

key points

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Inflammatory bowel disease (IBD) is a chronic inflammatory condition which runs a relapsing and remitting course. The aetiology remains unclear but is thought to involve genetic susceptibility, altered gut microbiota, changes in immunological response and environmental triggers. Ulcerative colitis (UC) is more common than Crohn's disease (CD). UC almost always affects the rectum and extends proximally and continuously to the colon to a variable extent. CD most commonly affects the terminal ileum or colon but can affect any part of the gastrointestinal tract from the mouth to the anus.

IBD may affect people at any age. The most common age of onset for CD is the early to mid-20s. UC has an initial peak at 15-25 years and a second smaller peak at 55-65. Chronic diarrhoea (≥ 4 weeks) is a common symptom of UC and CD. The vast majority (90%) of people with UC report bloody stools compared with less than 50% of those with CD. Diarrhoea in UC is commonly associated with urgency and there may be cramping lower abdominal pain. CD is characterised by a triad of abdominal pain, diarrhoea and weight loss. Perianal disease is more common in CD and can consist of skin tags, fissures, abscesses and fistulae.

Fatigue is common and may be idiopathic or due to anaemia, sleep disturbance or depression. IBD can also affect other parts of the body in around 25% of cases. Patients may suffer from arthropathies, erythema nodosum, pyoderma gangrenosum, ocular conditions such as episcleritis, scleritis and uveitis, aphthous oral ulcers, osteopenia, primary sclerosing cholangitis and autoimmune hepatitis.

If IBD is suspected, the severity of symptoms should be assessed and risk factors such as smoking history and family history reviewed. A full blood count, U&E, inflammatory markers (CRP and ESR) and haematinics should be requested. Patients should be asked about foreign travel and a stool sample sent for microscopy, culture and a *Clostridium difficile* toxin assay. Testing for amoebic or Shigella dysentery should be performed if the travel history is suggestive. In patients at low risk for malignancy, where other causes have been excluded and where there is diagnostic uncertainty, faecal calprotectin can be used as a rule-out test.

Patients fulfilling the Truelove and Witts' criteria for a severe flare require hospital admission. Otherwise patients with suspected IBD, should be referred directly to a consultant gastroenterologist specialising in IBD. UC is most commonly diagnosed with flexible sigmoidoscopy and histological assessment of mucosal biopsies. In CD the first-line investigation is an ileocolonoscopy with mucosal biopsies from the colon and ileum. IBD patients with colonic disease should be offered ileocolonoscopy eight years after symptom onset to assess cancer risk and determine the frequency of further colorectal screening.