Inflammatory Bowel Disease

Crohn's and ulcerative colitis · Acute severe colitis is a medical emergency, not a gastro outpatient problem

DAY 3 DECIDES
in acute severe UC

TELL THEM APART *the distinction changes drugs, surgery and prognosis*

ULCERATIVE COLITIS

Continuous mucosal inflammation from the rectum proximally, never skipping. **Bloody diarrhea with urgency and tenesmus.** Limited to the colon, so **colectomy is curative of the colitis**. Smoking is paradoxically associated with milder disease, which is never a reason to advise it.

CROHN'S DISEASE

Patchy, skip-lesion, transmural inflammation anywhere from mouth to anus, with a predilection for the terminal ileum. Because it is transmural it produces **strictures, fistulae, abscesses and perianal disease**. **Smoking clearly worsens it**, and cessation is a genuine disease-modifying intervention.

SHARED FEATURES

Extraintestinal manifestations: arthritis, erythema nodosum, pyoderma gangrenosum, episcleritis and uveitis, and **primary sclerosing cholangitis** — which tracks with UC and demands its own cancer surveillance. Also **iron and B12 deficiency, osteoporosis and a markedly raised VTE risk**.

ACUTE SEVERE ULCERATIVE COLITIS *a Truelove and Witts diagnosis made at the bedside*

1. **Define it: six or more bloody stools a day** plus at least one systemic feature — **temperature above 37.8°C, pulse above 90, hemoglobin below 10.5 g/dL, or CRP above 30 mg/L (ESR above 30)**. This is an **admission**, on intravenous steroid, with surgical involvement from day one.
2. **The admission bundle: intravenous corticosteroid** (hydrocortisone 100 mg four times daily or equivalent methylprednisolone), **stool cultures and *C. difficile* testing**, plain abdominal film, and **flexible sigmoidoscopy without full bowel preparation** with biopsies for **CMV**. Correct potassium and magnesium, and transfuse as needed.
3. **Give VTE prophylaxis despite the rectal bleeding.** Active IBD is a strong prothrombotic state and thromboembolism, not hemorrhage, is what kills these patients. **Stop opioids, antidiarrheals, anticholinergics and NSAIDs**, all of which precipitate toxic dilatation.
4. **Reassess on day 3 using the Oxford criteria: more than 8 stools a day, or 3 to 8 stools with a CRP above 45 mg/L**, predicts a very high chance of colectomy on that admission. **That is the trigger for rescue therapy, not for another 3 days of steroid.**
5. **Rescue with infliximab or cyclosporine** — randomized comparisons show broadly equivalent efficacy, so choose on comorbidity, local expertise and future maintenance plans. **Book the surgeon in parallel, not afterwards.** Delayed colectomy carries far worse outcomes than a timely one, and offering it early is not a failure.

WHAT TO EXCLUDE BEFORE ESCALATING *immunosuppressing an infection is the classic disaster*

Consider	Clue and action
C. difficile	**Test every flare, every admission.** It is commoner in IBD, often without prior antibiotics, and worsens outcomes. Treat it alongside the flare rather than choosing between them.
CMV colitis	Suspect in **steroid-refractory** disease. Diagnose on **colonic biopsy with immunohistochemistry**, not serology, and treat with ganciclovir where confirmed.
Toxic megacolon	**Transverse colon above 6 cm with systemic toxicity.** Falling stool frequency with a worsening patient is ominous, not reassuring. **Urgent surgical review**; perforation carries very high mortality.
Abscess in Crohn's	**Never start an anti-TNF into undrained sepsis.** Cross-sectional imaging first; **drain and give antibiotics**, then immunosuppress. Distinguish inflammatory from fibrostenotic stricture — drugs do not open scar.
Screening before biologics	**Latent tuberculosis (interferon-gamma release assay plus chest radiograph), hepatitis B and C, HIV, varicella status**, and bring vaccinations up to date. **Live vaccines are contraindicated once immunosuppressed**, so give them beforehand.

MAINTENANCE AND ESCALATION *steroids are for induction only, never for maintenance*

Class	Role and caveats
5-aminosalicylates	**Induction and maintenance in ulcerative colitis**, oral plus **topical** for distal disease — the rectal preparation is routinely omitted and materially improves response. **Little or no role in Crohn's disease.**
Corticosteroids	**Induction only.** If the patient cannot come off them, the maintenance strategy has failed and needs escalating. Budesonide gives lower systemic exposure in ileocaecal Crohn's. Give **bone protection** with prolonged courses.
Thiopurines	Steroid-sparing maintenance and used to **reduce immunogenicity alongside anti-TNF**. **Check TPMT or NUDT15 before starting**, monitor blood count and liver function, and counsel on **lymphoma and non-melanoma skin cancer risk** with sun protection.
Anti-TNF	**Infliximab and adalimumab.** The agents of choice for **perianal fistulising Crohn's** and for acute severe UC rescue. **Measure drug levels and antibodies when response is lost** rather than switching blindly.
Newer targets	**Vedolizumab** (gut-selective, favorable safety in the older or infection-prone patient), **ustekinumab and risankizumab** (interleukin-12/23 and 23), **ozanimod**, and **JAK inhibitors** such as tofacitinib and upadacitinib, which act fast but carry **cardiovascular, thrombotic and malignancy warnings** in older patients with risk factors.
Long-term care	**Colonoscopic dysplasia surveillance from about 8 years of colitis**, iron and B12 replacement, bone density, smoking cessation in Crohn's, contraception and pre-pregnancy planning, and dermatology and cervical screening on immunosuppression.

PEARLS & PITFALLS

- **Rescue therapy doses on day 3: infliximab 5 mg/kg** or **cyclosporine 2 mg/kg/day by infusion**. Either is reasonable; what harms the patient is **letting day 3 drift into day 7** while steroids are continued in the hope of a turn.
- **Day 3 is a decision point, not a review.** Persisting with steroid alone past it is the commonest error in acute severe colitis.
- **Give thromboprophylaxis even with bloody stool.** The VTE risk in a flare far outweighs the bleeding risk.
- **Test for *C. difficile* and CMV before blaming the IBD** — both change treatment entirely.
- **Falling stool frequency in a deteriorating patient suggests toxic dilatation**, not improvement.
- **Drain the abscess before you immunosuppress.** Anti-TNF into undrained sepsis is a recognized catastrophe.
- **Involve surgery on day one.** An elective colectomy in a well-optimized patient beats an emergency one in a septic patient.

References: ACG clinical guidelines on ulcerative colitis and on Crohn's disease in adults · ECCO guidelines on medical treatment and on diagnosis · Truelove and Witts severity criteria · Travis (Oxford) day-3 predictive index · randomized comparisons of infliximab and cyclosporine rescue therapy.

Educational aid; verify against local gastroenterology and surgical protocol and patient factors.