum and do rectal examination. Is there any sepsis present? As a general rule, if the patient is unable to sit properly they should be referred	Give Metronidazole or Ciprofloxacin for 14 days in the first instance Most patients will need a MRI or an EUA – engage with local IBD Service at an early stage	Admit to hospital under surgical team for further management

www.niibdflarecard.co.uk

Helping Patients Own Their IBD Step by Step

Self-Management for Ulcerative Colitis relapse & how to extinguish the Flame

SCAN ME

- Managing my IBD
- Step 1 - Bloods
- Step 2 - Stools
- Step 3 - Medicines
- Step 4 - IBD Adviceline
- Step 5 - IBD Wellbeing
- Medical Need Card

Public Health Agency, 12 – 22 Linhall Street, Belfast, BT2 8BS

Ferring Pharmaceuticals sponsored the development of this web app Ferring had no input into the content.

WHEN TO CONSIDER ADMISSION FOR PATIENTS WITH KNOWN UC

Acute Severe UC – 6 or more bowel movements/24h **plus** 2 or more features of systemic upset;

- visible blood in stool
- T >37.8
- HR>90
- anaemia (Hb<105)
- CRP >30.

WHEN TO CONSIDER ADMISSION FOR PATIENTS WITH KNOWN CROHN'S DISEASE

- Perianal sepsis/abscess (for EUA under the colorectal team). A good rule of thumb is to refer for admission **if unable to sit down properly.**

- Obstruction (i.e. vomiting *and* post prandial abdominal pain, weight loss) – Surgical service

- Active Crohn's symptoms plus systemic upset e.g. fever, tachycardia, hypotension or anaemia

Thank you

Questions?

