key points

SELECTED BY

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Ulcerative colitis (UC) and Crohn's disease together constitute inflammatory bowel disease (IBD). They characteristically present in young adults, but may present at any time of life.

UC always affects the rectum and then progresses to a variable extent around the colon, but never extends into the small bowel. By contrast, Crohn's disease may occur anywhere in the GI tract, from the mouth to the anus, with skip lesions – inflamed areas affected by Crohn's disease – separated by areas of apparently normal mucosa.

Patients with distal colonic disease tend to present with rectal bleeding. This may be associated with the passage of mucus and/or diarrhoea, although if the disease is very distal the number of bowel motions may be normal or the patient may even be constipated, with bleeding being the predominant feature. Patients with more extensive colonic disease can present with bloody diarrhoea and the passage of mucus. Associated systemic symptoms including weight loss and lethargy may also be present. Small bowel Crohn's disease may present more insidiously, with generalised symptoms of weight loss, anorexia, tiredness and incidental iron deficiency anaemia.

Initially, FBC, U&Es, LFTs, CRP, tissue transglutaminase and ESR should be performed. Three stool samples should be sent for microscopy, culture and sensitivity.

Patients should be referred to a gastroenterologist for endoscopy if they have any of the following symptoms: persistent diarrhoea for longer than one month, particularly with the passage of blood; significant weight loss and abdominal pain or markedly abnormal inflammatory markers with negative stool cultures.

Patients should be referred urgently if they present with any of the following: significant abdominal distension or systemic upset with fever; tachycardia; anaemia or passing bloody diarrhoea more than six times a day.

The treatment of IBD depends on both its severity and its site. In UC, topical treatment should be considered for patients with distal disease who do not have systemic symptoms. Mesalazine, either as a suppository or an enema, is the most effective topical treatment, but if the patient is intolerant then steroid suppositories or enemas may be used. Generally, extensive disease requires systemic treatment. Mesalazine may be used if there are no features of severe disease. Patients who meet the criteria for acute severe disease or have evidence of dilatation of the gut should be referred urgently for inpatient management. The treatment for colonic Crohn's disease is similar to UC. However, mesalazine is less effective in Crohn's than UC and oral prednisolone may therefore be required earlier. Oral prednisolone is the first-line treatment for adults with diffuse small bowel Crohn's disease.