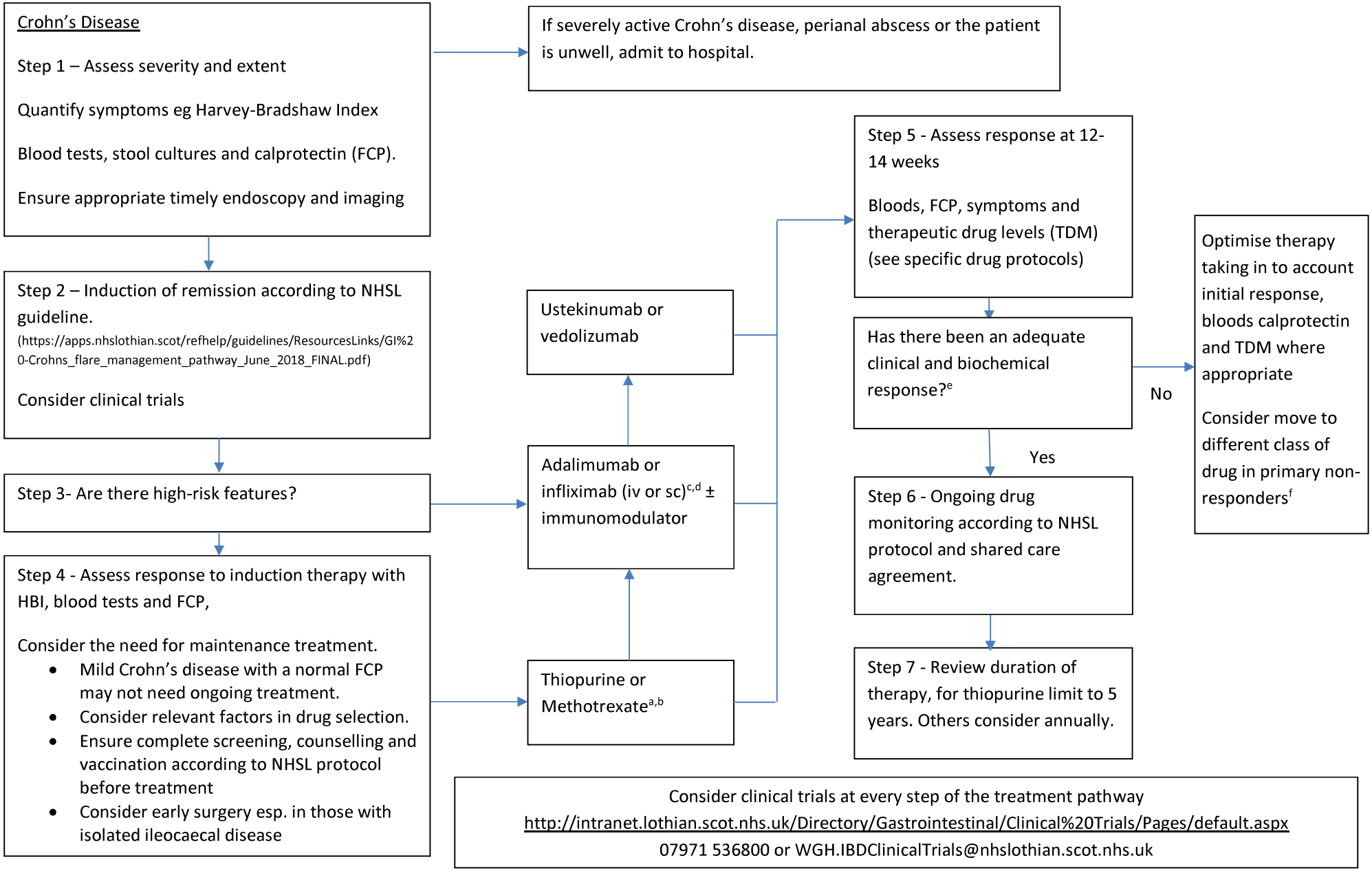
Crohn's Disease
Step 1 – Assess severity and extent
Quantify symptoms eg Harvey-Bradshaw Index
Blood tests, stool cultures and calprotectin (FCP).
Ensure appropriate timely endoscopy and imaging
If severely active Crohn's disease, perianal abscess or the patient is unwell, admit to hospital.
Step 2 – Induction of remission according to NHSL guideline.
(https://apps.nhslothian.scot/refhelp/guidelines/ResourcesLinks/GI%20-Crohns_flare_management_pathway_June_2018_FINAL.pdf)
Consider clinical trials
Step 3- Are there high-risk features?
Step 4 - Assess response to induction therapy with HBI, blood tests and FCP,
Consider the need for maintenance treatment.
Mild Crohn's disease with a normal FCP may not need ongoing treatment.
Consider relevant factors in drug selection.
Ensure complete screening, counselling and vaccination according to NHSL protocol before treatment
Consider early surgery esp. in those with isolated ileocaecal disease
Ustekinumab or vedolizumab
Adalimumab or infliximab (iv or sc)c,d ± immunomodulator
Thiopurine or Methotrexatea,b
Step 5 - Assess response at 12-14 weeks
Bloods, FCP, symptoms and therapeutic drug levels (TDM) (see specific drug protocols)
Has there been an adequate clinical and biochemical response?e
No
Yes
Optimise therapy taking in to account initial response, bloods calprotectin and TDM where appropriate
Consider move to different class of drug in primary non-responders f
Step 6 - Ongoing drug monitoring according to NHSL protocol and shared care agreement.
Step 7 - Review duration of therapy, for thiopurine limit to 5 years. Others consider annually.
Consider clinical trials at every step of the treatment pathway
http://intranet.lothian.scot.nhs.uk/Directory/Gastrointestinal/Clinical%20Trials/Pages/default.aspx
07971 536800 or WGH.IBDClinicalTrials@nhslothian.scot.nhs.uk

High Risk or Complex IBD

1. Young patients (less than 40 years)
2. Fulminant disease
3. Previous surgery especially with early recurrence
4. FIstulating disease at presentation
5. Unable to use steroids as a bridge to immunosuppression
6. Already on immunosuppression

Factors to Consider When Choosing a Biologic or Immunosuppressive Drug in IBD

1. Route of administration
2. Speed of response
3. Potential immunogenicity and need for combination therapy
4. Side effects including cancer
5. Persistence of drug therapy
6. Availability of infusion facilities and TDM
7. Overall cost

Prescribing Notes

a) Those unsuitable for a thiopurine include EBV negative males, history of lymphoma, skin cancer, cervical neoplasia, those over the age of 50 years.
b) Azathioprine and methotrexate should not be used as monotherapy for the induction of remission in Crohn's disease.
c) When choosing an infliximab preparation, iv should be the first line option, but subcutaneous infliximab may be preferable for those (who have failed adalimumab) in whom an immunomodulator cannot be used, with poor iv access and are less able to access infusion facilities. This decision may also be influenced by HLA testing when available.
d) There is consistent evidence from clinical trials and real world data that patients who lose response to / or do not respond to anti-TNF therapy respond less well to subsequent biologic therapy and may require dose escalation of these drugs.
e) Define treatment goals at the start of treatment which for most patients should be steroid free, clinical and biochemical remission.
f) These treatment decisions are best supported by the virtual biologics clinic or specific drug MDM.