

Practice Guidelines

Crohn's Disease: ACG Releases Updated Management Guidelines

Key Points for Practice

- Fecal calprotectin testing can help distinguish inflammatory bowel disease from irritable bowel syndrome.
- Short-term oral corticosteroids can be prescribed to treat moderate to severe Crohn's disease.
- Nonsteroidal anti-inflammatory drugs and cigarette smoking should be avoided because of their link to worsening disease activity.

From the AFP Editors

Options for managing Crohn's disease continue to increase, as does the prevalence of the disease. The American College of Gastroenterology (ACG) has released an updated clinical practice guideline outlining features of the disease, as well as diagnosis and treatment options. Treatment guidance is based on the location and severity of disease, adverse effects, and prognosis; treatment options should be individualized to each patient based on their response and tolerance levels. Patients with mild to moderate Crohn's disease are typically ambulatory and can tolerate oral nutrition without adverse effects (e.g., dehydration, intestinal obstruction, abdominal pain, weight loss), whereas patients with moderate to severe disease are those whose condition is not amenable to treatment used for mild to moderate disease or who experience more severe symptoms such as significant weight loss, abdominal pain, or anemia. Patients with severe disease have symptoms of intestinal obstruction and peritoneal signs or symptoms that persist despite treatment with corticosteroids or biologic agents in the outpatient setting.

Recommendations

HIGH-LEVEL EVIDENCE

Moderate to Severe Disease. In persons with moderate to severe Crohn's disease who are naïve to immunomodulators

or infliximab (Remicade), treatment with these medications combined is more effective than monotherapy. Patients in whom corticosteroids, thiopurines, methotrexate, or anti-tumor necrosis factor (TNF) inhibitors have been ineffective, as well as those who have not taken anti-TNF inhibitors previously, should receive ustekinumab (Stelara). For those in whom symptom remission is desired, treatment with natalizumab (Tysabri) alone or vedolizumab (Entyvio) with or without an immunomodulator should be considered.

MODERATE-LEVEL EVIDENCE

Fecal calprotectin testing can be considered in all patients with Crohn's disease to help distinguish inflammatory bowel disease from irritable bowel syndrome.

Mild to Moderate Disease. Persons with mild to moderate Crohn's disease should not receive oral mesalamine because it has not been consistently shown to be more effective than no treatment for initiating remission or healing mucosa.

Moderate to Severe Disease. Short-term oral corticosteroids can be prescribed to treat moderate to severe Crohn's disease, with azathioprine (Imuran) and 6-mercaptopurine considered to support remission. Cyclosporine (Sandimmune), mycophenolate (Cellcept), and tacrolimus (Prograf) should be avoided because they are not effective. For disease not amenable to corticosteroids, thiopurines, or methotrexate, anti-TNF agents (e.g., infliximab, adalimumab [Humira], certolizumab pegol [Cimzia]) are recommended. Natalizumab should only be continued to maintain remission if results of serum antibody to John Cunningham virus testing are negative, with testing performed every six months and treatment halted upon a positive result.

LOW-LEVEL EVIDENCE

When patients have a high risk of colorectal neoplasia, chromoendoscopy, which uses stains to identify colorectal dysplasia and is superior to standard definition endoscopy,

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should be used in conjunction with colonoscopy. Stress, depression, and anxiety can result in reduced quality of life in persons with Crohn's disease, as well as less compliance with physician guidance; therefore, these conditions should be addressed as part of each patient's treatment plan. Non-steroidal anti-inflammatory drugs and cigarette smoking should be avoided because of their link to worsening disease activity. Of note, antibiotics should not be avoided as a method to prevent flares.

Mild to Moderate Disease. Treatment with antimycobacterials should not be used as the main treatment for any patient with mild to moderate Crohn's disease. Metronidazole (Flagyl) should not be used as the main treatment regimen, and ciprofloxacin is not recommended for luminal inflammatory disease. Sulfasalazine (Azulfidine) can be used in persons with colonic mild to moderate Crohn's disease, and controlled ileal-release budesonide (Entocort EC) can be used in persons with mild to moderate ileocecal disease. If patients are unlikely to have the condition advance, management options include antidiarrheal or other non-specific medications, and changes in diet (e.g., elemental, defined) in conjunction with careful monitoring.

Moderate to Severe Disease. Corticosteroids should be used cautiously in patients with moderate to severe Crohn's disease. Although azathioprine and 6-mercaptopurine should not be used to initiate symptom remission in the short term, they may be effective in reducing corticosteroid use, and thiopurine methyltransferase testing should be considered before they are initiated. Methotrexate is an option to sustain remission, as well as to treat patients dependent on corticosteroids.

Guideline source: American College of Gastroenterology

Evidence rating system used? Yes

Systematic literature search described? Yes

Guideline developed by participants without relevant financial ties to industry? No

Recommendations based on patient-oriented outcomes? Yes

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