Inflammatory bowel disease

References:
1. Flare management IBD, Webinars for GPs, July 2018
2. RCGP toolkit.
3. Gastroenterology consultant New Cross, 2018.
4. Primarycare Heath conference May 2019.
5. Ingest podcast April 2023.

Microscopic colitis

Medications that are associated with the condition are:

High likelihood:
Acarbose
Aspirin
Clozapine
Entocapone
NSAIDs
PPI
Sertraline

Intermediate likelihood:
Carbamazapine
Celecoxib
Duloxetine
Fluvastatin
Flutamide
Oxetorone
Madopar
Paroxetine
Simvastatin
Stalevo

Low likelihood:
Cimetidine
Gold salts

Symptoms

Luminal symptoms
- FHx of IBD.
- Diarrhoea.
- Bowels open at night.
- Mouth ulcers.
- Unexplained fever.
- Weight loss.
- Anaemia.

Extra-luminal
- Arthritis.
- Erythema nodosum.
- Pyoderma gangrenosum.
- Primary sclerosing cholangitis.
- Uveitis.
- Iritis or episcleritis.

Investigations

REAL LIFE Advice & Guidance:
Q) 23y with folic acid, B12 and Vit D deficiency. Just replace or do gastro need to see?
A) Do calprotectin to r/o IBD. If no features of malabsorption e.g. low BMI, just replace deficiencies.

- FBC.
- ESR, CRP.
- Coeliac screen.
- Faecal calprotectin.

- Recurrent/persistent pain.
- Diarrhoea.

<50	normal
50-100/150	intermediate
>100	high

- Functional disease i.e. IBS likely.

- Repeat in 4/52 (stop meds if possible cause).
- Can be raised with PPI, regular NSAIDs, post gastro enteritis.
- If still >50 refer to gastroenterology.

- Refer to gastroenterology.

New Cross Hospital Dec 2021 Guidance

Calprotectin <150ug/g : not indicative of active GI inflammation

Calprotectin 150 250ug/g: indeterminate result, repeat in 6 weeks
If repeat <150: not indicative of active GI inflammation.
If ≥150: indicative of active GI inflammation, gastroenterology referral recommended.

Calprotectin >250: indicative of active GI inflammation, and gastroenterology referral recommended.

- Not recommended in children in 1o care as no data about normal levels.
- Do not measure in >45y. Better to do colonoscopy. Your not thinking IBD in them.
- What happens in the ones you should not measure i.e. > 45y:
- Studies did not find a single IBD in anyone over 45y.

- Distribution of disease affects calprotectin. If distal then likely detects. If small bowel then might miss disease if just looking at calprotectin.

- Should not do calprotectin for 6 weeks after diarrhoea as can be infection related.
- If frank PR bleed will give false +ve. So get sample when not bleeding. If cant manage that because there is so much frequent blood , then clearly need colonoscopy/referral.

Management

Flare up

UC
- Make sure it's not alternative diagnosis e.g. travellers diagnosis.
- 1st line = oral AND rectal mesalazine.
- Give both for nearly every pt, unless very distal disease in which case rectal alone is sufficient.
- Increase mesalazine to max dose = 4.8g per day as a single dose.
- Take 1-2/52 to make a difference. Wish is fine if not acutely unwell.
- If any worse must reassess to ensure not dehydrated or septic.

if fails
- Steroids.
- Prednisolone for 8/52.
- 40mg OD, then reduce by 5mg per week.
- Rx 252 tablets to make it 8/52 course.

Crohns
- Steroids.
- Prednisolone for 8/52.
- 40mg OD, then reduce by 5mg per week.
- Rx 252 tablets to make it 8/52 course.

- ≥ 2 courses in 1yr.
- Can't reduce prednisolone <15mg OD.
- Another flare up within 6/52 of stopping course.

- Advice pt to contact their IBD nurse.
- May need alteration of maintenance dose.

- Just ensuring concordance to current meds might work.
- As there is only 50% concordance to meds for IBD.

Pred 40mg OD for 1 week and reduce by 5mg weekly.
Give Adcal D3.
R/v in 2 weeks.

REAL LIFE CASE STUDY Crohns disease flare up
- Discharge letter stated Budesonide M/R 9mg for 2/52.
THEN
- 6mg for 2/52.
THEN
- 3mg for 2/52.
THEN STOP