

# Managing IBD in General Practice

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Dr Karl Hazel, MD MRCPI  
Consultant Gastroenterologist

# Overview

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- IBD
- When to refer?
- Current management
- Managing a flare
- Healthcare maintenance

# Inflammatory Bowel Disease

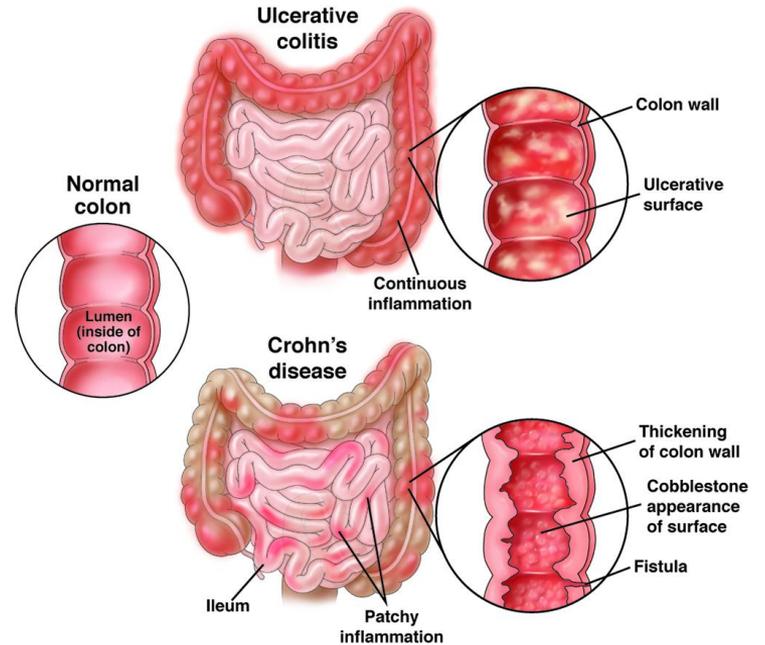
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- ▶ Incidence of Ulcerative colitis : 10/100,000
- ▶ Incidence of Crohn's disease : 7/100,000



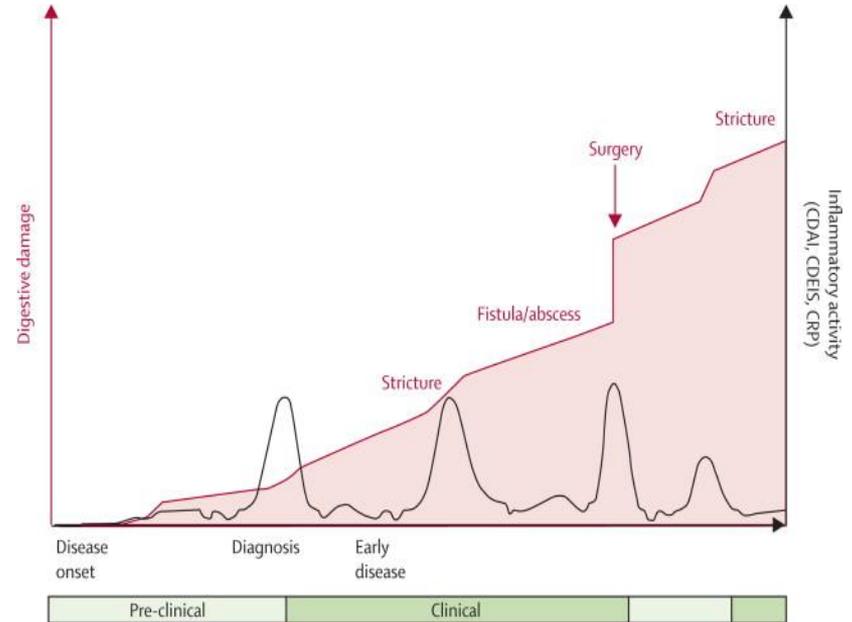
# Inflammatory Bowel Disease

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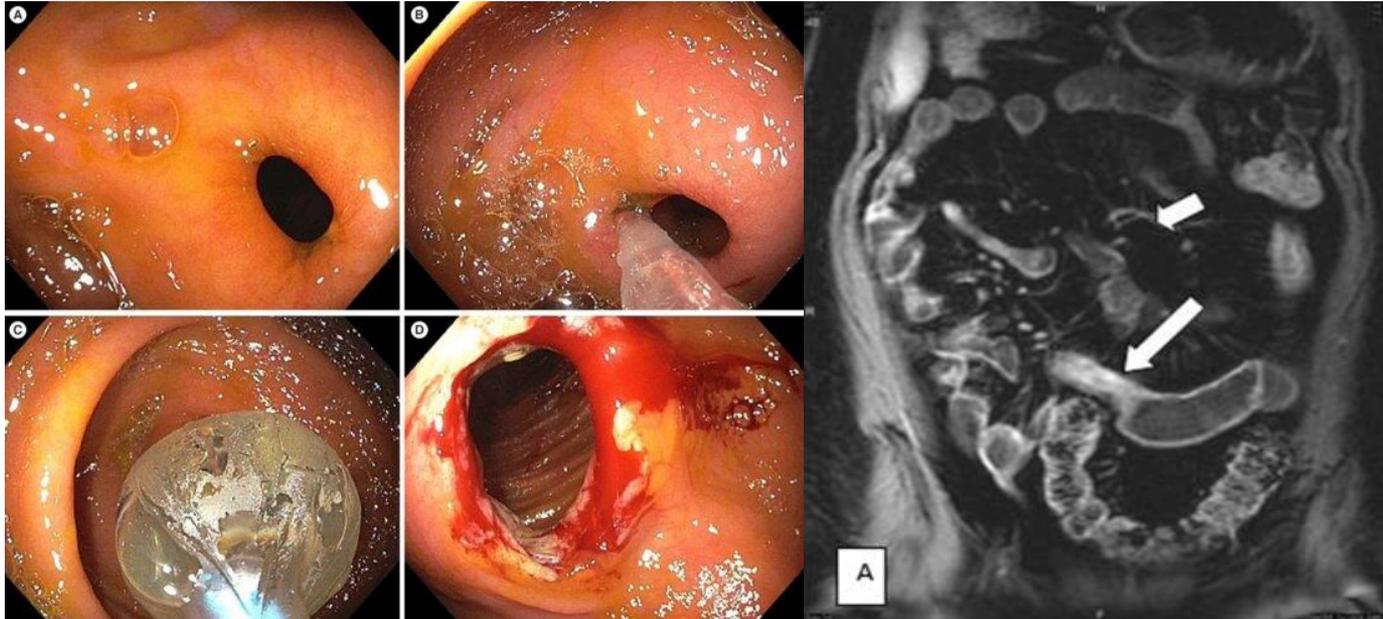
# Inflammatory Bowel Disease

- Average time to diagnosis 7 – 15 months (CD)
- 3 – 7 months (UC)

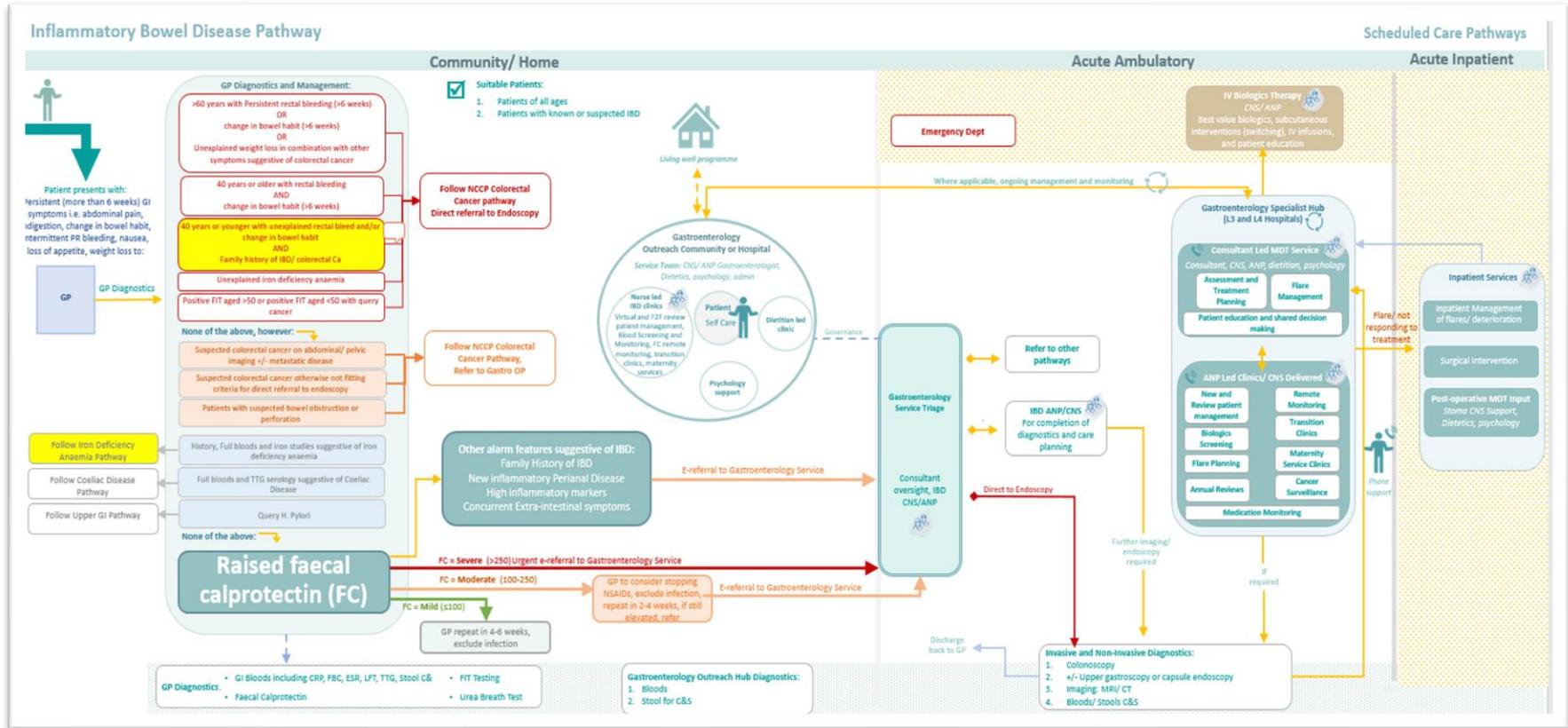


# Inflammatory Bowel Disease

- 2 – 4 times more likely to need surgery



# When to Refer?



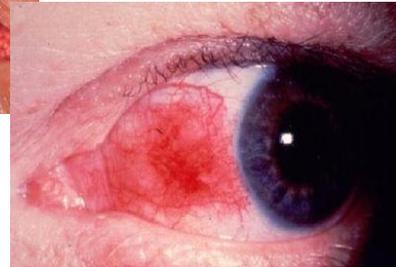
## When to Refer?

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- Chronic diarrhoea (> 4 weeks)
- Bloods +/- mucus in stool
- Abdominal pain
- Weight loss
- Fatigue
- Anaemia

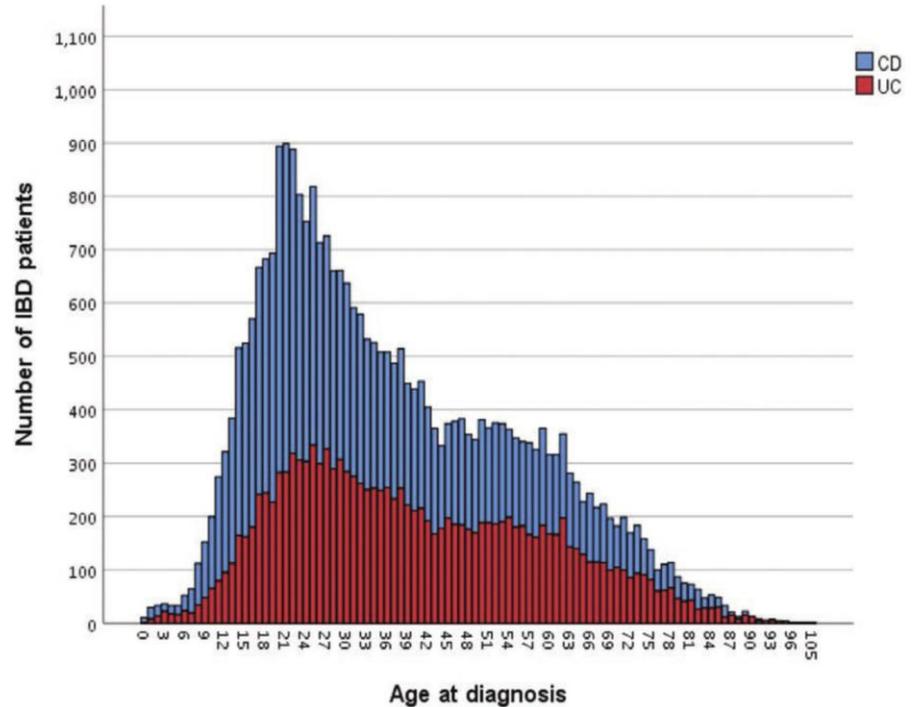
# When to Refer?

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- EIMs

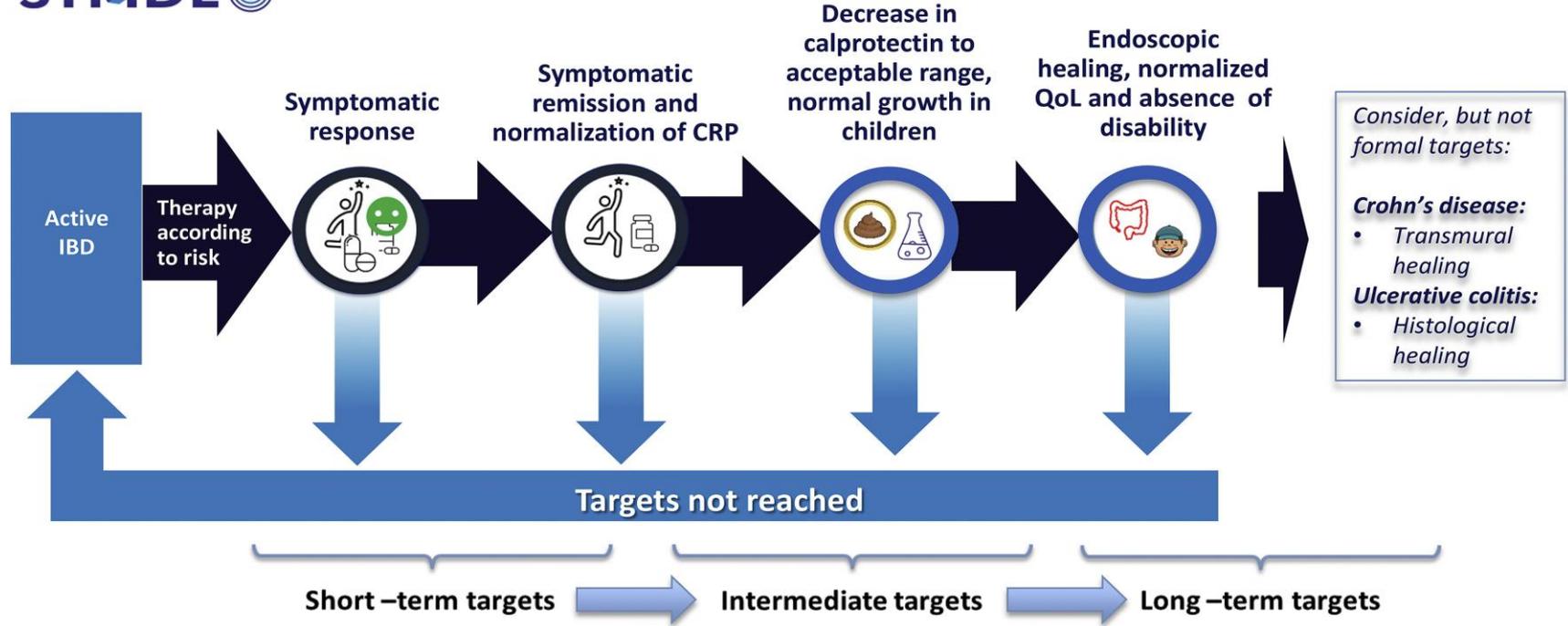


# When to Refer?

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- Weight loss
- Fatigue
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- EIMs



# Treatment Goals



# Treatment



Pill not actual size

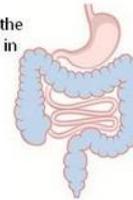


# Managing Flares

- Is it a flare?
  - F. Cal
  - Stool MC+S
- Should I give steroids?
  - Prednisolone
  - Budesonide

## Uceris™ : MMX® Technology Allows Budesonide to Target the Full Length of the Colon

Uceris (budesonide)  
Uceris is indicated for the induction of remission in patients with active, mild to moderate UC.



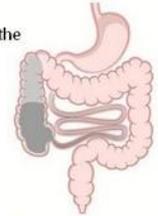
Uceris, unlike Entocort® EC, is designed for targeted local action at the entire site of UC

Target:  
Full length of colon

MMX technology:  
Pill dissolves at pH  $\geq 7.0$ , the approximate pH level near the entry to the colon

Dosage:  
9 mg tablet QD

Entocort® EC (budesonide)  
Entocort® EC is indicated for the treatment of active, mild to moderate Crohn's disease involving the ileum and/or ascending colon



Target:  
Ileum/ascending colon

Controlled ileal release:  
Pill dissolves at pH  $> 5.5$  the approximate pH level of the duodenum

Dosage:  
3 mg x 3 capsules QD

# Managing Flares

- Is it a flare?
  - F. Cal
  - Stool MC+S
- Should I give steroids?
  - Prednisolone
  - Budesonide

## Oral Budesonide Formulations

### Budenofalk®

#### Indications

- Crohn's disease
  - ◊ 9mg cap OD mane or 3mg cap TDS, for up to 8 weeks
  - ◊ 9mg granules OD mane, for up to 8 weeks
- Collagenous colitis
  - ◊ Induction of remission:
    - 9mg cap OD mane, for up to 8 weeks
    - 9mg granules OD mane, for up to 8 weeks
  - ◊ Maintenance: 6mg cap OD mane or, 6mg cap OD mane alternating with 3mg cap, for up to 8 weeks
- Autoimmune hepatitis
  - ◊ Induction of remission: 3mg TDS
  - ◊ Maintenance: 3mg BD for at least 24 months

Gradually reduce dose over last 2 weeks

#### Formulations

- 3mg capsules
- 9mg granules sachet

#### Release mechanism

pH-dependent modified release

#### Site of release

Ileum and ascending colon

<https://bnf.nice.org.uk/drug/budesonide/>  
<https://www.medicines.org.uk/ems/search?q=budesonide>  
<https://www.drifalk.co.uk/budenofalk-oral-preparations/>

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### Jorveza®

#### Indications

- Eosinophilic oesophagitis
  - ◊ 1mg tab BD for 6 weeks (up to 12 weeks), to be taken after food

#### Formulations

- 1mg tablet

#### Site of release

Oesophagus

### Cortiment®

#### Indications

- Ulcerative colitis, Collagenous colitis
    - ◊ Induction of remission: 9mg tab OD mane, for up to 8 weeks
- Avoid in patients with hypersensitivity to peanuts or soya (contains soya lecithin).*

#### Formulation

- 9mg tablet

#### Release mechanism

MMX® extended release

#### Site of release

Ascending, transverse and descending colon

### Entocort®

#### Indications

- Crohn's disease
  - ◊ 9mg (3 caps) OD mane, for up to 8 weeks.
- Collagenous colitis
  - ◊ Induction of remission: 9mg (3 caps) OD mane
  - ◊ Maintenance: 6mg (2 caps) or lowest effective dose, OD mane

Gradually reduce dose for last 2-4 weeks of therapy

#### Formulation

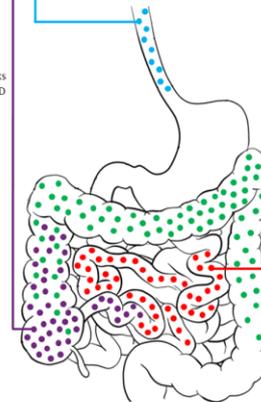
- 3mg capsules

#### Release mechanism

Controlled extended release

#### Site of release

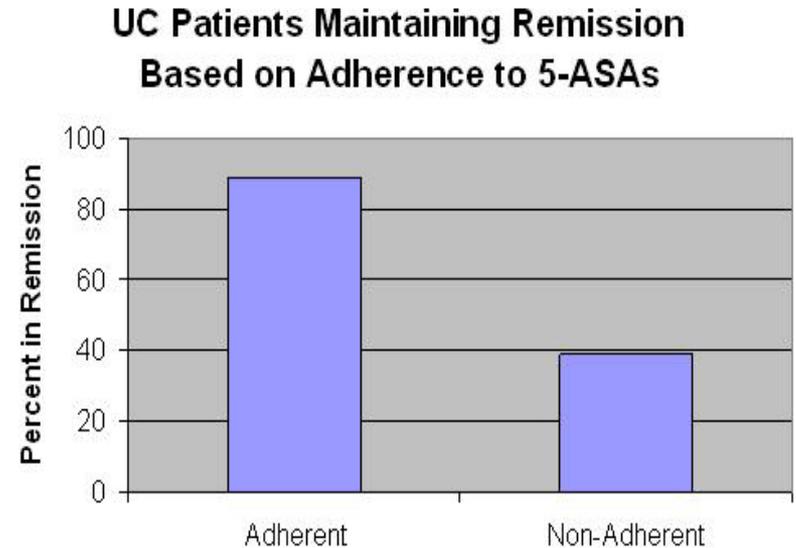
Jejunum



SANTARIS

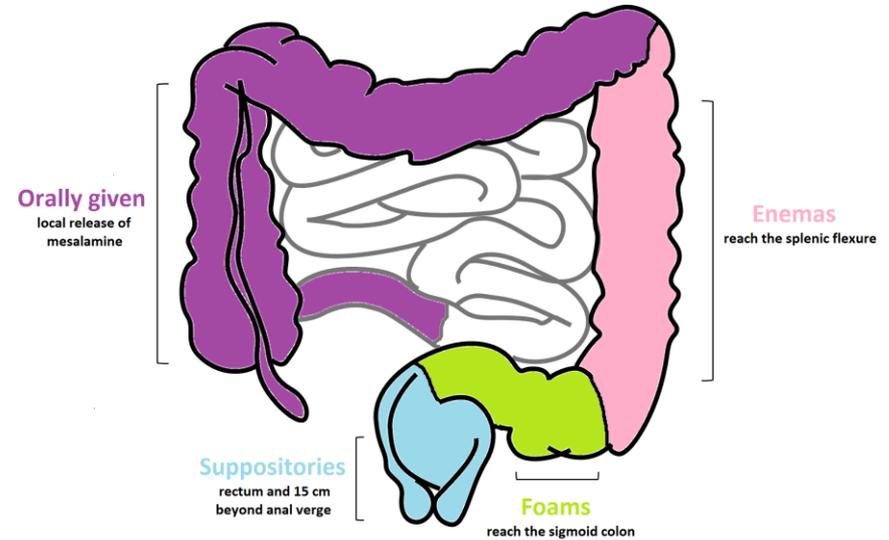
# Managing Flares

- Is it a flare?
  - F. Cal
  - Stool MC+S
- Should I give steroids?
  - Prednisolone
  - Budesonide
- Are the current treatments optimised?



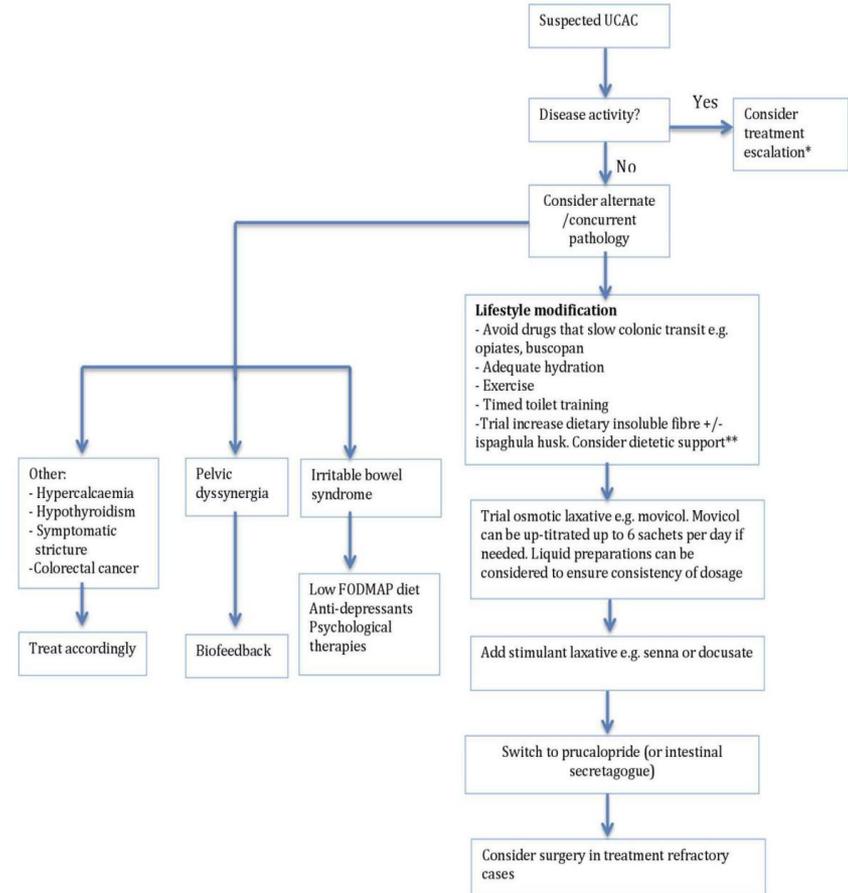
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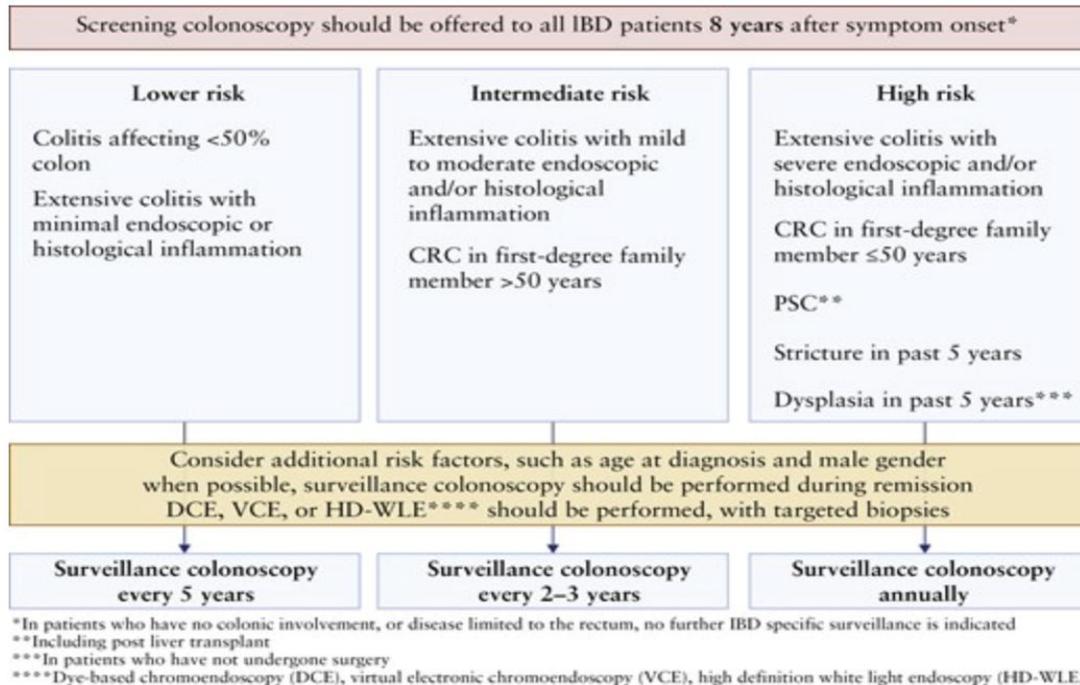
# Managing Flares

- Is it a flare?
  - F. Cal
  - Stool MC+S
- Should I give steroids?
  - Prednisolone
  - Budesonide
- Are the current treatments optimised?
- Constipation under-treated



# Healthcare Maintenance

- Surveillance



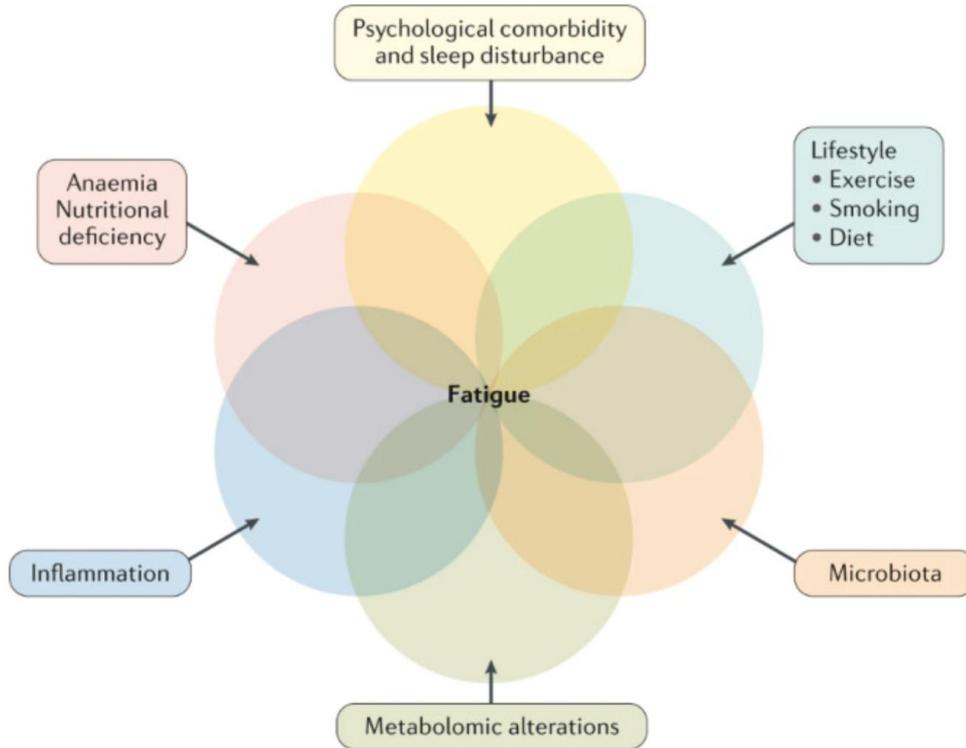
- Malignancy

Cancer risk associated with conventional and advanced IBD therapies

Drug	Cancer	Evidence level	Additional considerations
Thiopurine	Lymphoproliferative Myeloproliferative NMSC Cervical	EL1 EL3 EL2 EL4	EBV exposure Age Gender Cervical cancer risk not replicated in all cohorts
TNF antagonist	Lymphoma Melanoma	EL2 EL2	Risk not replicated in all cohorts
TNF antagonist with thiopurine	Lymphoma	EL2	Risk increased compared with both unexposed populations and monotherapy
Vedolizumab	None	EL4	Limited duration of follow-up
Ustekinumab	None	EL4	Limited duration of follow-up in IBD; data from non-IBD indications with lower doses
JAK inhibitors	All except NMSC	EL4	In high-risk RA population only Not replicated in IBD
Methotrexate	NMSC	EL5	Risk not replicated NMSC in all cohorts

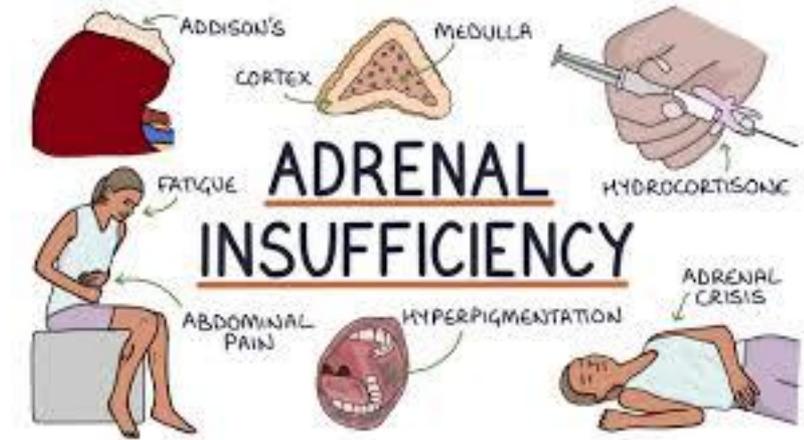
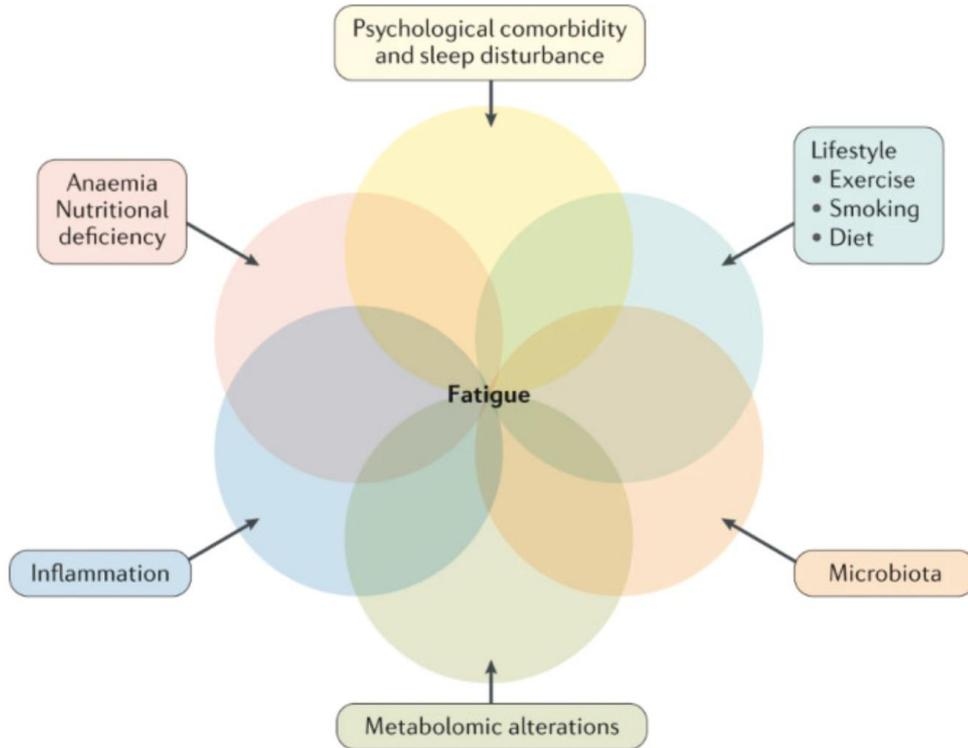
# Healthcare Maintenance

- Fatigue



# Healthcare Maintenance

- Fatigue



- Fertility, pregnancy, breast-feeding

## Global Consensus on the Management of Pregnancy in Inflammatory Bowel Disease

### Key Points:

- Reduced fertility with active disease and IPAA
- No risk of flare with oocyte retrieval
- Increased risk of pre-term delivery
- Increased risk of spontaneous abortion with active disease
- Increased risk of VTE



### Clinical Guidance:

- Continue all biologics and thiopurines throughout pregnancy and lactation
- Avoid small molecules during pregnancy and lactation
- Provide preconception counseling to improve outcomes
- Provide low dose aspirin to reduce pre-term preeclampsia
- Perform a cesarean section for delivery if active perianal fistula, rectovaginal fistula, IPAA

### Key Points:

- Increased risk of IBD if first degree relative with IBD
- Increased risk of low birth weight with active maternal IBD
- Increased risk of NICU
- Increased risk of SGA with active maternal IBD
- No increased risk of infant infections, malignancy, or developmental delay with biologic exposure



### Clinical Guidance:

- Inactive vaccines should be given on schedule regardless of medication exposure
- Live vaccines should be given on schedule EXCEPT BCG, which can be given after six months in infants exposed to biologics in utero

IPAA: Ileal pouch anal anastomosis  
VTE: Venous thromboembolism  
IBD: Inflammatory Bowel Disease

NICU: Neonatal intensive care unit  
SGA: Small Gestational Age  
BCG: Bacillus Calmette-Guérin

- Fertility, pregnancy, breast-feeding

**Table 9.** IBD Medications From Preconception Through Pregnancy and Lactation

Medication	Preconception	First trimester	Second trimester	Third trimester	Lactation
Aminosalicylates o Folic acid supplementation with sulfasalazine	✓	✓	✓	✓	✓
Thiopurine o Monitor metabolites, liver enzymes	✓	✓	✓	✓	✓
Methotrexate o Teratogen o Cessation 1–3 months prior to conception	✗	✗	✗	✗	✗
Corticosteroids o Minimize use o Employ steroid-sparing therapy	✓	✓	✓	✓	✓
Anti-TNF	✓	✓	✓	✓	✓
Anti-integrin	✓	✓	✓	✓	✓
Anti interleukin-12/23 or anti interleukin-23	✓	✓	✓	✓	✓
JAKi o Avoid o Use only if no other viable option for maternal health	!	!	!	!	!
S1P receptor modulator o Avoid o Use only if no other viable option for maternal health	!	!	!	!	!

# Healthcare Maintenance

- Fertility, pregnancy, breast-feeding



**Figure 3.** Relative infant dose: estimating infant exposure to monoclonal antibodies via breast milk.

## Last Points

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- AIN with mesalazine
- Vaccinations
- Prescribe PJP prophylaxis if adding steroids in patients with anti-TNF/AZA
- Osteoporosis/osteopenia screening as per general population
- Rising LFTs think of PSC-IBD

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# Thank you