

key points

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The two major types of inflammatory bowel disease (IBD)

are ulcerative colitis and Crohn's disease. Both are characterised by a relapsing and remitting course. In ulcerative colitis the mucosal inflammation affects the rectum and to a variable extent the areas proximal to the rectum in a continuous pattern. Crohn's disease is characterised by discontinuous areas of transmural inflammation that can affect any part of the GI tract but most frequently involves the distal small intestine and proximal colon. IBD has a prevalence of around 400 per 100,000 in the UK. There is a bimodal age of presentation with an initial peak in the second and third decades of life followed by another peak in the sixth decade.

Acute ulcerative colitis typically presents with bloody

diarrhoea with the passage of mucus, urgency and cramping abdominal pain. A severe attack is usually considered to be associated with bloody stools six times a day or more plus one of the features of systemic toxicity. Patients with a severe attack require hospitalisation and intensive inpatient treatment. Inflammatory markers in the blood are not always raised in ulcerative colitis. The diagnosis is confirmed by typical histological features on biopsy.

Crohn's disease presents with a typical combination of

abdominal pain, diarrhoea and weight loss. Pain or fever may also signify the development of an abscess and stricture formation will lead to obstructive symptoms. Perianal disease in the form of abscesses or fistulae may be present in 35 to 45% of patients during the course of their disease.

Oral aminosalicylates are first-line maintenance therapy

in left-sided and extensive ulcerative colitis. Azathioprine or 6-mercaptopurine should be considered for maintaining remission. Surgery may be required as an emergency during an acute severe attack of ulcerative colitis for perforation, toxic dilatation, massive haemorrhage or where an attack does not settle with medical treatment. Surgery may also be considered in patients with frequent relapses or less severe chronic symptoms despite medical therapy and where surgery may restore quality of life.

Crohn's disease treatment usually follows a sequential

step-up approach, in which less aggressive treatments are initiated first, followed by more potent drugs or surgery if the initial medical therapy fails. Aminosalicylates have limited benefit for maintenance of remission in Crohn's disease. Azathioprine/6-mercaptopurine should be considered as the first-line maintenance treatment in the following cases: after an acute severe attack or two more relapses in a 12-month period requiring corticosteroid therapy.