Inflammatory Bowel Disease
Primary Care Update

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Overview

• Clinical history to flag IBD
  • Primary care investigations
  • Primary care management

• Challenges / New Services
Pre-symptomatic detection

BSG 2016

PTH-091 Incidental Diagnosis of Inflammatory Bowel Disease Through The Bowel Cancer Screening Programme: A 7 Year Experience

An incidental diagnosis of IBD at screening is not uncommon, with an incidence of 1.0% in our cohort. A proportion of patients demonstrate significant disease progression requiring immunomodulation, biologic therapy or surgery.
Suspected cancer: recognition and referral
NICE GUIDANCE 2017

Consider a suspected cancer pathway referral (for an appointment within 2 weeks) for colorectal cancer in adults aged under 50 with rectal bleeding and any of the following unexplained symptoms or findings:
abdominal pain
change in bowel habit
weight loss
iron-deficiency anaemia.

Absence of above: faecal calprotectin (FCP)
## Who else to refer?

<table>
<thead>
<tr>
<th>Item</th>
<th>Coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-healing or complex perianal fistula or abscess or perianal lesions (apart from haemorrhoids)</td>
<td>4.648</td>
</tr>
<tr>
<td>First-degree relative with confirmed inflammatory bowel disease</td>
<td>4.282</td>
</tr>
<tr>
<td>Weight loss (5% of usual body weight) in the last 3 months</td>
<td>3.303</td>
</tr>
<tr>
<td>Chronic abdominal pain (&gt;3 months)</td>
<td>2.928</td>
</tr>
<tr>
<td>Nocturnal diarrhoea</td>
<td>2.541</td>
</tr>
<tr>
<td>Mild fever in the last 3 months</td>
<td>2.169</td>
</tr>
<tr>
<td>No abdominal pain 30–45 min after meals, predominantly after vegetables</td>
<td>1.581</td>
</tr>
<tr>
<td>No rectal urgency</td>
<td>1.569</td>
</tr>
</tbody>
</table>

**Crohn’s Red Flag Index**
Ultrasound Small Bowel with Contrast

Small intestine contrast ultrasonography for the detection and assessment of Crohn‘s disease
A meta-analysis

Conclusion:
Is accurate enough to make a complete assessment about the location, extent, number, and almost all kinds of complications in CD small-bowel lesions
Diagnostic Pathway

Absence of Red Flag Symptoms
(Absence of Crohn’s Red Flag Index)

No FH of GI malignancy

CRP, Coeliac serology, Thyroid Function, Calcium, FBC

Faecal Calprotectin

Contrast US Small Bowel – consider in individuals needing further reassurance
Clinical scoring index

Crohn’s Disease – Harvey Bradshaw Index

• general well-being (0 = very well, 1 = slightly below average, 2 = poor, 3 = very poor, 4 = terrible)
• abdominal pain (0 = none, 1 = mild, 2 = moderate, 3 = severe)
• number of liquid stools per day
• abdominal mass (0 = none, 1 = dubious, 2 = definite, 3 = tender)
• IBD clinical complications, (1 point for each, joint pains, eye symptoms, rash, fistula, mouth ulcers, fever)

Score of 3 or less: clinical remission
Score of 8 or more is severe flare
Clinical scoring index

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel frequency (day)</td>
<td></td>
</tr>
<tr>
<td>1–3</td>
<td>0</td>
</tr>
<tr>
<td>4–6</td>
<td>1</td>
</tr>
<tr>
<td>7–9</td>
<td>2</td>
</tr>
<tr>
<td>&gt;9</td>
<td>3</td>
</tr>
<tr>
<td>Bowel frequency (night)</td>
<td></td>
</tr>
<tr>
<td>1–3</td>
<td>1</td>
</tr>
<tr>
<td>4–6</td>
<td>2</td>
</tr>
<tr>
<td>Urgency of defecation</td>
<td></td>
</tr>
<tr>
<td>Hurry</td>
<td>1</td>
</tr>
<tr>
<td>Immediately</td>
<td>2</td>
</tr>
<tr>
<td>Incontinence</td>
<td>3</td>
</tr>
<tr>
<td>Blood in stool</td>
<td></td>
</tr>
<tr>
<td>Trace</td>
<td>1</td>
</tr>
<tr>
<td>Occasionally frank</td>
<td>2</td>
</tr>
<tr>
<td>Usually frank</td>
<td>3</td>
</tr>
<tr>
<td>General well being</td>
<td></td>
</tr>
<tr>
<td>Very well</td>
<td>0</td>
</tr>
<tr>
<td>Slightly below par</td>
<td>1</td>
</tr>
<tr>
<td>Poor</td>
<td>2</td>
</tr>
<tr>
<td>Very poor</td>
<td>3</td>
</tr>
<tr>
<td>Terrible</td>
<td>4</td>
</tr>
<tr>
<td>Extracolonic features</td>
<td></td>
</tr>
<tr>
<td>1 per manifestation</td>
<td></td>
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</tbody>
</table>

Simple clinical colitis activity index
Score of 5 suggests relapse
>8 or more liquid stools per day suggests severe flare
6 or more liquid stools per day all with blood suggests severe flare
Management

Left sided disease
Mild flares
Additional treatment for moderate flares

Always consider first line for proctitis

CD – steroids preferentially
UC – mesalazine slightly more effective
Management

Mesalazine (5-ASA)

Meta-analysis data suggests not effective in treating CD for induction or maintaining remission

Potential role in prevention of colorectal cancer in individuals with Crohn’s Colitis

In UC – very effective for mild to moderate flares
60% to 70% will improve within 2 weeks, mucosal healing in majority
Combination of oral and topical more effective
Maximum dose 4.8g for most preparations (pentasa 4g).
Potential role in prevention of colorectal cancer

Acute side effects are very rare – 5% get drug related diarrhoea
6 monthly FBC, Renal function and LFTs check
Management

Corticosteroids:
Prednisolone 40mg OD, wean by 5mg every week after 1 to 2 weeks of 40mg
Bone protection with AdCal D3 2 caplets once daily, Omeprazole 20mg OD

Short term side-effects: common infections, weight gain, diabetes, psychosis and acne

When: Moderate and severe clinical flares.
When CRP rising despite other treatment.
CRP > 20 – low threshold to start
60% will feel better, mucosal healing in 20% (vs 10% in placebo)

Other options: Budesonide 9mg OD for 2 to 4 weeks, then wean by 3mg every 2nd week for ileal / right sided CD
Clipper 5mg to 10mg for 4 to 8 weeks for UC
Biologics and Immunosuppressive treatment

With hold if ALT > 200

With hold if acute rise in bilirubin > 50

Let relevant team know urgently, and needs CLD screen and US Liver / biliary tree

With hold if neutrophils <1 or lymphocytes <0.5 – urgently discuss, because fever will need GSCF cover if neutrophils rapidly falling

Fever and neutrophils < 0.5 need admission to side room
Biologics and Immunosuppressive treatment

Biologics:
Risk of TB – TNF pathway suppression predisposes

Azathioprine / Mercaptopurine:
Skin cancer and skin warts risk – all should be using minimum factor 30 sun block. No sunbathing.
Dermatology referral if any new lesion develops
With hold if acute EBV – treat with ganciclovir

Both:
Varicella active or exposure – discuss with us or viral team ASAP – will need treatment with IG and aciclovir
New Services

- Rapid access to a preoperative optimisation clinic
- Rapid access to maternal medicine service
- Increased access to clinical trials
- Business cases for a dedicated IBD pharmacist
- Business case for Band 8a CNS
Challenges

Ensure oral steroids are being prescribed appropriately
   Not for mild flares

Ensure escalation to steroid sparing agent is appropriate
   If more than 2 courses needed within 12 months
   If ongoing biochemical activity on 5-ASA (CRP / FCP)
   If ongoing morphological / endoscopic activity on 5 - ASA
Challenges

Everyone receiving immunosuppressive therapy requires:
Vaccinations – Hep B, Varicella. Ideally 3 months before immunosuppression started

Appropriate cancer screening (in accordance with national guidelines)
   Breast, cervical, prostate
   Skin review

IBD needs additional cancer surveillance
Challenges

Targets:
Clinical remission
Biochemical remission
Morphological / endoscopic remission

Currently 20% of IBD cohort have multiple admissions to A & E annually
  no rapid access service
  no ambulatory monitoring pathway – FCP can predict a flare 3 months in advance
IBD CNS ratio for population is 33% what it needs to be for the population we serve
Trends in biologic use 2015-18

ALL
IFX
ADA
VEDO
USTE
Case 1

HB 83, CRP 201, Alb 22
24 weeks pregnant