

Treatment – Ulcerative Colitis		IBD and Cancer		Immunosuppressants (cont)		UC vs CD		
Mild-Moderate disease	5-Aminosalicylates (suppository or enema possibly combined with oral aminosalicylates) If unable to tolerate aminosalicylates: Steroids (topical corticosteroid or oral prednisolone)	Increased risk of colorectal cancer (CRC) in UC and Crohn's colitis 20-30% risk at 30 years from diagnosis Regular surveillance colonoscopy performed from 8-10 years post-diagnosis 5-ASAs are protective		BSG guidelines advise use in following situations	Severe relapse or frequently relapsing disease. 2 or more steroid course required within 12 months. Relapse below 15mg prednisolone. Relapse within 6 weeks of stopping steroids.	SKIN	UC	CD
Resistant Disease	Immunosuppressants (eg Azathioprine, Mercaptopurine) Anti-TNF monoclonal Ab (Infliximab, Adalimumab)	Risk of CRC particularly high in patients with UC + Primary Sclerosing Cholangitis PSC also carries a high risk of cholangiocarcinoma		Pathology of UC		EYE	Iritis	Iritis
Severe colitis	Intravenous corticosteroids Cyclosporin Infliximab (5 mg/kg infused over 2 hours at 2 and 6 week intervals) (Assuming 3 doses, average cost per patient = £5,035) Surgery	Ciclosporin		Idiopathic chronic inflammatory disorder of the colonic mucosa, with the potential for extraintestinal inflammation.		The disease extends proximally from the anal verge in an uninterrupted pattern to involve all or part of the colon		
Therapeutic Pyramid for Active UC		Calcineurin inhibitor Prevents clonal expansion of T cell subsets Rapid onset of action		Diagnosis of IBD		KIDNEY	Calculi (kidney stones)	Calculi pyelonephritis
Mild:	Topical Steroids: Aminosalicylates	Used as salvage therapy for severe UC not responding to IV steroids Usually introduced on day 3 of steroids IV 2mg/kg/day Responders converted to oral Cyclosporin for 3-6 months and switched to Azathioprine/6-MP (Cyclosporin not used long-term)		Endoscopy and biopsy	Flexible sigmoidoscopy or Colonoscopy	Pyelonephritis (inflammation of the kidney due to bacterial infection)		
Moderate:	Infliximab, Systemic Corticosteroids, Oral steroids	Requires regular monitoring of Drug levels/Full blood count/Renal function/Blood pressure		Radiology	Contrast enhanced ultrasound, Barium studies, CT, MRI, Capsule endoscopy	LIVER	Sclerosing cholangitis (inflammation of bile ducts: impeding bile flow)	Systemic amyloidosis (deposition of amyloid proteins)
Severe:	Surgery, Cyclosporine, Infliximab	Immunosuppressants		Exclude infection				
		Indicated for severe or refractory IBD		Blood tests helpful but not diagnostic				
		Thiopurines.						
		Methotrexate.						
		Ciclosporin.						

UC vs CD (cont)			Aetiology (cont)		Histopathology of UC (cont)		Ciclosporin – side effects		
JOINTS	Serone- gative polyarthritis (blood test –ve for rheumatoid factor protein and cyclic-citru- linated peptide)	Serone gative polyar- thritis	Genetics	47 loci associated with UC (and counting)	The most intense inflam- mation begins :	the lower right in the sigmoid colon and extends upward and around to the ascending colon. At the lower left is the ileocecal valve with a portion of terminal ileum that is not involved.	Tremor		
			Smoking (May prevent UC and may cause CD)				Paraesthesia		
			Histopathology of UC				Malaise		
			Superficial diffuse inflammation in the lamina propria affecting the colon only				Headache		
			Chara- cter- istics	Continuous from the rectum up to the caecum	Repeated ulceration and healing cycles result in:		Abnormal liver function tests		
				Crypt abscesses, goblet cell depletion and crypt distortion			Hirsutism		
				Can affect the distal few cm of small bowel – ‘backwash ileitis’	Anti-TNFs adverse effects		Gingival hyperplasia		
				Non-smokers					
Aetiology							Thiopurines		
Inappr- opriate immune response	Increased pro-in- flammatory cytokines eg TNF- α, IL-1β, IL-6						Side effects	Nausea	Advise patients to take it at night
Breakdown in tolerance to gut microbial load	Altered gut flora. Defects in mucosal immunity.							Allergic reaction	Fever/- Rash/A- rthralgia
Combin- ation of factors	Enviromental factors. Triggered by particular bacterial pathogen.							Myelosuppression	
	Genetic – increased risk in twins/other relative							Hepatotoxicity	
	Diet							Pancreatitis	
	Smoking						Monitoring	FBC/LFT every 2 weeks for first 2 months, Then every 4-8 weeks up to ~6/12, Then every 3/12	
					Infections				
					Steroids/Immunosuppressa- nts/Anti-TNF all increase risk of infection				
					Two or more therapies in combination increases risk 15 fold				
					Active infection/abscesses must be excluded before commencing anti-TNF treatment				
					Patients should be screened for exposure to TB (CXR/Tuberculin skin test)				
					Malignancy				
					Increased risk of lymphoma (but overall risk still v low)				
					Heart failure				
					Anti-TNFs contraindicated in severe heart failure				
							Azathioprine (Aza)		
							Mercaptopurine (6-MP)		
							Purine antimetabolites inhibiting DNA synthesis		
							Aza is metabolised to 6-MP		
							Doses mg/kg/day		
							6-MP 0.75-1mg/kg/day		

Treatment – Crohn's		Distribution of Crohn's disease (cont)		Corticosteroids (cont)		Differential Diagnosis of UC (cont)	
Initial diagnosis if mild to moderate:	5-ASA's less effective but may have a chemoprotective effect against cancer risk. Glucocorticosteroids	Anus	33% have anal disease. Other (gastroduodenal, oesophageal, oral). Rare.	Side effects:	Skin thinning. Osteoporosis. Osteonecrosis Easy bruising. Cushing's syndrome (moon face, acne, hirsutism, striae). Cataracts. Diabetes. Hypertension. Psychosis.	<i>Yersinia</i>	
Severe active Crohn's (including fistulising Crohn's)	Immunosuppressants Azathioprine, Mercaptopurine, Methotrexate Anti-TNF therapy (Infliximab) (sever active Crohn's)	Treatment		Corticosteroids are very effective at inducing remission They are not a long-term maintenance therapy because of the effect on cortisol levels on the hypothalamus and anterior pituitary.		<i>Amoebic Dysentery</i>	
For perianal Crohn's:	Antibiotics (Metronidazole, Ciprofloxacin) –	UC and Crohn's are lifelong relapsing-remitting conditions		Ciclosporin & Tacrolimus (FK506)		Ischaemic Colitis	
Smoking cessation		Treatment is not curative but aims to suppress inflammation and thereby maintain normal gut structure and function		Ciclosporin		*Pseudomembranous Colitis	
Nutritional Support		Corticosteroids		Inhibits dephosphorylation of nuclear factor of activated T cells (NFATc)		Clostridium difficile infection	
Surgey		Oral		Tacrolimus (FK506)			
Emotional support: possible delayed growth and onset of puberty in young people		Intravenous:		Both prevent		Anti-TNF Therapy	
Possibility of requiring surgery		Topical		Differential Diagnosis of UC			
Distribution of Crohn's disease				Crohn's Colitis			
Small Bowel	80% of cases small bowel involved. Majority distal ileum. 1/3 exclusively ileitis.			Infective colitis:			
Ileo-colonic	50% have ileocolitis			<i>E.coli</i>			
Colonic	20% colonic disease only			<i>Campylobacter</i>			
				<i>Salmonella</i>			

Pathology of Crohns Disease (cont)

Typically there is patchy disease in the gastro-intestinal tract with intervening areas of normal mucosa "Skip lesions"

Transmural inflammation with lymphoid aggregates (clusters of lymphoid cells-include T-cells, B-cells and NK cells.)

Non caseating granulomas (60% cases) Caseating "turning to cheese"

Skip Leisons

***Strictures and fistula formation** In Crohn's, strictures make the bowel too tight, and fistulas create unnatural pathways—both are serious complications.

Perianal disease

Can affect any part of the GI tract

Smokers

Treatments Summary

Crohn's & Ulcerative Colitis

Salicylates

5-Amino salicylic acid (5-ASA); mesalamine (Asacol)

Steroids (glucocorticoids): Methylprednisolone (Medrol)

Immunosuppressants: Azathioprine & mercaptopurine

Treatments Summary (cont)

Ciclosporin A (Sandimmun or Neoral) Tacrolimus (FK-506, Fujimycin) (Prograf, Advagraf, Protopic)

NOVEL TREATMENTS

Nicotine: useful in UC?
LTB4 antagonists eg zileuton.
Fish oils, eicosapentanoic acid diverts LT production towards LTB5 production.
IL1 receptor antagonists (UC).
Short Chain fatty acids.
CuZnSOD and desferrioxamine (Peroxyl scavenger).

Epidemiology

Crohn's disease	Ulcerative Colitis
Incidence 8-10/100,000 in UK	Incidence 15/100,000 in UK
Prevalence ~150 per 100,000 (1 in 660 people)	Prevalence 200 per 100,000 (1 in 500 people)

Peak age at diagnosis 20-40, second smaller peak aged ~60

5-ASAs

5 Aminos alicyclic acid (Mesalazine) Moderate inflammatory cells and cytokine release from epithelial cells. Mechanism not fully understood but involves inhibition of cyclooxygenase and prostanoic formation and N-acetyl-5-ASA through PPAR gamma (Peroxisome Proliferator Alpha Receptor gamma)

5-ASAs (cont)

Uses - UC Maintenance of remission – mainstay of long-term treatment for UC. Treatment of mild-moderate flares. Chemoprotective effect against colorectal cancer.

Uses – Crohn's Limited effectiveness compared to UC. Limited effectiveness in active Crohn's or maintaining remission. May reduce risk of relapse after surgery.

5-ASAs (cont)

Side Effects: Diarrhoea! Nausea. Headache Rash (rarely Stevens-Johnson syndrome). Nephrotoxicity (Interstitial nephritis & Nephrotic syndrome). Agranulocytosis (low white blood cell count). Pancreatitis.

Oral

pH dependent resin (Asacol, Salofalk, Mesren)
Time-controlled (Pentasa)
Multimatrix pH dependent delivery (Mezavant)
Carrier molecules split by colonic bacterial enzymes (Sulfasalazine, Olsalazine, Balsalazide)

Dose

1.6-4.8g/per day
Single daily dosing seems as effective as traditional bd/tds

Topical

Suppositories - Proctitis
Foam or Liquid enemas - Distal colitis (rectum and sigmoid)
Check FBC/Renal function annually

UC vs CD

Ulcerative colitis	Crohn's disease
Affects the colon only	Affects any part of the GI tract
Male:F-emale 1:1	Male: Female 1:2

UC vs CD (cont)		Clinical Presentation – Crohn's		UC AND CROHNS (cont)	
Bloody diarrhoea	Abdominal pain	Typical Features:	Abdominal Pain. Diarrhoea. Weight loss. Anorexia.	Malignant change common	Malignant change rare
Abdominal pain	Perianal disease	Obstruction secondary to strictures Abscesses, Fistulae Depends on portion of GI tract involved		Fistulae less common	10% have fistulae
Continuous, always begins in rectum	Bloody diarrhoea			25% have anal involvement	60% have anal involvement
No strictures	Skip lesions	Histopathology Crohn's Disease of Ileum Inflammatory cells (the bluish infiltrates) extend from mucosa through submucosa and muscularis. On the serosal surface inflammatory cells appear as nodular infiltrates with pale granulomatous centres.		Muscular shortening of the colon	Fibrous shortening
Stricture and fistula formation with perianal disease				No skip lessons	Skip lesions
Mucosal inflammation	Transmural inflammation throughout bowel wall, lymphoid aggregates and non-necrotising granulomas. Can develop fissuring ulcers, crypt abscesses, goblet cell depletion and crypt distortion	Clinical Presentation of UC 'Bloody diarrhoea' and passage of mucus Urgency Abdominal Discomfort (pain unusual) Usually insidious onset Can be severe with systemic upset, fever Requires hospitalisation May need urgent surgery		No fat or vitamin malabsorption	Fat & vitamin malabsorption
Diffuse inflammation in the lamina propria				No granulomas (collection of macrophages)	Granulomas in 50%
Patchy ulceration with crypt abscesses, goblet cell depletion and crypt distortion		UC AND CROHNS Ulcerative Colitis Only affects colon No fissures, horizontal ulcers		Mild lymphoid reaction	Marked lymphoid reaction (increased WBC)
Terminal ileum in 10% cases	Often affects the terminal ileum (80%) Any part of alimentary tract can be affected			Mild fibrosis	Fibrosis
No fistulas	Fistulas	Crohn's Disease Affects mouth to anus Deep ulcers & fissures		Mild Serositis	Serositis (inflammation, serous membranes)
				Raised ANCA (antineutrophil cytoplasmic antibodies. Autoantibodies directed against own neutrophils.)	ANCA normal
				More common in non-smokers or ex smokers	Increased incidence in smokers