AGA INSTITUTE GUIDELINES FOR THE
Identification, Assessment and Initial Medical Treatment
in Crohn’s Disease

CLINICAL DECISION SUPPORT TOOL

Review online at www.gastro.org/IBDcarepathway.
Assess symptoms/signs
- Fever
- Abdominal pain
- GI bleeding
- Localized tenderness
- Weight loss
- Joint pain
- Cutaneous signs

Perform clinical lab testing:
- CBC
- CRP
- CMP
- Fecal calprotectin
- ESR

Select imaging modalities (if indicated)

Perform endoscopy

Identify symptoms without inflammatory markers

Identify symptoms with inflammatory markers‡

Perform CT-enterography OR magnetic resonance enterography(*,1,2,3)

* Selection depends on local expertise and experience with imaging modalities. Magnetic resonance enterography is preferred due to the reduction in ionizing radiation, particularly for younger patients. If patient is less than 50 years of age, we suggest using magnetic resonance enterography.

‡ Consideration could be given as to whether to make treatment decisions based on inflammatory markers versus confirming with colonoscopy. This may depend on whether there was historically good correlation between the biomarker selected and colonoscopy in the specific patient.
Infections

- C. difficile, CMV, food poisoning

- Abnormal imaging (bowel dilation)
  - Obstructive symptoms
  - Weight loss

- Bile acid diarrhea
  - Bacterial overgrowth
  - Steatorrhea/fat malabsorption

- Recent introduction of new agent; drug holiday

Symptoms related to prior surgery

- Pain, fistula drainage, fever

- Weight loss

Stricture/remodeling

- Pain, fistula drainage, fever

Adverse reaction to medical therapy

- Pain, fistula drainage, fever

Abdominal abscess or fistula

- Pain, fistula drainage, fever

Perianal abscess or fistula

Assess comorbidities and disease and therapy related complications

Review online at www.gastro.org/IBDcarepathway.
Assess current and prior disease burden

Identify patient as low risk
- Age at initial diagnosis > 30 years
- Limited anatomic involvement
- No perianal and/or severe rectal disease
- Superficial ulcers
- No prior surgical resection
- No stricturing and/or penetrating behavior

Identify patient as moderate/high risk
- Age at initial diagnosis < 30 years
- Extensive anatomic involvement
- Perianal and/or severe rectal disease
- Deep ulcers
- Prior surgical resection
- Stricture involving and/or penetrating behavior

Perform initial treatment

Low-risk patient
- Ileum and/or proximal colon — none to minimal systemic symptoms
  Options:
  - Budesonide 9 mg per day with or without AZA
  - Tapering course of prednisone with or without AZA

Diffuse or left colon — none to minimal systemic symptoms
  Options:
  - Tapering course of prednisone with or without AZA

Mod/high-risk patient
- Moderately severe Crohn’s
  Options:
  - Use anti-TNF monotherapy over no therapy or thiopurine monotherapy
  - Use anti-TNF + thiopurine over thiopurine monotherapy or anti-TNF monotherapy
  - Use methotrexate for patients who do not tolerate purine analog in combination with anti-TNF

§ Combination therapy with immunosuppressant and anti-TNF biologic offers improved efficacy and durability compared with anti-TNF monotherapy and should be considered for mod/high-risk patients requiring 2nd or 3rd biologic.
Options: [14]
- Stop therapy and observe (high chance of relapse over 1 year)
- Budesonide 6 mg/day (median time to relapse prolonged by approximately 114 days, but no difference in remission rates versus placebo at 1 year)*
- Immunosuppressive therapy (AZA, 6MP and MTX have been shown to be effective for maintaining steroid-induced remissions with prednisone or prednisolone, but are associated with rare risk of infection and lymphoma)
*Consider bone mineral density monitoring

Low-risk patient

Perform treatment for patient in remission

Remains in remission for 6 months

Define resolution of inflammation and ulcers

Re-assess inflammatory markers every 3 months

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H Mod/high-risk patient*

Steroid induced remission [33]
- Use immunomodulator (thiopurine or MTX) over no immunomodulator
- Use anti-TNF +/- thiopurine over no anti-TNF

Anti-TNF or anti-TNF + thiopurine induced remission [33]
- Use anti-TNF +/- thiopurine over no anti-TNF

Does not remain in remission for 6 months

*Combination therapy with immunosuppressant and anti-TNF biologic offers improved efficacy and durability compared with anti-TNF monotherapy and should be considered for mod/high-risk patients requiring 2nd or 3rd biologic.

Review online at www.gastro.org/IBDcarepathway.
Perform treatment for patient not in remission

Low-risk patient

Options:
• Immunosuppressive
• Assess drug levels
• Consider anti-TNF therapy

Mod/high-risk patient

Options:
• Use anti-TNF monotherapy over no therapy or thiopurine monotherapy
• Use anti-TNF + thiopurine over thiopurine monotherapy

Failure to respond

Low or undetectable drug concentration and low or undetectable anti-drug

Increase drug dose

Low or undetectable drug concentration and high anti-drug antibody

Switch within drug class

Therapeutic drug concentration and low or undetectable anti-drug antibody

Assess inflammation

Inflammation present

Switch to another drug class

Inflammation not present

Continue drug at current dose and look for other causes

Positive response

Low-risk patient

Options:
• Use anti-TNF monotherapy over no therapy or thiopurine monotherapy
• Use anti-TNF + thiopurine over thiopurine monotherapy

Mod/high-risk patient

Options:
• Use anti-TNF monotherapy over no therapy or thiopurine monotherapy
• Use anti-TNF + thiopurine over thiopurine monotherapy

Inflammation present

Switch to another drug class

Inflammation not present

Continue drug at current dose and look for other causes
NOTE: Clinicians should regularly reassess treatment strategy to aim for control of symptoms and inflammation and to minimize future complications.

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References
5Lawlor G, Moss AC. Cytomegalovirus in inflammatory bowel disease: pathogen or innocent bystander? Inflammatory Bowel Diseases 2010;16(9):1620-7.
7Swoger JM, Binion DG. Supportive therapy in IBD: what additional diagnoses and conditions must be treated? Digestive Diseases 2010;28(3):452-62.
10Hofmann AF, Poley JR. Role of bile acid malabsorption in pathogenesis of diarrhea and steatorrhea in patients with ileal resection. I. Response to cholestyramine or replacement of dietary long chain triglyceride by medium chain triglyceride. Gastroenterology 1972;62(5):918-34.