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

A

Assess inflammatory status

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

Symptoms related to prior surgery

Stricture/remodeling

Adverse reaction to medical therapy

Abdominal abscess or fistula

Perianal abscess or fistula

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

Pain, fistula drainage, fever

Pain, fistula drainage, fever

Assess comorbidities and disease and therapy related complications

Review online at www.gastro.org/IBDcarepathway.
C
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
- Stricturing and/or penetrating behavior

D
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

E
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.
Perform treatment for patient in remission

Low-risk patient

Options:
• 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

Steroid induced remission:
Options:
• Use immunomodulator (thiopurine or MTX) over no immunomodulator
• Use anti-TNF +/- thiopurine over no anti-TNF

Anti-TNF or anti-TNF + thiopurine induced remission:
• Use anti-TNF +/- thiopurine over no anti-TNF

Remains in remission for 6 months

Define resolution of inflammation and ulcers

Re-assess inflammatory markers every 3 months

Continued on next page

Mod/high-risk patient

Does not remain in remission for 6 months

Anti-TNF or anti-TNF + thiopurine induced remission:
• Use anti-TNF +/- thiopurine over no anti-TNF

Remains in remission for 6 months

Define resolution of inflammation and ulcers

Re-assess inflammatory markers every 3 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.

Continued on next page
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

Review online at www.gastro.org/IBDcarepathway.
**NOTE:** Clinicians should regularly reassess treatment strategy to aim for control of symptoms and inflammation and to minimize future complications.

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