

# Inflammatory bowel disease

## Five Things Physicians and Patients Should Question

by

Canadian IBD Network for Research and Growth in Quality Improvement

Crohn's and Colitis Canada

Canadian Association of Gastroenterology

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### 1 **Don't use steroids (e.g., prednisone) for maintenance therapy in inflammatory bowel disease (IBD).**

While systemic corticosteroids (e.g., prednisone) are effective in inducing symptomatic remission in IBD, they are ineffective as maintenance therapy and are associated with both short- and long-term serious adverse effects. Consequently, if the initial steroid taper is unsuccessful or more than two courses of steroids are required within a year, health providers should consider adding a steroid-sparing agent that has proven efficacy and safety as maintenance therapy in IBD patients.

### 2 **Don't use opioids long-term to manage abdominal pain in inflammatory bowel disease (IBD).**

While opioids may be used to manage abdominal pain in select acute settings in IBD patients, their prolonged use may mask the symptoms of active IBD or its complications (e.g., bowel perforation or megacolon). Chronic opioid use has been proven ineffective for non-malignancy associated chronic pain and is associated with excess mortality. Moreover, because of their potential risk for dependence, their long-term use for managing IBD-related abdominal pain should be avoided especially in the context of the opioid crisis in North America.

### 3 **Don't unnecessarily prolong the course of intravenous corticosteroids in patients with acute severe ulcerative colitis (UC) in the absence of clinical response.**

Non-response to intravenous corticosteroids for acute severe UC can be predicted after the first 72 hours of treatment. However, about a third of non-responders receive systemic steroid monotherapy beyond 7 days. This prolonged use of ineffective systemic steroids may unnecessarily lengthen hospitalization days and increase risk of postoperative complications in those who eventually require colectomy.

### 4 **Don't initiate or escalate long-term medical therapies for the treatment of inflammatory bowel disease (IBD) based only on symptoms).**

Clinical symptoms often prompt initiation or escalation of medical treatments for inflammatory bowel disease (IBD). However, functional bowel disorders (e.g., irritable bowel syndrome) coexist in 20% of IBD patients and can mimic symptoms of the latter. Clinical symptoms, in fact, do not correlate well with IBD disease activity. Consequently, relying on only clinical symptoms without confirming active disease may commit patients to long-term treatments that have potentially significant adverse effects and resource implications.

### 5 **Don't use abdominal computed tomography (CT) scan to assess inflammatory bowel disease (IBD) in the acute setting unless there is suspicion of a complication (obstruction, perforation, abscess) or a non-IBD etiology for abdominal symptoms.**

Abdominal CT scanning is effective for the time-sensitive diagnosis of IBD complications such as obstruction, perforation, or non-IBD related causes of abdominal pain when these are suspected. The effective ionizing radiation dose from a single conventional abdominal CT scan (10-20mSv) is within acceptable safety limits (<50mSv). However, minimizing inappropriate utilization of CT is a priority because repeated exposure to ionizing radiation over a lifetime, particularly among younger IBD patients, may potentially increase the risk of malignancy. In the acute setting (e.g., emergency department), abdominal CT scan should only be used when there is suspicion of a complication of IBD and should not be used for the assessment of disease activity.

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## How the list was created

The recommendation list was developed by the Canadian IBD Network for Research and Growth in Quality Improvement (CINERGI) in collaboration with Crohn's and Colitis Canada (CCC) and the Canadian Association of Gastroenterology (CAG). The CINERGI group comprises 14 gastroenterologists specialized in the care of inflammatory bowel disease representing 12 academic centres across Canada. A preliminary survey was sent to the CINERGI working group to solicit candidate recommendations. The top ten recommendations were selected by the working group members through an online voting platform. During a face-to-face consensus meeting in Toronto on November 4, 2016 that included CINERGI working group members, two radiologists, representatives from CCC and CAG, and two patient representatives, a modified Delphi process was used to select the top five recommendations. This list was submitted to the CAG Quality Affairs Committee, the Executive Board, and the CAG general membership for feedback and approval.

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## Sources

- 1 Bressler B, et al. Clinical practice guidelines for the medical management of nonhospitalized ulcerative colitis: the Toronto consensus. *Gastroenterology*. 2015 May;148(5):1035-1058.e3. [PMID: 25747596](#).  
Gomollón F, et al. 3rd European Evidence-based Consensus on the Diagnosis and Management of Crohn's Disease 2016: Part 1: Diagnosis and Medical Management. *J Crohns Colitis*. 2017 Jan;11(1):3-25. [PMID: 27660341](#).  
Harbord M, et al. Third European Evidence-based Consensus on Diagnosis and Management of Ulcerative Colitis. Part 2: Current Management. *J Crohns Colitis*. 2017 Jul 1;11(7):769-784. [PMID: 28513805](#).  
Terdiman JP, et al. American Gastroenterological Association Institute guideline on the use of thiopurines, methotrexate, and anti-TNF biologic drugs for the induction and maintenance of remission in inflammatory Crohn's disease. *Gastroenterology*. 2013 Dec;145(6):1459-63. [PMID: 24267474](#).
- 2 Targownik LE, et al. The prevalence and predictors of opioid use in inflammatory bowel disease: a population-based analysis. *Am J Gastroenterol*. 2014 Oct;109(10):1613-20. [PMID: 25178702](#).
- 3 Bitton A, et al. Treatment of hospitalized adult patients with severe ulcerative colitis: Toronto consensus statements. *Am J Gastroenterol*. 2012 Feb;107(2):179-94. [PMID: 22108451](#).  
Kaplan GG, et al. Impact of hospital volume on postoperative morbidity and mortality following a colectomy for ulcerative colitis. *Gastroenterology*. 2008 Mar;134(3):680-7. [PMID: 18242604](#).  
Nguyen GC, et al. Quality of Care and Outcomes Among Hospitalized Inflammatory Bowel Disease Patients: A Multicenter Retrospective Study. *Inflamm Bowel Dis*. 2017 May;23(5):695-701. [PMID: 28426451](#).  
Randall J, et al. Delayed surgery for acute severe colitis is associated with increased risk of postoperative complications. *Br J Surg*. 2010 Mar;97(3):404-9. [PMID: 20101648](#).
- 4 Abdalla MI, et al. Prevalence and Impact of Inflammatory Bowel Disease-Irritable Bowel Syndrome on Patient-reported Outcomes in CCF Partners. *Inflamm Bowel Dis*. 2017 Feb;23(2):325-331. [PMID: 28092305](#).  
Colombel JF, et al. Management Strategies to Improve Outcomes of Patients with Inflammatory Bowel Diseases. *Gastroenterology*. 2017 Feb;152(2):351-361.e5. [PMID: 27720840](#).
- 5 Kim DH. ACR Appropriateness Criteria Crohn Disease. *J Am Coll Radiol*. 2015 Oct;12(10):1048-57.e4. [PMID: 26435118](#).  
Smith-Bindman R, et al. Radiation dose associated with common computed tomography examinations and the associated lifetime attributable risk of cancer. *Arch Intern Med*. 2009 Dec 14;169(22):2078-86. [PMID: 20008690](#).

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## About the Canadian IBD Network for Research and Growth in Quality Improvement

CINERGI is a research network of 14 inflammatory bowel disease (IBD) specialists representing 12 Canadian academic institutions spanning 7 provinces. Collectively, we have research expertise in epidemiology, clinical trials, health services research, economic analysis, and quality improvement. We are committed to a diverse array of initiatives to improve healthcare delivery in IBD.

## About the Crohn's and Colitis Canada

Crohn's and Colitis Canada is the only national, volunteer-based charity focused on finding the cures for Crohn's disease and ulcerative colitis and improving the lives of children and adults affected by these diseases. Crohn's and Colitis Canada focuses on transforming the lives of people affected by Crohn's and colitis (the two main forms of inflammatory bowel disease) through research, patient programs, advocacy, and awareness.

## About the Canadian Association of Gastroenterology

The CAG represents more than 1,100 members across Canada, including physicians, basic scientists, and affiliated health care providers who work in the field of gastroenterology. The CAG is a member-focused organization with a mission to support and engage in the study of the organs of the digestive tract in health and disease, as well as to promote and advance gastroenterology by providing leadership in patient care, research, teaching and continuing professional development.

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## About Choosing Wisely Canada

Choosing Wisely Canada is the national voice for reducing unnecessary tests and treatments in health care. One of its important functions is to help clinicians and patients engage in conversations that lead to smart and effective care choices.

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