Dr Bernard Chin, Gastroenterologist

IBD Update, Part 1

Given the latest advances in the treatment of Inflammatory Bowel Disease (IBD), this will be the first of a 4 part series on essential updates for GPs and management of these patients.

Ulcerative Colitis

Different distributions:

Proctitis and left sided colitis have little or no risks of colonic dysplasia and adenocarcinoma over and above the standard population risks. These are best treated with topical agents.

Proctitis: First line treatment is topical 5ASA. They mostly work in the same way, so a standard Mesalazine suppository of 1g nocte for 1 or 2 months should suffice. If patients have recurrent flares, their options are high dose oral 5ASA or regular 5ASA suppositories. I have moved away from corticosteroid suppositories/enemas now that Budenofalk (Budesonide has limited systemic corticosteroid effects) is available on the PBS (1 nocte for 1-2 months)

Left sided colitis: It is important to treat the proctitis component first, as the reduced compliance and irritability of the rectum will result in poor retention of the enema. I approach this with a 5ASA suppository 1g bd for 2 weeks BEFORE starting a 5ASA enema of your choice (2g or 4g nocte for 1 month). Again, Budenofalk nocte for 1 month is a fallback solution if the patient responds poorly to topical 5ASA.

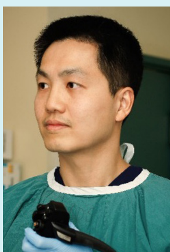
Pancolitis: These patients are at risk of colonic mucosal dysplasia and adenocarcinoma after more than 8 years from diagnosis. They should have 3 yearly colonoscopies for endoscopic examination and random colonic biopsies to detect early dysplasia. In mild initial UC and flares, I would use a maximum dose of oral 5ASA up to 5g daily. There is no evidence that doses beyond 5g daily are useful and these higher doses may cause side effects. Slow release preparations like Mezavant are probably best positioned here. Topical 5ASA can also be combined with oral treatment for faster response (eg, Salofalk 2g nocte for 1 month). If remission is not achieved in 4 weeks, an “IBD course” of steroids should be considered. Once in remission, the oral 5ASA dose can be wound back slowly by trial and error to discover the remission dosage, which is usually between 1-2 g daily.

Corticosteroids

Corticosteroids have often not been used correctly for IBD in GP land. It is important to note that unlike other inflammatory conditions (asthma, dermatitis etc); one cannot place patients on a short course (1-2 weeks) of steroids without a moderate to high risk of rebound flare of the IBD. A decision to use steroids is a commitment to a high initial dose and slowly taper over 2 or more months. My typical approach is Prednisolone at 50mg daily for 1 week, to be decreased by 5mg every week until zero is achieved.

One can also consider oral Budesonide 9mg daily until remission is achieved, but as it is not on the PBS, the cost tends to be prohibitive.

Next Episode: Immunomodulators and IBD



About Dr Bernard Chin

Dr Chin graduated from the University of Adelaide and completed his Gastroenterology training in Sydney. He has an interest in the latest endoscopic obesity treatments and bowel cancer screening. He is the founder and principal of Cairns Gastroenterology since 2007, operating at both Cairns Private Hospital and Cairns Day Surgery.

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