



INFLAMMATORY BOWEL DISEASE (IBD)

Top tips for MURs

- Discuss with the patient that IBD is a lifelong condition, with unpredictable relapses and remissions
- Counsel patients on the need to take medication regularly and the address any compliance issues
- Check that regular monitoring is being done:
 - Renal function tests after 3 months of treatment and then annually for patients taking oral aminosalicylates (more often if renal impairment)
 - Full blood tests, renal and liver function tests frequently for patients taking methotrexate, azathioprine and 6-Mercaptopurine. Once stabilised monitoring should be at least every 3 months (Refer to individual SPCs)
- Advise patients taking oral aminosalicylates to report any bleeding, bruising, purpura, sore throat, fever and malaise to their prescriber
- Ensure that methotrexate tablets are taken once a week, on the same day each week They should be swallowed whole, after food (Dose range 10mg – 25mg weekly)
- Advise the patient that live vaccines are contraindicated if taking immunosuppressants
- Advise patients who suffer from a lot of diarrhoea and pain of the importance of continuing to eat and drink enough in order to stay well-nourished and hydrated
- Where it is deemed necessary to change to a different brand of mesalazine, advise the patient to report any changes in symptoms
- Advise the patient to stay safe in the sun if taking photosensitive medication such as Azathioprine, 6-Mercaptopurine and Methotrexate
- Advise patient that full beneficial effect from methotrexate may not occur for up to twelve weeks after initiation and may take as long as 6 months for them to see the full effect
- Advise patient that patients with IBD have an increased risk of colorectal cancer. Signpost patients to GP/ specialist to discuss their level of risk and whether further assessment is required
- Counsel patients on signs / symptoms of complications that need referral (**see red flags below**) and common side effects (**see side effects overleaf**)
- Report any relevant adverse drug reactions to the Scheme Yellow Card Scheme

Pathophysiology of IBD

Inflammatory bowel disease is an umbrella term used to describe two main conditions: ulcerative colitis (UC) and Crohn's disease. Both are chronic, relapsing inflammatory conditions that affect the gastrointestinal tract and other parts of the body. The symptoms of these two illnesses can be similar, but the areas affected in the GI tract are different. Crohn's can affect any part of the digestive system from the mouth to the anus (usually rectal sparing). UC affects the rectum and a varying extent of the colon. Principal features of the disease include urgent and frequent diarrhoea together with rectal bleeding, pain and bloating. Extraintestinal symptoms include arthritis, skin and ocular complications, anaemia and fatigue. Although the cause is unknown, both diseases are believed to be triggered by environmental factors in genetically susceptible individuals. Possible factors include gut flora, food constituents and infection. It is likely that the cause of IBD is multifactorial.

Lifestyle issues

- Advise patients who smoke of benefits of smoking cessation and refer to Pharmacy Stop Smoking or Stop Smoking Wales services if willing to stop, as Crohn's is more likely to occur in people who smoke. Stopping smoking can reduce the severity of Crohn's and reduce the need for immunosuppression.
- Counsel patient on reducing alcohol intake to within safe limits (up to 14 units a week, spread evenly over 3 more days, with several alcohol free days)
- Advise patients that they can reduce the risk of developing osteoporosis by eating plenty of calcium rich foods, maintaining an active lifestyle, with regular weight-bearing exercises, as patients with IBD are at a higher risk of osteoporosis

Red flags that need referral

- Bleeding with bowel movements
- Weight loss
- Signs of anaemia or infection
- Signs of blood dyscrasias (unexplained bleeding, bruising, purpura (rash of purple spots on the skin), sore throat, fever, malaise)
- Signs of liver toxicity (nausea, vomiting, abdominal discomfort, pale stools & dark urine)
- Signs of respiratory distress (shortness of breath, cough & fever)





How do drugs used to treat IBD work?

Aminosalicylates (balsalazide, mesalazine, olsalazine and sulfasalazine)	Thought to act on epithelial cells by a variety of mechanisms to moderate the release of lipid mediators, cytokines and reactive oxygen species. Aminosalicylates can be given orally or rectally depending on the location of inflammation in the bowel.
Corticosteroids (budesonide, prednisolone & hydrocortisone)	Corticosteroids are potent anti-inflammatory agents for moderate to severe relapses of both UC and CD. They have no role in maintenance therapy for either disease.
Immunomodulators Therapy (azathioprine, 6-mercaptopurine, methotrexate & ciclosporin)	Azathioprine, 6-Mercaptopurine - Interferes with synthesis of purine ribonucleotides, leading to decrease in immune cell production. Methotrexate - slows the production of new cells by the immune system, which causes a reduction in inflammation and bowel damage. Ciclosporin - reduces the response of cytotoxic T lymphocytes to alloantigenic challenge expansion of T-cell subsets.
Biologic Therapy (infliximab Remicade®, Remsima®, Inflectra®, adalimumab, golimumab & vedolizumab)	Infliximab, adalimumab & golimumab -Neutralises the TNF- , along with specific molecular effects, leading to reduced immune response. Vedolizumab – binds to the gut selective 4 7 integrin, reducing gastrointestinal inflammation.
Antibiotics	The rationale for antibiotic therapy in IBD is based upon a body of evidence demonstrating that luminal bacteria and perhaps fungi have an important role in the pathogenesis of IBD. Antibiotics have an established role in treating complications of Crohn's including abscesses and fistulae.

What are the common side effects to look out for?

Medication	Common side effects	Recommendation
Aminosalicylates	Patients receiving aminosalicylates are at risk of blood dyscrasias and interstitial nephritis. Arthralgia and headaches are reported initially	Advise patient to report any unexplained bleeding, bruising, purpura (rash of purple spots on the skin), sore throat, fever, malaise that occurs during treatment. Refer to GP or IBD nurse.
Immunomodulator therapy	Patients receiving treatment with immunosuppressives are at risk of blood dyscrasias or suppression of bone marrow production e.g. leucopenia, thrombocytopenia.	For patients using biologic therapy, ensure a record is made on their patient record.
Biologic Therapy	These medications have a significant adverse effect profile. Most importantly, as a result of generalised effect on the immune system, infection risk is increased.	
Corticosteroids	The long term risks of steroids are well known – osteoporosis, thinning of the skin, hypertension, diabetes, weight gain and fluid retention.	Advise the patient to carry a card showing the dose of steroids they are taking and the date treatment began.

Potential serious drug interactions?

Medication used to treat IBD can interact with other medicines – **See BNF Appendix1 : Interactions, for more details**

- The SPCs for Asacol® MR and Ipocol® MR both state that the tablets should not be given with lactulose or similar preparations which lower stool pH and may prevent release of mesalazine (not considered to be clinically significant)
- Sulfasalazine may reduce absorption of digoxin and folate
- Concurrent use of thiopurines with co-trimoxazole and trimethoprim increases the risk of haematological toxicity
- Thiopurines given with aminosalicylates may contribute to bone marrow toxicity/risk of leucopenia, additional monitoring may be required when initiating the combination
- Care must be taken with co-prescriptions of allopurinol and thiopurines as it enhances the effect of azathioprine/mercaptopurine and causes increased toxicity. Dose of the thiopurine will need to be reduced

Where can you find more information?

- Lower GI disease: Inflammatory bowel disease (IBD); e-learning module. WCPPE website (www.wcppe.org.uk)
- BNF sub section 1 Gastro-intestinal system (www.bnf.org)
- NICE bites Ulcerative Colitis CG166; Crohn's Disease NICE CG152;2012
<http://www.elmmb.nhs.uk/newsletters-minutes/nicebites/?assetdetesc1486923=52434>
<http://www.elmmb.nhs.uk/newsletters-minutes/nice-bites/?assetdetesc1486923=53430>
- Clinical Knowledge Summary; <http://cks.nice.org.uk/ulcerative-colitis>, <http://cks.nice.org.uk/ulcerative-colitis>
- <http://www.crohnsandcolitis.org.uk/>

