crohn's colitis

Name of Clinical Care Pathway

Therapy Decision Tree—Crohn's Disease

Objective

Provide direction regarding the choice of therapy for patients with Crohn's disease

Patient Population

Adult patients (≥18years) with a known diagnosis of Crohn's disease

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These clinical decision support tools were developed by Canadian experts in IBD, based on their interpretation of current evidence and considerations specific to Canadian healthcare, including recommendations based on government policies and reimbursement policies by payers. International guidelines from Europe and the United States are available. However, these may reflect regional factors not directly applicable in Canada.

Abbreviations

CCP	Clinical Care Pathway
CBC	Complete blood count
CD	Crohn's disease
CDAI	Crohn's Disease Activity Index
CMV	Cytomegalovirus
CRP	C-reactive protein
CT	Computed tomography
FCP	Fecal calprotectin
GI	Gastrointestinal
HBI	Harvey-Bradshaw Index
IBD	Inflammatory bowel disease
MMX	Multi Matrix System
PO	Per oral

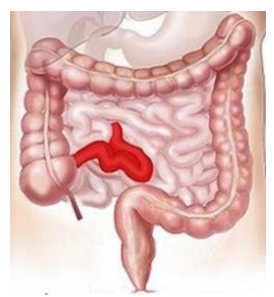
Highlights from this CCP

Therapy decisions are based on anatomic location of disease, severity of disease, disease complications, extra-intestinal manifestations of the disease, other comorbidities, and patient preference. Treatment goals include induction and maintenance of remission. New therapies are constantly being developed and should be considered.

Introduction

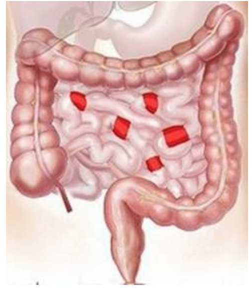
Crohn's disease (CD) is a chronic inflammatory condition that may affect any portion of the gastrointestinal tract from the mouth to the anus and perianal region. Extra-intestinal manifestations and/or complications can occur. The most commonly affected parts of the GI tract are the terminal ileum and colon. Inflammation is typically segmental, asymmetrical and transmural. Most patients are diagnosed with an inflammatory phenotype at first presentation, but over time, complications such as strictures, fistulas or abscesses can develop in over half of patients. These complications often require surgery.

Types of CD

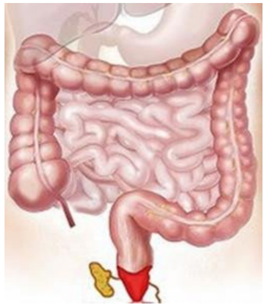


Ileal

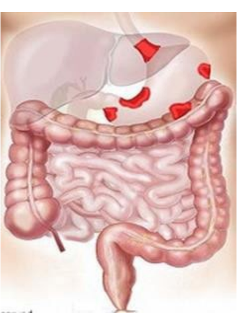
Colonic



Proximal small bowel



Perianal



Gastroduodenal

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The Montreal classification is commonly used to classify the major phenotypic features of CD based on age at diagnosis, location of the disease and disease behavior.

Clinical factors	Montreal classification
Age at diagnosis (A)	A1: 16 years or younger A2: 17-40 years A3: Over 40 years
Disease location (L)	L1: Ileal L2: Colonic L3: Ileocolonic L4: Upper GI*
Disease behavior (B)	B1**: Inflammatory B2: Stricturing B3: Penetrating p***: Perianal disease modifier

*L4 is a modifier that can be added to L1-3 when concomitant upper GI disease is present

**B1 category should be considered 'interim' until a pre-specified time has elapsed from the time of diagnosis. Such a time period may vary from study to study (e.g. 5-10 years is suggested) but should be defined in order for B1 behavior to be considered 'definitive.' GI—Gastrointestinal

***p is a modifier that can be added to B1-3 when concomitant perianal disease is present

Prior to therapy decisions, the following assessments should be carried out and treatment goals discussed with the patient.

Goal of therapy: Deep and prolonged remission with long-term goal of preventing complications and halting the progressive course of the disease. Deep remission is a combination of symptomatic and endoscopic remission.

Assess the inflammatory status of the disease:

- Symptoms: Fever, abdominal pain, diarrhea, GI bleeding, localized tenderness, weight loss and symptoms of extraintestinal manifestations of IBD
- Exclude infections: Clostridium difficile, cytomegalovirus (CMV)
- Exclude symptoms not related to active inflammation: Bile acid diarrhea, bacterial overgrowth, steatorrhea/fat malabsorption
- Perianal or abdominal abscess or fistula: Pain, fistula drainage, fever (see Management of Perianal Penetrating Crohn's Disease)
- Clinical laboratory testing: Complete blood count (CBC), C-reactive protein (CRP), fecal calprotectin (FCP)
- Imaging: Endoscopy and computed tomography (CT), enterography or magnetic resonance enterography or intestinal ultrasound
- Exclude stricture: Abnormal imaging (bowel dilation), obstructive symptoms, stricture on endoscopy

Assess comorbidities as well as disease and therapy-related complications:

- Review prior IBD medication exposure
- Immune mediated inflammatory conditions: Ankylosing spondylitis, arthritis, psoriasis, pyoderma gangrenosum, uveitis, etc.
- History of malignancies

Predicted severity of disease course:

Moderate/high risk:

- Active smoking
- Recurrent hospitalizations

- Perianal disease, stricturing/penetrating disease
- >1 bowel resection
- Length of affected bowel (ileocolonic and/or small bowel involvement)
- Diagnosis at a younger age (pediatric onset disease diagnosis or <40 years)

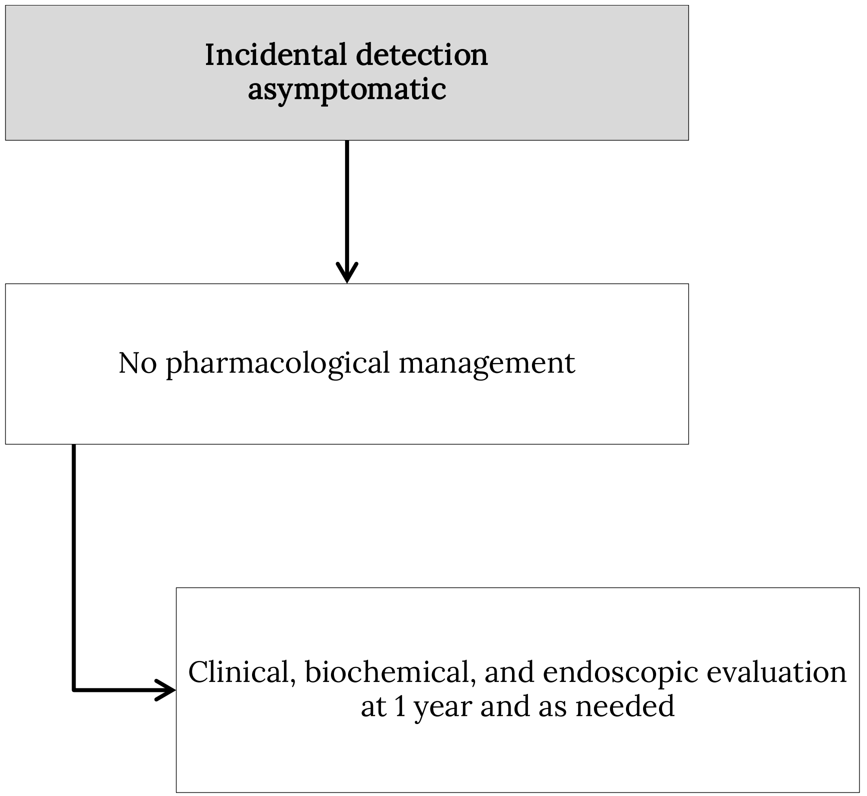
The absence of the above-mentioned factors is indicative of low risk

Management of mild Crohn's disease (CD)

Mild disease is defined as CDAI <220 or HBI ≤7.

Following complete evaluation with endoscopy (ileocolonoscopy ± upper endoscopy) and/or imaging and lab tests, the choice of treatment will in part depend on the distribution of disease as well as disease activity.

Flowchart 1.1: If the diagnosis of CD is incidental and the patient is asymptomatic



If the patient is symptomatic, proceed to Flowchart 1.2

Flowchart 1.2: If the patient is diagnosed with CD and is symptomatic

Symptomatic

↓

Topical or oral MMX budesonide (+ optional taper) and consider initiation of thiopurine/methotrexate or sulfasalazine* PO for mild colonic disease

↓

Assess in 3 months for symptomatic response, and biochemical response if elevated at baseline

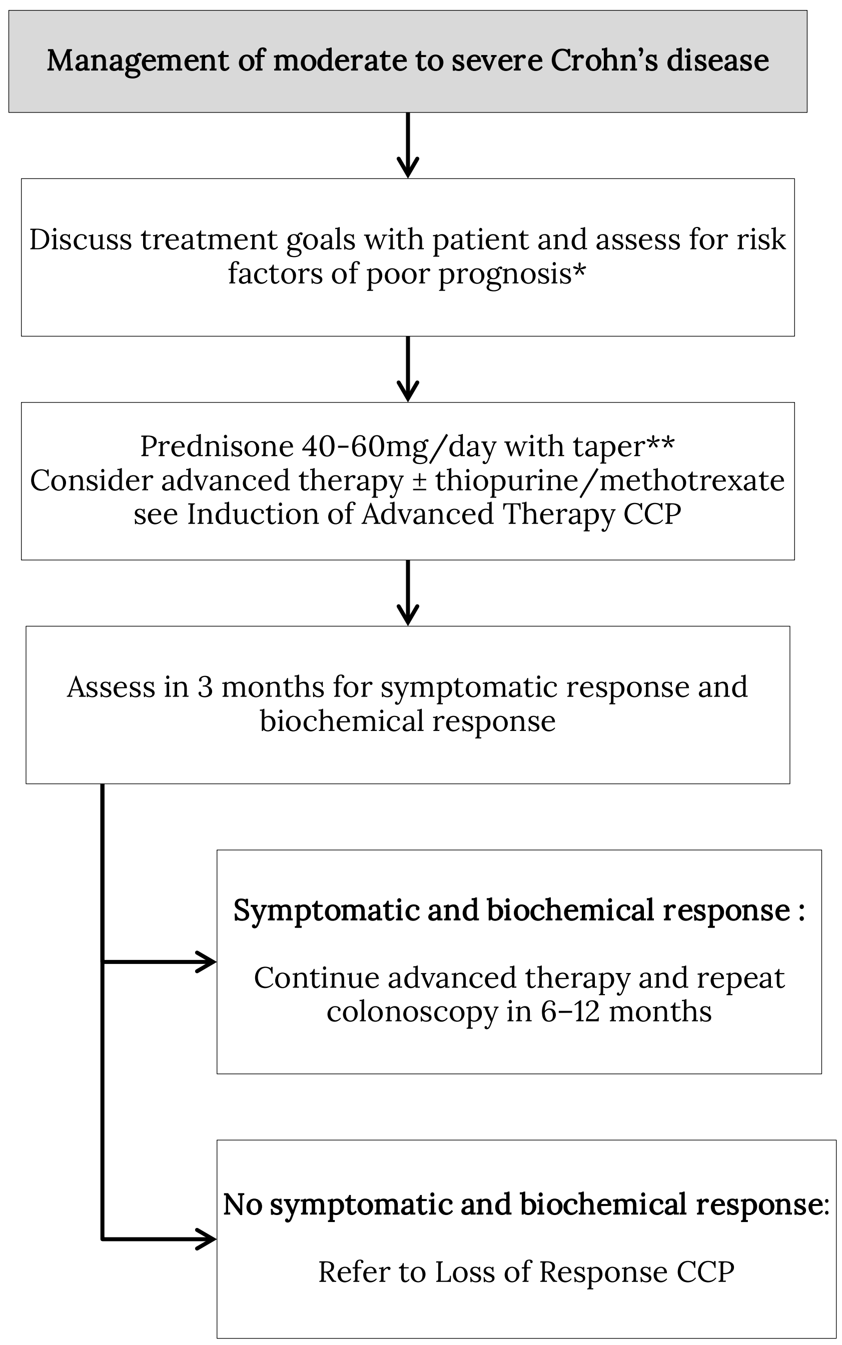
→ **Symptomatic and biochemical response**: Continue thiopurine or methotrexate maintenance

→ **No symptomatic and biochemical response:** Refer to the management of moderate to severe Crohn's disease (Flowchart 2)

*Sulfasalazine may be considered as an adjunct in patients with concurrent arthralgias/arthropathy

Disclaimer statement: Clinical care pathways never replace clinical judgement. Care outlined in this pathway must be altered if it is not clinically appropriate for the individual patient.

Flowchart 2: Management of moderate to severe Crohn's disease



Instruct the patient to contact the office if new symptoms occur.

*Consider early ileal resection (especially in localized ileocecal disease and stricturing disease).
**Ongoing use of steroids is not recommended; do not prescribe more than 2 courses of steroids over 12 months.

Link to: Induction of Advanced Therapy CCP   Link to: Loss of Response CCP

Other Resources

IBD providers

Inflammatory Bowel Disease: Drug Comparison chart (Link)

Patients

Crohn's and Colitis Canada: IBD journey webpage (Link)

UpToDate® - Patient education: Crohn's disease (Beyond the Basics) (freely accessible) https://www.uptodate.com/contents/crohn-disease-beyond-the-basics?search=crohns%20disease&source=search_result&selectedTitle=1~20&usage_type=default&display_rank=1 (Link)

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