Ulcerative colitis and Crohn's disease are the two main forms of inflammatory bowel disease. These chronic ongoing conditions of the gastrointestinal tract cause a range of humiliating and often painful symptoms, the severity of which depends on the extent and distribution of the disease. Patients easily become debilitated and suffer as a consequence of this.¹

Inflammatory bowel disease (IBD) typically follows a fluctuating course, with symptomatic flares lasting days or weeks, separated by, hopefully, longer periods of remission. The impact of IBD on society is disproportionately high, as presentation often occurs at a young age. The peak age for diagnosis is 15-40 years old, which can have a huge impact on developing relationships, careers, family and financial commitments. However, most patients can achieve reasonable symptom control with outpatient medication and support from a multidisciplinary team.

The cause of IBD is uncertain. The general consensus is that it results from an abnormal immune response.² Advances have been made in understanding the genetics, immunology and inflammatory mechanisms, and environmental triggers that can contribute to IBD.³ While the cause remains uncertain, a permanent cure remains elusive.

Chronic diseases are disruptive for patients and place considerable demands on health service costs and manpower.⁴ The white paper, Saving Lives, Our Healthier Nation⁵ first announced the Government's intention to help people with chronic diseases to

Patients with IBD are often diagnosed during the most productive years of their lives, making ongoing support and early detection of relapses vital in preventing life-long ill health.
The disease may progress with time in patients who are initially diagnosed with distal colitis. Treatment options vary according to the site and severity of involvement. Surgery is the only cure for colitis but means removing the colon.

Bloody diarrhoea with the passage of mucus is the most common symptom. Lower abdominal pain, relieved on defecation, urgency and tenesmus are common with proctitis and distal disease. Diarrhoea (more than 8 days) with severe pain, fever and abdominal distension is a symptom of fulminant colitis and necessitates urgent hospital admission.

**Crohn’s disease**

Crohn’s disease is an inflammatory disorder that can affect any part of the gastrointestinal tract, from mouth to anus. It maintains their health and improves their quality of life.

Inflammatory bowel disease is more common than people think. Crohn’s disease and ulcerative colitis affect 1 in 400 people, a similar number to Parkinson’s disease (1 in 500) and are more common than multiple sclerosis (1 in 700). The incidence of Crohn’s disease is generally lower than that of ulcerative colitis, but the number of young people with Crohn’s disease is rising steadily.

**ULCERATIVE COLITIS**

Ulcerative colitis is an inflammatory disorder of the lining of the colon, the mucosa. It is confluent and always affects the rectum (Box 1; Box 2). It is subdivided according to the site of involvement:

- proctitis involves only the rectum
- distal or rectosigmoiditis involves both rectum and sigmoid colon
- left-sided colitis is continuous to the splenic flexure
- pancolitis involves the whole colon.

**BOX 1. PATHOLOGY OF IRRITABLE BOWEL DISEASE**

<table>
<thead>
<tr>
<th>Ulcerative colitis</th>
<th>Crohn’s disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starts at the rectum, continuous</td>
<td>Patchy disease with skip lesions</td>
</tr>
<tr>
<td>Has a definite end point</td>
<td>Can affect any part of digestive tract</td>
</tr>
<tr>
<td>Involves only mucosa</td>
<td>Involves mucosa, muscular layer and serosal layer</td>
</tr>
<tr>
<td>Rarely involves the anus</td>
<td>Often involves the anus</td>
</tr>
<tr>
<td>Never involves the small bowel</td>
<td>Often involves the small bowel</td>
</tr>
</tbody>
</table>

**BOX 2. [BOX HEADING?]**

**Ulcerative colitis**

Always affects the rectum. Some or all of the rest of the colon may also be involved. Disease is confluent.

| Proctitis (rectum only) | 40% |
| Distal colitis (rectum and sigmoid colon) | 25% |
| Pancolitis (rectum and whole colon) | 20% |
| Sub-total (rectum and transverse colon) | 10% |
| Left-sided colitis (rectum and colon up to splenic flexure) | 5% |

**Crohn’s disease**

Can occur in any part of the gastrointestinal tract. Disease may be patchy (in more than one place).

| Ileocaecal junction | 40% |
| Terminal ileum | 25% |
| Colon only | 25% |
| Extensive small bowel only | 5% |
| Other (upper gastrointestinal tract, rectal) | 5% |

The disease may progress with time in patients who are initially diagnosed with distal colitis. Treatment options vary according to the site and severity of involvement. Surgery is the only cure for colitis but means removing the colon.

Bloody diarrhoea with the passage of mucus is the most common symptom. Lower abdominal pain, relieved on defecation, urgency and tenesmus are common with proctitis and distal disease. Diarrhoea (more than 8 days) with severe pain, fever and abdominal distension is a symptom of fulminant colitis and necessitates urgent hospital admission.

**CROHN’S DISEASE**

Crohn’s disease is an inflammatory disorder that can affect any part of the gastrointestinal tract, from mouth to anus (Box 1; Box 2). It differs from ulcerative colitis in that it is a patchy disease with typical skip lesions. It can also be subdivided.

Inflammatory Crohn’s disease affects the mucosa; stricturing disease affects the muscular layer; and fistulating Crohn’s goes deeper into the serosal layer. Again, treatment depends on the area and severity of involvement. Surgery is not a cure.

Diarrhoea and pain are the two most common presenting symptoms (Box 3).
Systemic symptoms such as anorexia, lethargy, weight loss and fever are also common. Patients with colonic disease will also have rectal bleeding and pain related to defecation. Patients with Crohn’s disease are usually thin and anaemic and can have nutritional deficiencies. Malnutrition is common and is an important source of morbidity in people with Crohn’s disease. Even relatively quiescent disease can significantly impair the patient’s clinical status and quality of life.

**INVESTIGATIONS FOR IBD**

Blood tests include assay of the inflammatory markers ESR (erythrocyte sedimentation rate) and CRP (c-reactive protein). Diagnosis is made on endoscopy, with supportive biopsies for ulcerative colitis and Crohn’s colitis, and on small bowel barium studies for Crohn’s disease.

**TREATMENT**

The aim of treatment is to control inflammation. Corticosteroids (oral, rectal or intravenous) are usually prescribed on first presentation. Then maintenance of remission is achieved with regular medication alone or a combination of 5-ASA (5-aminosalicylate) agents (oral or rectal, these act locally within the mucosa), immunosuppressant therapy (by targeting immune response), biological therapy, nutrition and surgery.

**THE NURSE SPECIALIST**

The nurse specialist is a relatively new role in the field of IBD, but the number of nurses taking up posts throughout the UK is steadily growing.

**FREQUENTLY ASKED QUESTIONS**

- **How can I prevent a flare up?**
  It is important to keep well. Smokers should consider quitting. People with Crohn’s disease who smoke experience the disease more severely. It is important to take the medication, even when the disease is quiescent, as this will help to keep you in a remission. Maintain good nutrition. Patients with Crohn’s disease are often malnourished and underweight and require vitamin and mineral supplements. Avoid trigger factors that can initiate a relapse. Seek advice at the start of a relapse to prevent a more prolonged attack.

- **Can stress cause IBD?**
  Stress does not cause IBD, but symptoms may flare up if you are under pressure. Having bleeding and incontinence are stressful, so if the symptoms are not brought into remission quickly stress will exacerbate the flare up.

- **I have a bottle of steroids in the cupboard. Can I take them if I need to?**
  Steroids have no role in maintenance for IBD. They are used only to bring an acute attack into remission. If you are taking regular medication and still need steroids then your regular therapy will need to be stepped up. Further investigation may be required as disease extent in ulcerative colitis can progress. Patients should not take more than 2-3 courses of steroids in a 12 month period as they can cause life-long side-effects.

- **Should I consider a special diet?**
  There is no evidence to suggest that particular foods will exacerbate symptoms of IBD. Patients may actively avoid certain foods, such as dairy and wheat, but this varies from patient to patient. There is evidence that omega-3 fatty acids can be beneficial in IBD due to their anti-inflammatory effect. A good balanced diet is important for maintaining health. Patients with small-bowel Crohn’s disease may have specific needs, such as vitamin B12 replacement and iron therapy. Most patients will benefit from advice from a gastrointestinal dietitian.

- **Can IBD cause cancer?**
  The risk of colorectal cancer in colitis to the splenic flexure is no greater than for the general population. Studies have shown up to 12-15% of patients who have had pancolitis for 20 years develop colonic carcinoma.

- **Is IBD hereditary?**
  Of those patients with IBD, 15% have a relative with Crohn’s or ulcerative colitis. Children of an affected parent have an 80-90% chance of not being affected.
Disease relapses rarely coincide with a planned clinic appointment. Therefore, it is vital that patients have a point of contact for appropriate advice on how to manage their symptoms without delay, thus avoiding complications and a prolonged relapse. Patients experiencing an exacerbation can usually contact an IBD nurse specialist via a telephone helpline or email where immediate advice and treatment can be initiated. Occasionally patients are admitted immediately after this contact, but most are managed on an outpatient basis.

Specialist nurses also undertake telephone clinics for follow-up of patients with quiescent IBD. This saves valuable outpatient sessions for patients in relapse. Patients who are suitable to be seen by a nurse specialist include:

- newly diagnosed, requiring education or discussion about their condition
- patients in relapse who need an urgent appointment
- all ward discharges, on reducing steroid therapy [please explain?] 
- patients being started on immunomodulatory therapies [ok?] requiring discussion before initiation and then for blood monitoring
- patients in remission on 6-monthly or annual reviews.

**ONGOING SUPPORT**

Health-related quality of life is significantly impaired in patients with IBD. Unfortunately the stigma attached to bowel conditions means symptoms are not discussed. Therefore, ongoing support and education is particularly important for this group of patients. When patients have a good understanding of their illness they seem to cope better. The patient then becomes the expert and takes an active role in the management of their condition.

Compliance with medication and subsequent blood monitoring are important factors in primary care. Mesalazine-based medications, such as 5-ASA, are first-line treatment options. [ok?] Topical therapy in the form of suppositories and foam enemas are valuable in treating distal disease. Azathioprine and 6-mercaptopurine (6-MP) are widely acknowledged as the mainstay therapy for maintenance of long-term symptomatic remission in IBD. However, the well-documented side-effects cause concern for both the clinician and patient and regular full blood count and liver function tests are necessary.

Adequate nutrition is of obvious importance in the ongoing management of patients with Crohn’s disease. Therefore, continuation of nutritional supplements after remission appears valuable, as patients can become ill and debilitated very quickly. A good indication of disease inactivity is if the patient is putting on and maintaining body weight. Patients with IBD can develop extra-intestinal manifestations. These include:

- joint inflammation, which is usually disease-activity related
- sacroilitis and ankylosing spondylitis, which are independent of disease activity
- sore red itchy eyes (uveitis)
- mouth ulcers
- hepatic complications, such as fatty liver, autoimmune hepatitis, primary sclerosing cholangitis and gall stones
- osteoporosis. Disease activity leads to loss of bone density and steroids may reduce bone density.

There is little evidence to support the use of homeopathic medicine in IBD, but complementary therapies, aloe vera with its anti-inflammatory properties, and probiotics, may help with wind and bloating and can benefit patients.

**CONCLUSION**

Education, active listening and emotional support are vital elements of a positive approach to treatment in IBD. This can be best achieved through interprofessional working involving primary and secondary care.

Treatment will vary according to the extent and severity of the condition and will include a combination of medication, 5-ASA (oral and rectal), corticosteroids, immunomodulatory therapies and biologics. Management of Crohn’s disease will also include nutritional therapy and surgery.

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**REFERENCES**


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**RESOURCES**

- [www.nacc.org.uk](http://www.nacc.org.uk)
  National Association for Colitis and Crohn’s Disease
  information line: 0845 130 2233
talk to someone with Crohn’s disease or colitis: 0845 1303344
  email: nacc@nacc.org.uk
- [www.ibdclub.org.uk](http://www.ibdclub.org.uk)
The IBD Club
- [www.ccfa.org](http://www.ccfa.org)
  Crohn’s and Colitis Foundation of America
- [www.digestivedisorders.org.uk](http://www.digestivedisorders.org.uk)
  Digestive Disorders Foundation
- [www.bsg.org.uk](http://www.bsg.org.uk)
  British Society of Gastroenterology