LEBANESE SOCIETY OF GASTROENTEROLOGY
الجمعية اللبنانية لأمراض الجهاز الهضمي

A User Guide for Inflammatory Bowel Disease

abbvie

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CROHN'S DISEASE

Definitions

Clinical remission:

Resolution of symptoms (stool frequency ≤ 3/day, no bleeding and no urgency)

Endoscopic remission:

Absent or minimal endoscopic lesions

No response:

No clinical improvement within 2-3 weeks of corticosteroid therapy, or up to 12 weeks of anti-TNF therapy

Relapse:

Flare of symptoms associated with evidence of inflammation as determined by CRP, fecal calprotectin, MR or CT enterography, endoscopy or ultrasound and absence of viral/bacterial infection

Recurrence:

The reappearance of lesions after surgical resection

Steroid-resistant:

Patients who have active disease despite prednisolone of up to 0.75 mg/kg/day over a period of 4 weeks

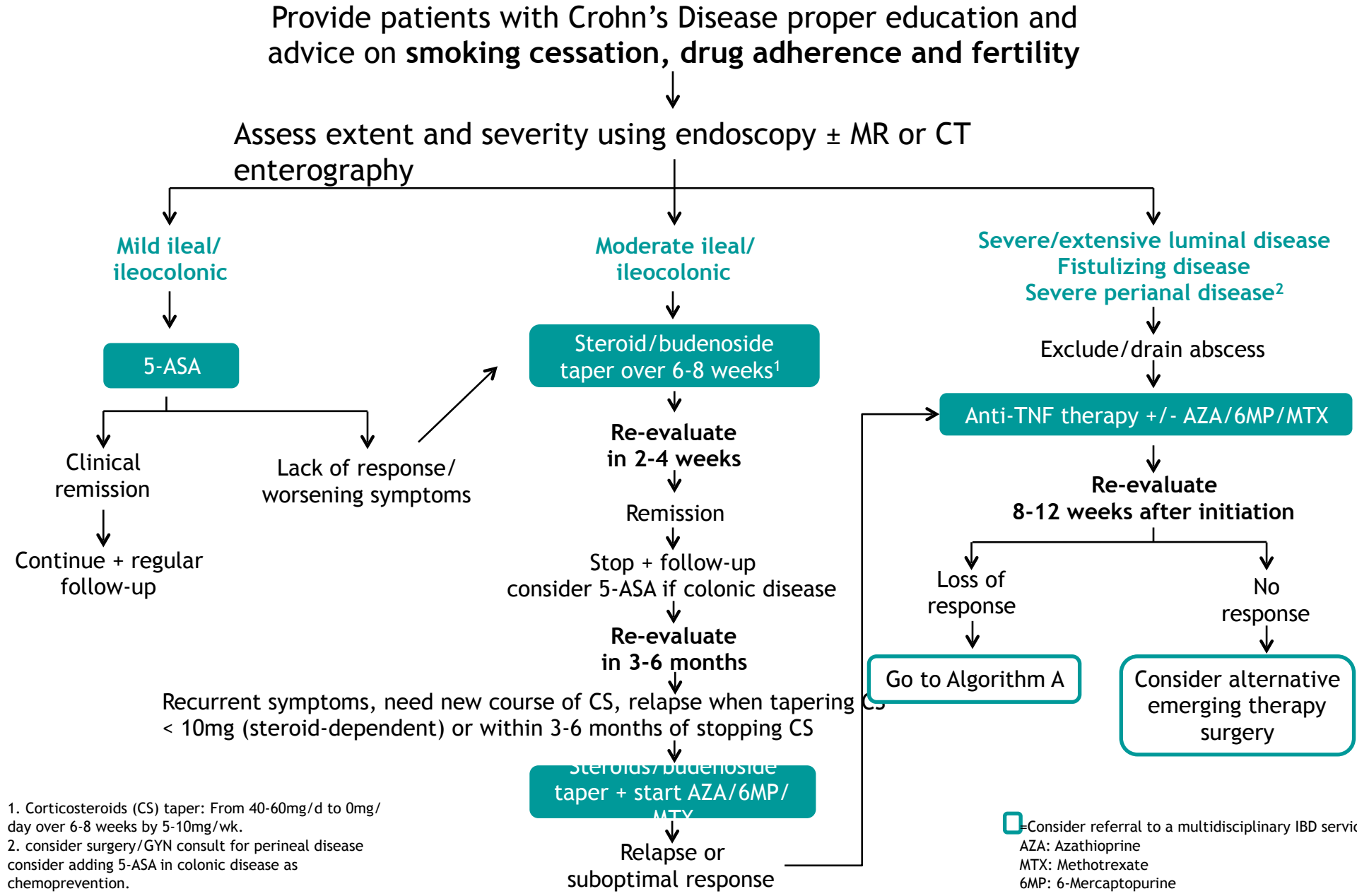
Steroid-dependent:

Patients who are either

-Unable to reduce steroids below the equivalent of prednisolone 10 mg/day within 3 months of starting steroids without recurrent active disease, or

-Who have a relapse within 3 months of stopping steroids

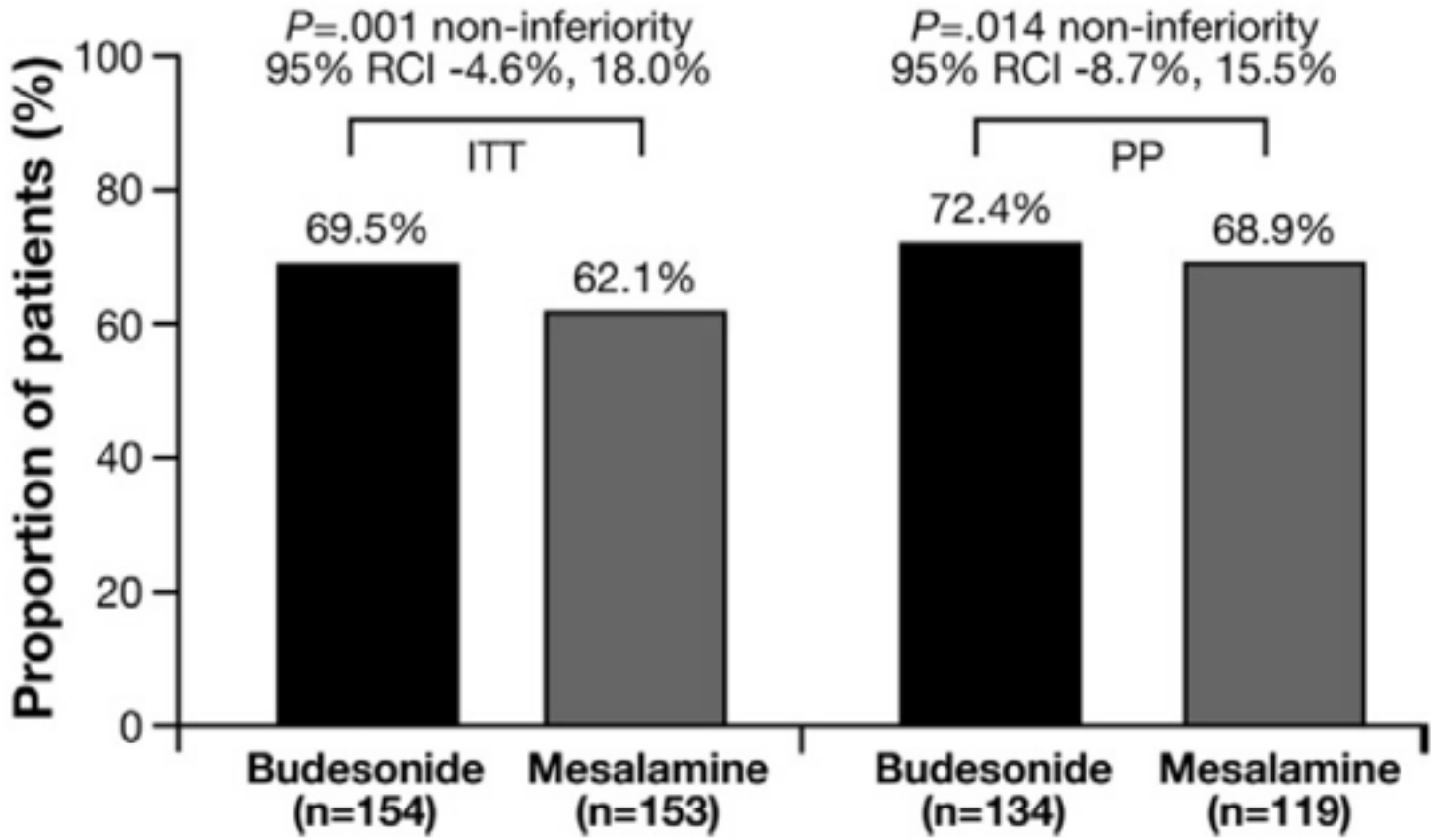
Treatment Algorithm for Crohn's Disease



1. Corticosteroids (CS) taper: From 40-60mg/d to 0mg/ day over 6-8 weeks by 5-10mg/wk.
2. consider surgery/GYN consult for perineal disease consider adding 5-ASA in colonic disease as chemoprevention.

=Consider referral to a multidisciplinary IBD servic
AZA: Azathioprine
MTX: Methotrexate
6MP: 6-Mercaptopurine

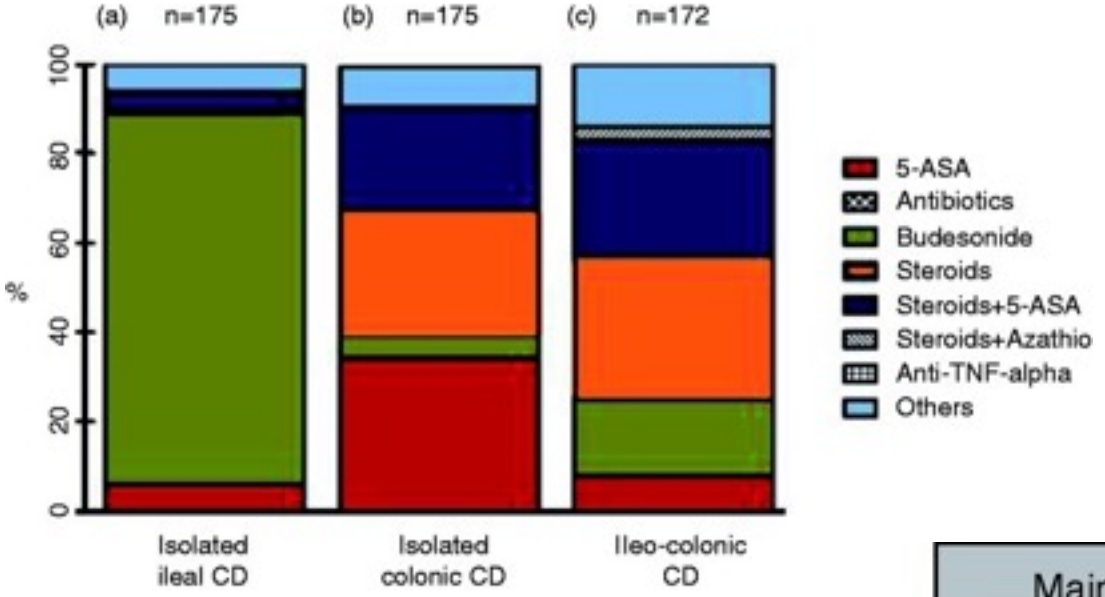
The meta-analysis of 3 large, double-blind, randomized studies in the treatment of active mild to moderate ileal or ileocolonic Crohn's disease confirms that Pentasa 4 g/day is superior to placebo in reducing the CDAI but the clinical significance of the magnitude of this difference is not clear. Hanauer SB, Stromberg U, 2004



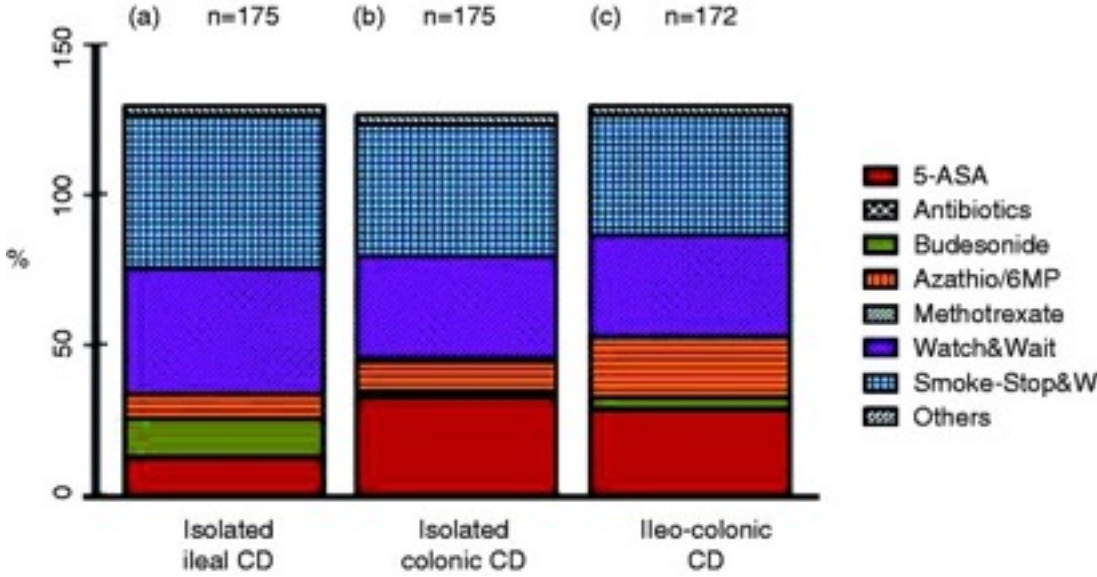
Salofalk 4.5gm/d, ileal and or ascending colon or distal colon

Tromm et al 2011

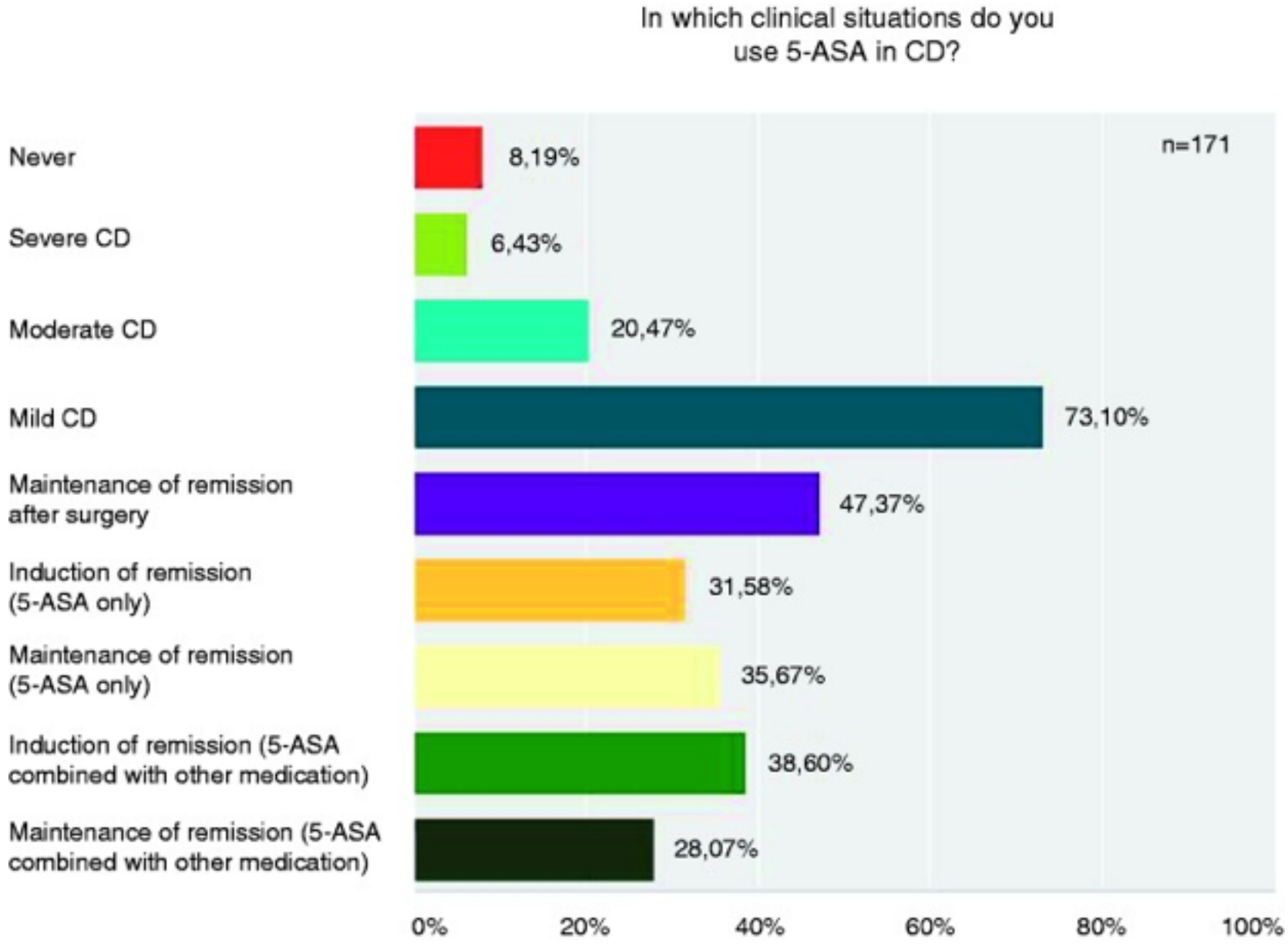
Induction of Remission



Maintenance of Remission



Klag T, et al. 2015



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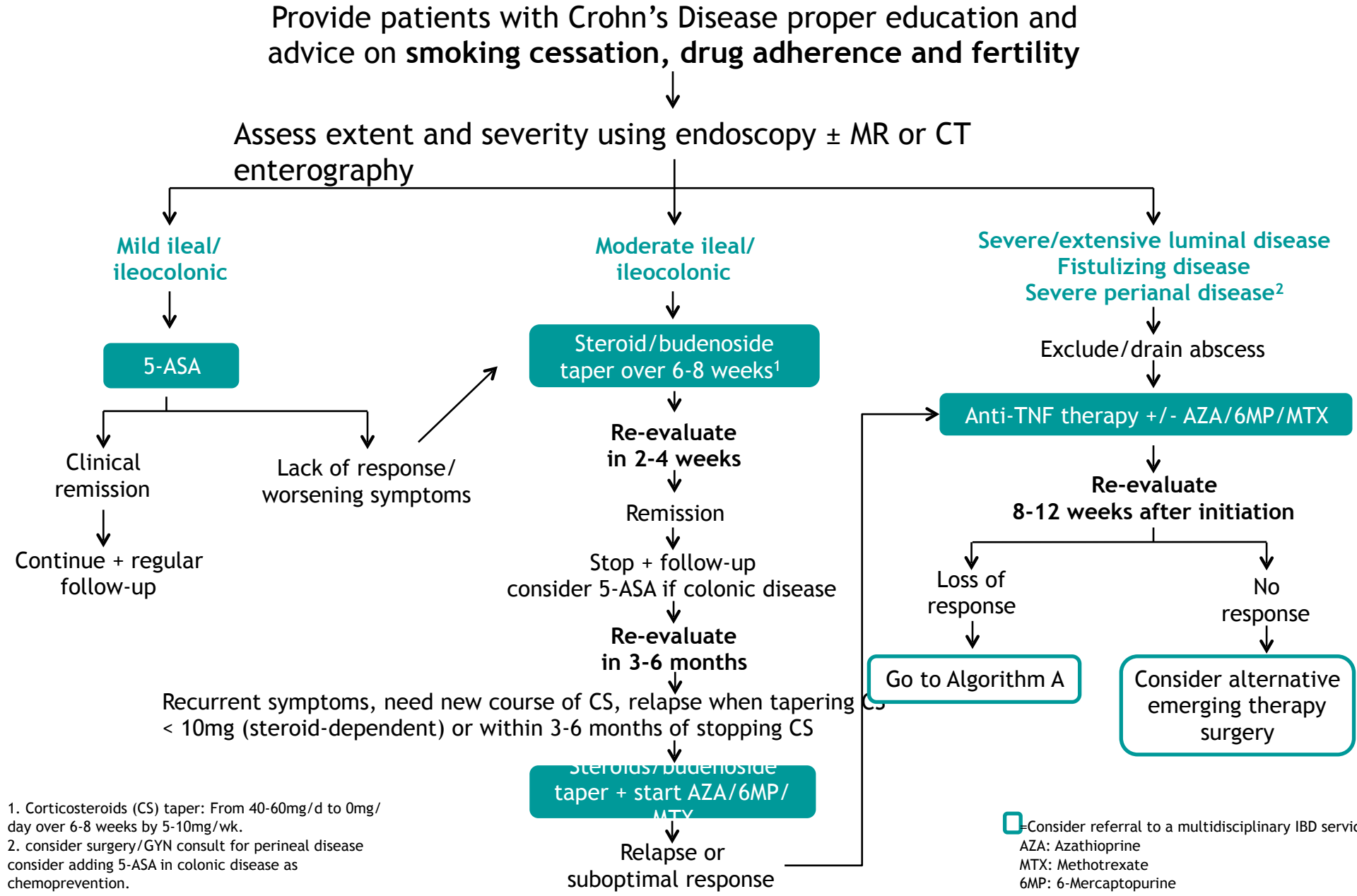

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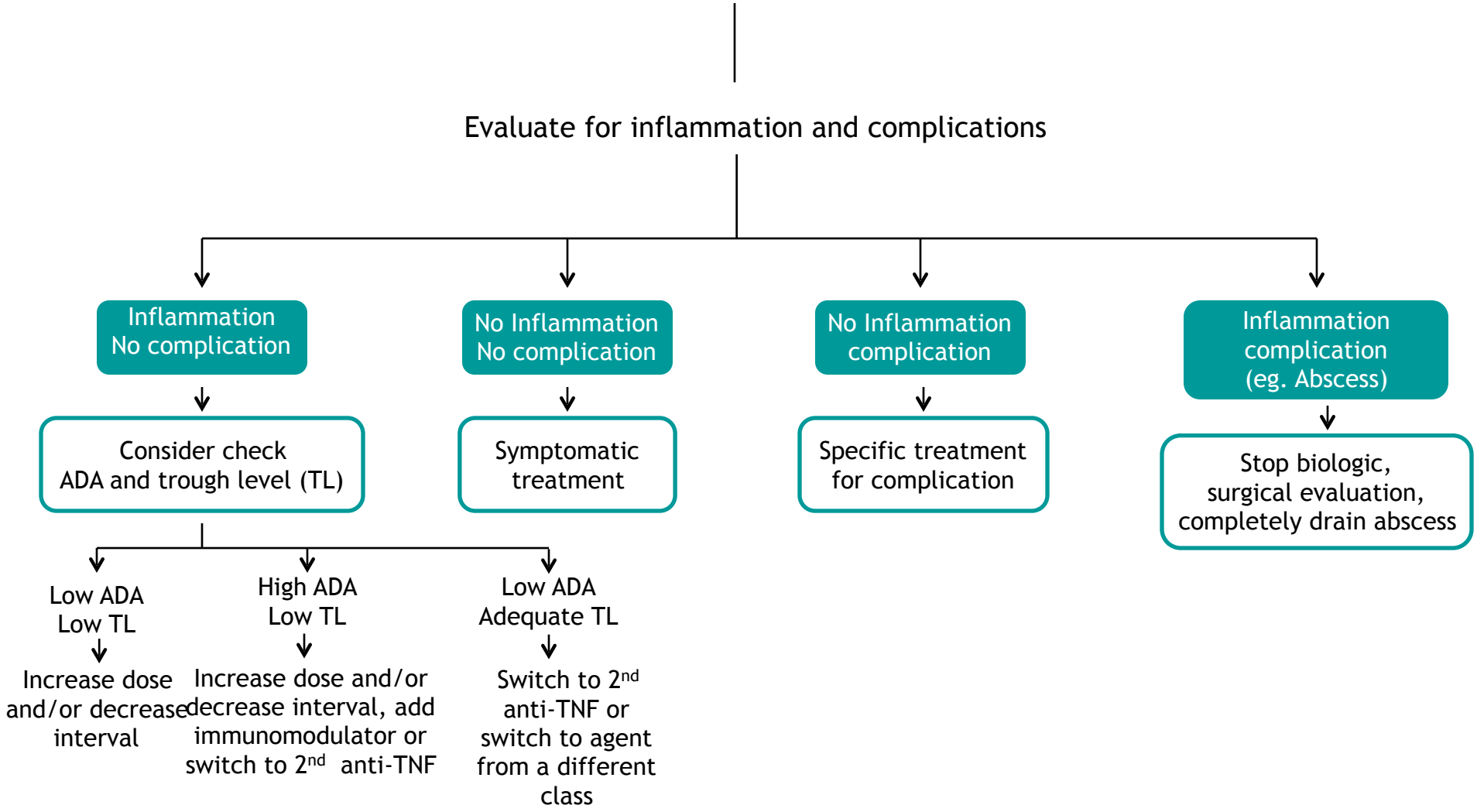
Algorithm A: Loss of Response to 1st Anti-TNF Agent



ADA: Anti-Drug Antibodies
TL: Trough Level

Vaccines guidelines before and during immunosuppressive treatment

Ideally at IBD diagnosis: HBV vaccine (in seronegative patients if risk factors are present)

Prior to immunomodulation:

Inactive trivalent influenza vaccine

(to be administered once a year in fall)

Pneumococcal vaccine (PCV)

Pneumococcal polysaccharide vaccine (PPSV23)

Booster injection: Pneumococcal polysaccharide vaccine (PPSV23)

(single booster injection 5 years later)

Patient education and referral to other practitioners

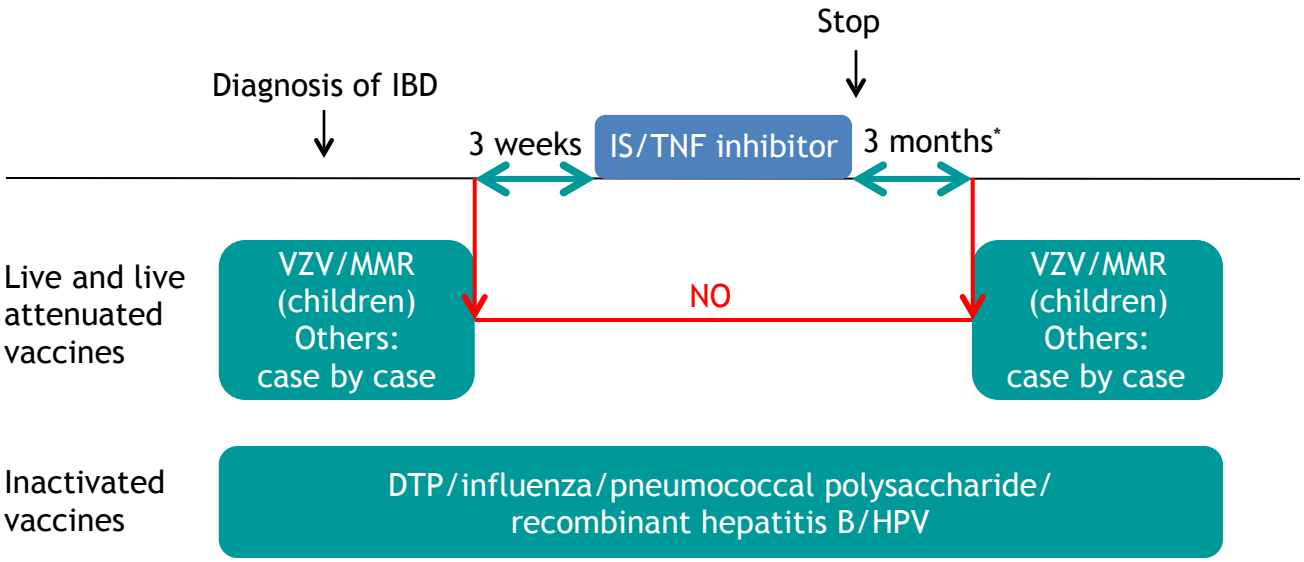
Cervical cancer screening and

consider HPV vaccine (refer to the GP or Gynecologist)

Specific vaccinations and treatment related to the area zone of travel
(refer to an infectious diseases specialist or appropriate travel clinic)

Special warning:
Live attenuated vaccines (such as MMR or yellow fever vaccines) must be avoided in patients on immunosuppressive treatment

Vaccines in IBD Patients



* This delay may be reduced to 1 month in case of use of corticosteroids alone

List of live vaccines

- VZV vaccine (chickenpox) or Zostavax vaccine (herpes zoster-shingles)
- Typhoid vaccine
- Intra-nasal influenza vaccine
- Yellow fever vaccine
- Measles vaccine
- Mumps vaccine
- Rubella vaccine
- Poliomyelitis vaccine

IS: immunosuppressant, DTP: diphtheria/tetanus toxoids and pertussis vaccine,
HPV: human papilloma virus vaccine, MMR: measles, mumps and rubella vaccine, VZV: varicella zoster virus vaccine