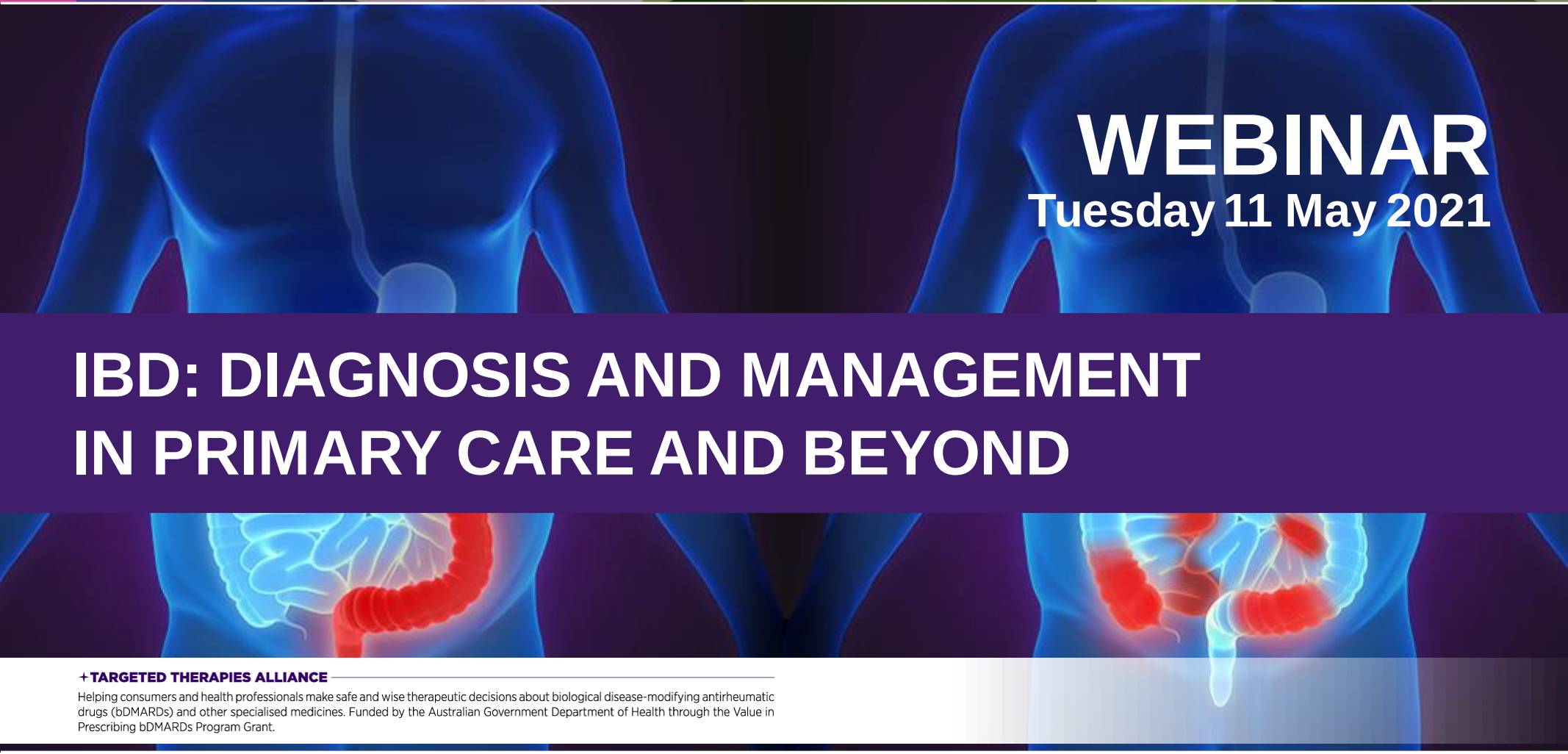

WEBINAR

Tuesday 11 May 2021

IBD: DIAGNOSIS AND MANAGEMENT IN PRIMARY CARE AND BEYOND

TARGETED THERAPIES ALLIANCE

Helping consumers and health professionals make safe and wise therapeutic decisions about biological disease-modifying antirheumatic drugs (bDMARDs) and other specialised medicines. Funded by the Australian Government Department of Health through the Value in Prescribing bDMARDs Program Grant.

TARGETED THERAPIES ALLIANCE

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OUTLINE

At the completion of the roundtable discussion participants will be able to:

- Describe the optimal use of the faecal calprotectin test to differentiate between IBD and IBS
- Optimise choice, adherence and persistence to first-line therapy for IBD
- Outline the current recommendations for monitoring disease activity and intensifying treatment

MEET THE PANEL

A/Prof Susan Connor
IBD Gastroenterologist

Dr Michael De Gregorio
General Gastroenterologist

A/Prof Morton Rawlin
GP

Declarations of interest provided at end of slides

MEET TOM

- Tom is 26 years old. Tom presents to his GP with recurrent abdominal pain, poor appetite, fatigue and watery diarrhoea 3–4 times a day for the past 4 weeks.

Medical history

- Previous appendicectomy
- Recurrent tonsillitis
- No significant family history

MEET TOM

Social history

- Tom works as a town planner for a local council and shares a house with friends. He plays soccer 3x/week and goes to the gym most mornings. He is a non-smoker and has 2 standard drinks most days, up to 12–15 standard drinks on weekends.
- He has not travelled internationally recently.

Allergies

- Nil

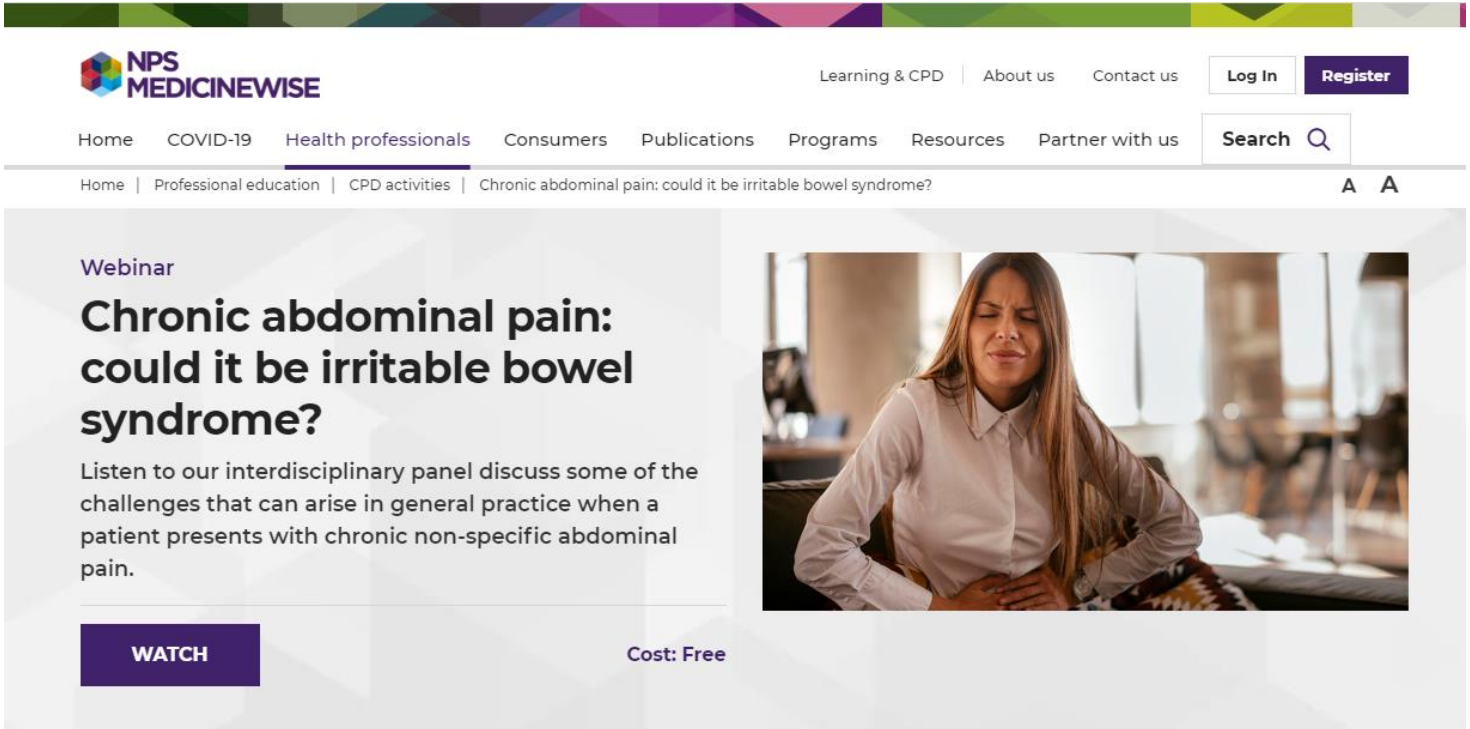
Medicines

- Occasional ibuprofen for an old knee injury

CASE QUESTION 1

After taking a patient history and conducting a physical examination, which investigations would you request to differentiate between IBS and IBD?

FEATURES: History/Bloods/Stool tests	IBD	IBS
Weight loss	✓	✗
Blood PR	✓	✗
Nocturnal symptoms	✓	✗
History duration	Short	Long
Bloods	Abnormal	Normal
↓Hb ↑WCC ↑platelets ↑ESR ↑CRP	Abnormal	Normal
↓Albumin ↓Fe studies –ve coeliac serology	Abnormal	Normal
Stool culture		
Faecal Calprotectin	↑	Normal



www.nps.org.au/cpd/activities/chronic-abdominal-pain-could-it-be-irritable-bowel-syndrome

CASE QUESTION 2

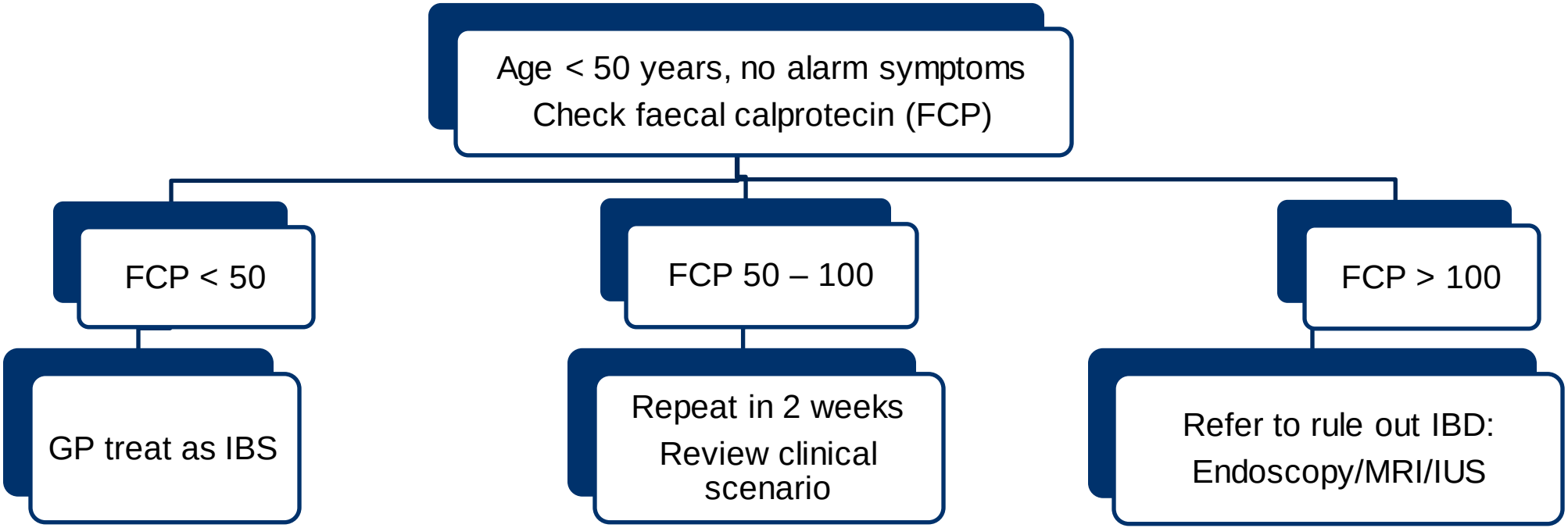
Tom's results include:

FBC	Platelets: 205 x10^9/L (150-400 x10^9/L), WCC: 8.2x10^9/L (4-10x10^9/L), Hb 140g/L(130-170 g/L)
U & E	Normal
ESR	22 mm/hr (0-10 mm/hr)
LFTs	Normal
CRP	4 mg/L (<5 mg/L)
Albumin	41 g/L (33-48 g/L)
Faecal calprotectin	90 µg/mg (<100 µg/mg)

CASE QUESTION 2

What are your next steps for Tom?

IBD VS IBS: ROLE OF FAECAL CALPROTECTIN



ibs4gps.com

FAECAL CALPROTECTIN: SCREENING TEST IN PRIMARY CARE

Category 6 – PATHOLOGY SERVICES

Proposed MBS item YYYYY

Faecal Calprotectin testing of patients aged ≤ 50 years with gastrointestinal symptoms suggestive of inflammatory or functional bowel disease of more than 6 weeks' duration who are presenting to a General Practitioner, General Physician or Specialist; where infectious causes have been excluded on the basis of time and the likelihood of malignancy has been assessed as low, and where *no clinical alarms* are present.

A maximum of 1 test may be performed in any 1-year period.

Fee: $80.00 **Benefit:** 75% = $60.00 85% = $68.00

Proposed MBS item ZZZZZ

Faecal Calprotectin testing of patients aged ≤ 50 years with gastrointestinal symptoms suggestive of inflammatory or functional bowel disease, presenting to a Specialist, in whom an initial faecal calprotectin test (MBS YYYYY) was inconclusive (50-100 µg/g), and where the Specialist feels an endoscopic examination is not initially warranted.

A maximum of 1 test may be performed in any 1-year period.

Fee: $80.00 **Benefit:** 75% = $60.00 85% = $68.00

Explanatory note:

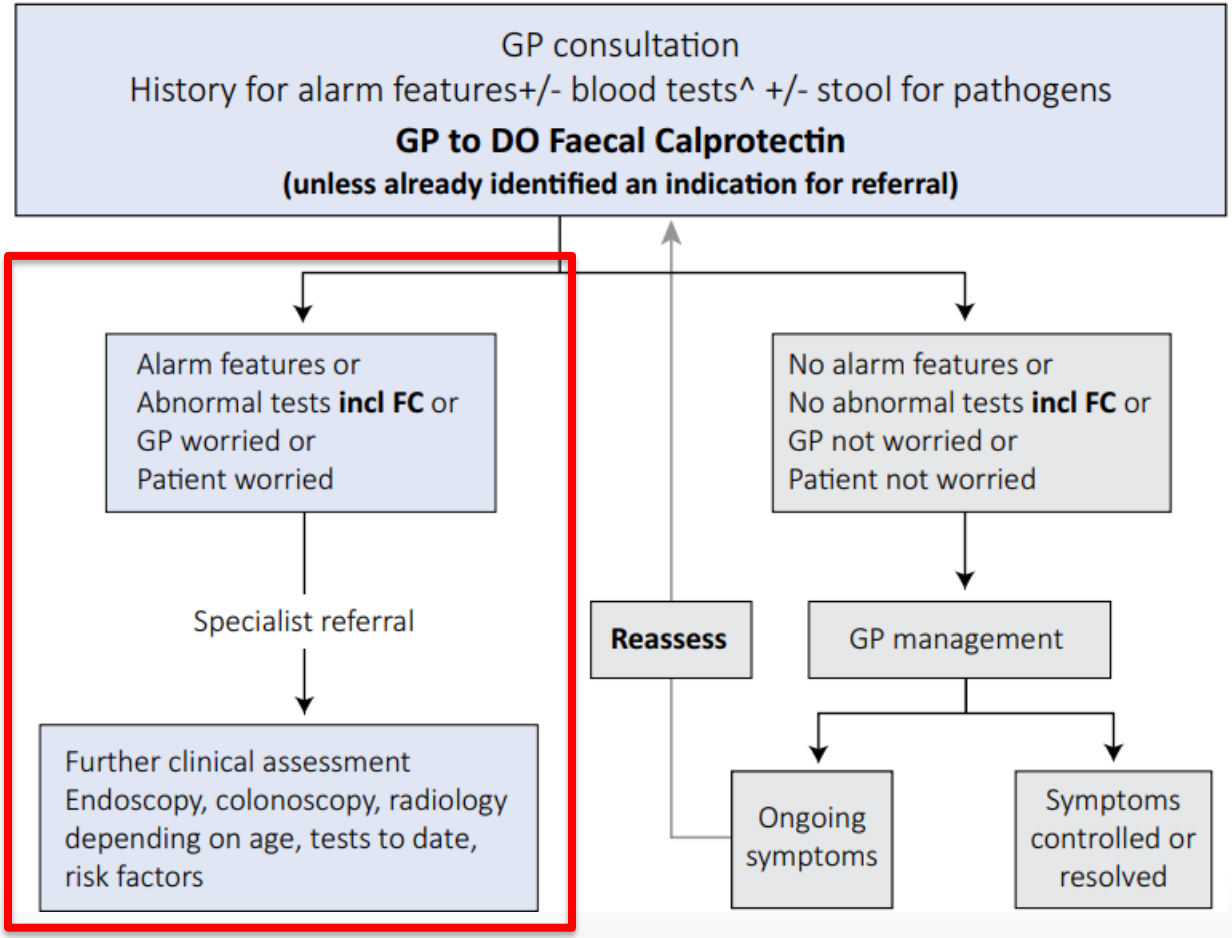
Clinical alarms

Unexplained weight loss (> 3 kg or 5% bodyweight), iron deficiency ± anaemia, melaena, overt rectal bleeding, positive faecal human haemoglobin, abdominal pain awaking patient from sleep, diarrhoea that is disturbing sleep or faecal incontinence, documented unexplained fever, family history of colon cancer, family history of inflammatory bowel disease (IBD) in symptomatic patients, or a family history of coeliac disease in symptomatic patients

CASE QUESTION 3

Tom’s faecal calprotectin result is 150µg/mg.

Discuss your next steps.



Source
GESA: Inflammatory Bowel Disease Clinical Update 2018

A link to download this resource is provided at the end of the presentation

MEET LIN

- Lin is 38 years old. She presented to her GP after 3 weeks of recurrent bloody diarrhoea, nocturnal diarrhoea, fever, nausea and weight loss.
- Initial investigations showed:
  - Hb 82 g/L (120-150 g/L)
  - Platelet 539 x 10^9/L (150-400 x 10^9/L)
  - ESR 48 mm/hr (0-12 mm/hr)
  - Ferritin 20 µg/L (30-150 µg/L)
  - Albumin 29 g/L (33-48 g/L)
  - Faecal calprotectin 190 µg/mg (<100 µg/mg)
- Stool culture was negative.

MEET LIN

- Lin was referred to a gastroenterologist and, following a colonoscopy, she was diagnosed with Crohn disease.

Medical history

- Previous IVF and caesarean section

Social history

- Lin is married, has a young child and is wanting to expand the family. Lin exercises regularly, has never smoked and has 4–5 standard drinks a week.

Allergies

- Penicillin
- Gluten – Lin reports that she suspects she is allergic to gluten so largely sticks to a gluten-free diet

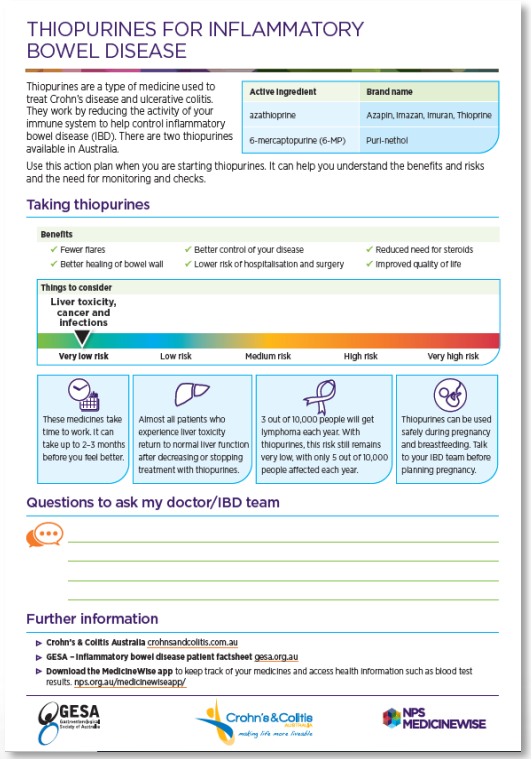
Medicines

Pregnancy multivitamin

CASE QUESTION 1

What would be your first steps for managing Lin’s IBD?

THIOPURINES FOR INFLAMMATORY BOWEL DISEASE PATIENT ACTION PLAN



THIOPURINES FOR INFLAMMATORY BOWEL DISEASE

Thiopurines are a type of medicine used to treat Crohn's disease and ulcerative colitis. They work by reducing the activity of your immune system to help control inflammatory bowel disease (IBD). There are two thiopurines available in Australia.

Active ingredient	Brand name
azathioprine	Azapin, Imazan, Imuran, Thioprine
6-mercaptopurine (6-MP)	Puri-nethol

Use this action plan when you are starting thiopurines. It can help you understand the benefits and risks and the need for monitoring and checks.

Taking thiopurines

Benefits

- ✓ Fewer flares
- ✓ Better control of your disease
- ✓ Reduced need for steroids
- ✓ Better healing of bowel wall
- ✓ Lower risk of hospitalisation and surgery
- ✓ Improved quality of life

Things to consider

Liver toxicity, cancer and infections

Very low risk | Low risk | Medium risk | High risk | Very high risk

These medicines take time to work, it can take up to 2–3 months before you feel better.

Almost all patients who experience liver toxicity return to normal liver function after decreasing or stopping treatment with thiopurines.

3 out of 10,000 people will get lymphoma each year. With thiopurines, this risk still remains very low, with only 5 out of 10,000 people affected each year.

Thiopurines can be used safely during pregnancy and breastfeeding. Talk to your IBD team before planning pregnancy.

Questions to ask my doctor/IBD team

Further information

- **Crohn's & Colitis Australia** crohnsandcolitis.com.au
- **GESA – Inflammatory bowel disease patient factsheet** gesa.org.au
- **Download the MedicineWise app** to keep track of your medicines and access health information such as blood test results. nps.org.au/medicinewiseapp/

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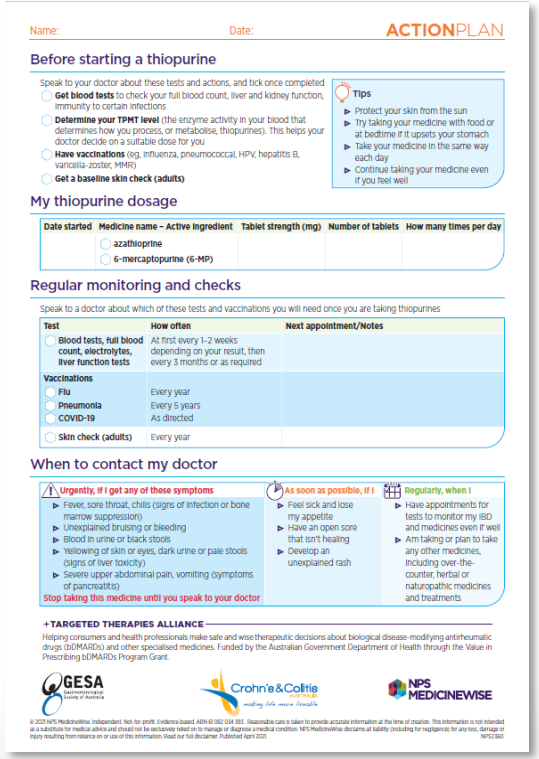

Name: Date: ACTIONPLAN

Before starting a thiopurine

Speak to your doctor about these tests and actions, and tick once completed

- **Get blood tests** to check your full blood count, liver and kidney function, immunity to certain infections
- **Determine your TPMT level** (the enzyme activity in your blood that determines how you process, or metabolise, thiopurines). This helps your doctor decide on a suitable dose for you
- **Have vaccinations** (eg, influenza, pneumococcal, HPV, hepatitis B, varicella-zoster, MMR)
- **Get a baseline skin check (adults)**

Tips

- Protect your skin from the sun
- Try taking your medicine with food or at bedtime if it upsets your stomach
- Take your medicine in the same way each day
- Continue taking your medicine even if you feel well

My thiopurine dosage

Date started	Medicine name – Active ingredient	Tablet strength (mg)	Number of tablets	How many times per day
	○ azathioprine ○ 6-mercaptopurine (6-MP)			

Regular monitoring and checks

Speak to a doctor about which of these tests and vaccinations you will need once you are taking thiopurines

Test	How often	Next appointment/Notes
○ Blood tests, full blood count, electrolytes, liver function tests	At first every 1–2 weeks depending on your result, then every 3 months or as required	
Vaccinations		
○ Flu	Every year	
○ Pneumonia	Every 5 years	
○ COVID-19	As directed	
○ Skin check (adults)	Every year	

When to contact my doctor

Urgently, if I get any of these symptoms

- Fever, sore throat, chills (signs of infection or bone marrow suppression)
- Unexplained bruising or bleeding
- Blood in urine or black stools
- Yellowing of skin or eyes, dark urine or pale stools (signs of liver toxicity)
- Severe upper abdominal pain, vomiting (symptoms of pancreatitis)

Stop taking this medicine until you speak to your doctor

As soon as possible, if I

- Feel sick and lose my appetite
- Have an open sore that isn't healing
- Develop an unexplained rash

Regularly, when I

- Have appointments for tests to monitor my IBD and medicines even if well
- Am taking or plan to take any other medicines, including over-the-counter, herbal or naturopathic medicines and treatments

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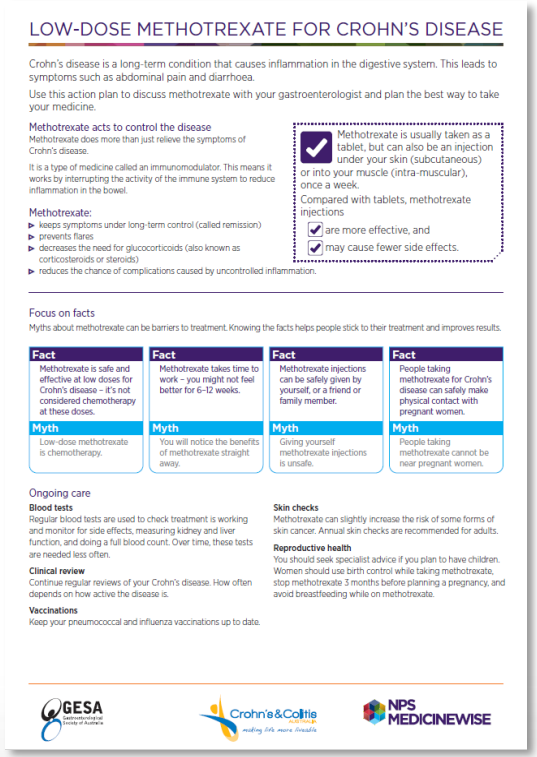
LOW-DOSE METHOTREXATE FOR CROHN'S DISEASE



LOW-DOSE METHOTREXATE FOR CROHN'S DISEASE

Crohn's disease is a long-term condition that causes inflammation in the digestive system. This leads to symptoms such as abdominal pain and diarrhoea.

Use this action plan to discuss methotrexate with your gastroenterologist and plan the best way to take your medicine.

Methotrexate acts to control the disease

Methotrexate does more than just relieve the symptoms of Crohn's disease.

It is a type of medicine called an immunomodulator. This means it works by interrupting the activity of the immune system to reduce inflammation in the bowel.

Methotrexate:

- keeps symptoms under long-term control (called remission)
- prevents flares
- decreases the need for glucocorticoids (also known as corticosteroids or steroids)
- reduces the chance of complications caused by uncontrolled inflammation.

Methotrexate is usually taken as a tablet, but can also be an injection under your skin (subcutaneous) or into your muscle (intra-muscular), once a week.

Compared with tablets, methotrexate injections

- are more effective, and
- may cause fewer side effects.

Focus on facts

Myths about methotrexate can be barriers to treatment. Knowing the facts helps people stick to their treatment and improves results.

Fact	Fact	Fact	Fact
Methotrexate is safe and effective at low doses for Crohn's disease – it's not considered chemotherapy at these doses.	Methotrexate takes time to work – you might not feel better for 6–12 weeks.	Methotrexate injections can be safely given by yourself, or a friend or family member.	People taking methotrexate for Crohn's disease can safely make physical contact with pregnant women.
Myth	**Myth**	**Myth**	**Myth**
Low-dose methotrexate is chemotherapy.	You will notice the benefits of methotrexate straight away.	Giving yourself methotrexate injections is unsafe.	People taking methotrexate cannot be near pregnant women.

Ongoing care

Blood tests
Regular blood tests are used to check treatment is working and monitor for side effects, measuring kidney and liver function, and doing a full blood count. Over time, these tests are needed less often.

Clinical review
Continue regular reviews of your Crohn's disease. How often depends on how active the disease is.

Vaccinations
Keep your pneumococcal and influenza vaccinations up to date.

Skin checks
Methotrexate can slightly increase the risk of some forms of skin cancer. Annual skin checks are recommended for adults.

Reproductive health
You should seek specialist advice if you plan to have children. Women should use birth control while taking methotrexate, stop methotrexate 3 months before planning a pregnancy, and avoid breastfeeding while on methotrexate.

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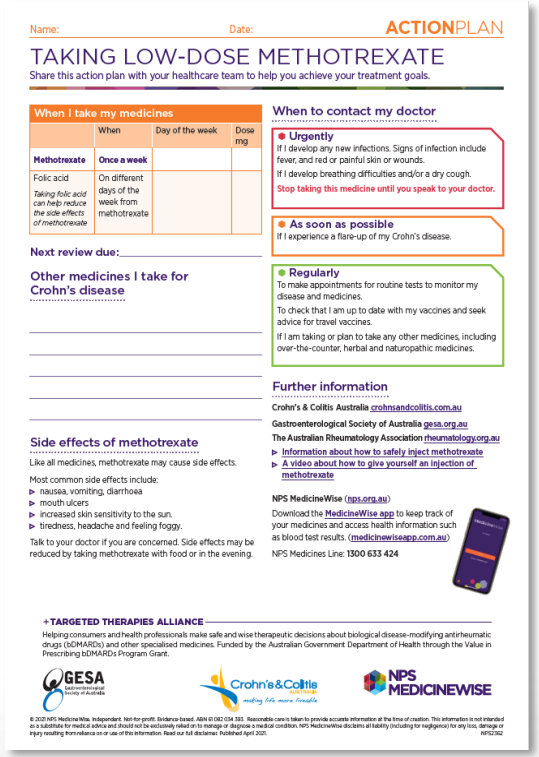

Name: Date: ACTIONPLAN

TAKING LOW-DOSE METHOTREXATE

Share this action plan with your healthcare team to help you achieve your treatment goals.

When I take my medicines

	When	Day of the week	Dose mg
Methotrexate	**Once a week**		
Folic acid *Taking folic acid can help reduce the side effects of methotrexate*	On different days of the week from methotrexate		

Next review due:

Other medicines I take for Crohn's disease

Side effects of methotrexate

Like all medicines, methotrexate may cause side effects.

Most common side effects include:

- nausea, vomiting, diarrhoea
- mouth ulcers
- increased skin sensitivity to the sun.
- tiredness, headache and feeling foggy.

Talk to your doctor if you are concerned. Side effects may be reduced by taking methotrexate with food or in the evening.

When to contact my doctor

Urgently
If I develop any new infections. Signs of infection include fever, and red or painful skin or wounds.
If I develop breathing difficulties and/or a dry cough.
Stop taking this medicine until you speak to your doctor.

As soon as possible
If I experience a flare-up of my Crohn's disease.

Regularly
To make appointments for routine tests to monitor my disease and medicines.
To check that I am up to date with my vaccines and seek advice for travel vaccines.
If I am taking or plan to take any other medicines, including over-the-counter, herbal and naturopathic medicines.

Further information

Crohn's & Colitis Australia crohnsandcolitis.com.au
Gastroenterological Society of Australia gesa.org.au
The Australian Rheumatology Association rheumatology.org.au

- Information about how to safely inject methotrexate
- A video about how to give yourself an injection of methotrexate

NPS MedicineWise (nps.org.au)
Download the MedicineWise app to keep track of your medicines and access health information such as blood test results. (medicinewiseapp.com.au)
NPS Medicines Line: 1300 633 424

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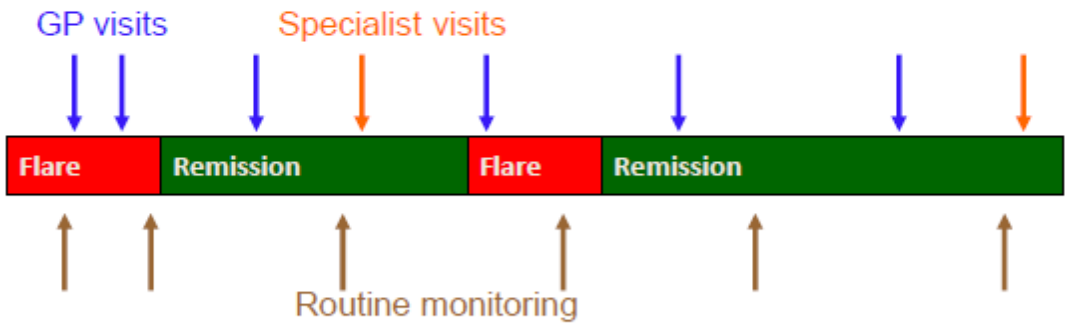
A link to download this resource is provided at the end of the presentation

CASE QUESTION 2

What ongoing monitoring is required for Lin, to assess treatment efficacy and detect side effects?

IBD management: PROACTIVE care to maintain remission/mucosal healing

Proactive care



Biomarkers: calprotectin/Bloods: CRP; Fe studies; Alb
Endoscopy
Imaging: intestinal ultrasound/ MRIs

CASE QUESTION 3

How does Lin’s plans for a second pregnancy impact her management?

PREGNANCY AND IBD

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GASTROENTEROLOGIST FACT SHEET

Pregnancy, Fertility and Inflammatory Bowel Disease

- Inflammatory bowel disease (IBD) affects patients in their peak reproductive years
- Active IBD increases the risk of adverse pregnancy outcomes, including spontaneous abortion, intrauterine growth restriction and preterm birth
- Patients should be counselled about the importance of controlling disease with medication both before conception and during pregnancy
- Most IBD medications are safe during pregnancy and breastfeeding
- Early preconception counselling has been shown to improve pregnancy outcomes

Ideally, all women of childbearing age should discuss pregnancy plans with their general practitioner, gastroenterologist and any treating obstetrician and gynaecologist from the time of IBD diagnosis. In these discussions, practitioners should inform patients that pregnancy outcomes are very good when IBD is in remission and that active disease increases the risk to the baby. Establishing and documenting disease remission before conception and determining who is in the obstetric care team is important. Most IBD medications are low risk during pregnancy and breastfeeding, and their use should be continued.

Preconception clinical and objective assessment

Ideally 3 to 6 months before conception, patients with IBD should attend for preconception counselling to confirm disease remission, receive pregnancy-related education and establish a pregnancy treatment plan that is also communicated to the patient's general practitioner and obstetrician.

Previous medical, surgical and obstetric history should be discussed, and clinical disease activity assessed. Objective assessment should be performed to confirm remission, including endoscopy and/or imaging, where relevant, and measurement of inflammatory markers, including C-reactive protein (CRP), nutritional markers (iron, vitamin B_{12}, red blood cell [RBC] folate, haemoglobin and albumin) and faecal calprotectin. Thiopurine metabolite concentrations should be measured, where available, and thiopurine dose optimised. It is strongly recommended that women achieve sustained remission, as confirmed by faecal calprotectin level or endoscopy, for at least 3 to 6 months before conception to maximise chances of a successful pregnancy.

The risk of adverse pregnancy outcomes associated with active disease should be discussed, and a recommendation to delay conception should be considered for patients with active disease, depending on the woman's age and situation.

General preconception health considerations should be addressed, including folate supplementation at least 1 month before conception, and ensuring patients have had their immunity to measles, mumps and rubella (MMR) checked.

Patients often worry about heritability of IBD and should be informed that the chance of a child developing IBD is about 5–8% when there is one affected parent and about 35% when there are two affected parents.

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GENERAL PRACTITIONER AND OBSTETRICIAN FACT SHEET

Pregnancy, Fertility and Inflammatory Bowel Disease

- Inflammatory bowel disease (IBD) affects patients in their peak reproductive years
- Active IBD increases the risk of adverse pregnancy outcomes, including spontaneous abortion, intrauterine growth restriction and preterm birth
- Most patients with IBD will require medication to control their disease, both before conception and during pregnancy and breastfeeding
- Preconception counselling has been shown to improve pregnancy outcomes
- Most IBD medications are considered safe during pregnancy and breastfeeding
- A multidisciplinary approach, with the involvement of general practitioners, midwives, obstetricians and gastroenterologists, is recommended

Ideally, all women of childbearing age should discuss pregnancy plans with their general practitioner, gastroenterologist and any treating obstetrician and gynaecologist from the time of IBD diagnosis. In these discussions, practitioners should inform patients that pregnancy outcomes are very good when IBD is in remission and that active disease increases the risk to the baby. Establishing and documenting disease remission before conception and determining who is in the obstetric care team is important. Most IBD medications are low risk during pregnancy and breastfeeding, and their use should be continued.

Preconception clinical and objective assessment

All patients should be asked about their fertility concerns and pregnancy wishes, including the number of children desired and likely timing of pregnancies. Patient preference on mode of delivery and obstetric hospital should be determined. Fears or concerns about having children should be elicited, to enable individualised education.

Three to 6 months before conception, patients should be reviewed by their gastroenterologist for preconception counselling to confirm disease remission, receive education about pregnancy and IBD and have a pregnancy treatment plan established. This plan should be communicated to all health practitioners involved in the care of the patient during the pregnancy. At this review, previous medical, surgical and obstetric history will be discussed, and clinical disease activity scores assessed. Objective assessment will also be performed to confirm remission, including endoscopy and/or imaging, where relevant, and measurement of inflammatory markers, including C-reactive protein (CRP), nutritional markers and baseline faecal calprotectin. Measurement of levels of medications, such as azathioprine, 6-mercaptopurine, infliximab and adalimumab, may be considered but is not currently reimbursed under the MBS. Medical treatment should be optimised, with the aim of achieving sustained remission for at least 3 to 6 months before conception to maximise chances of a successful pregnancy.

Cessation or modification of IBD treatment is usually not necessary, with the exception of methotrexate, thalidomide and allopurinol, and any changes to medical therapy should be made in consultation with the treating gastroenterologist.

A link to download this resource is provided at the end of the presentation

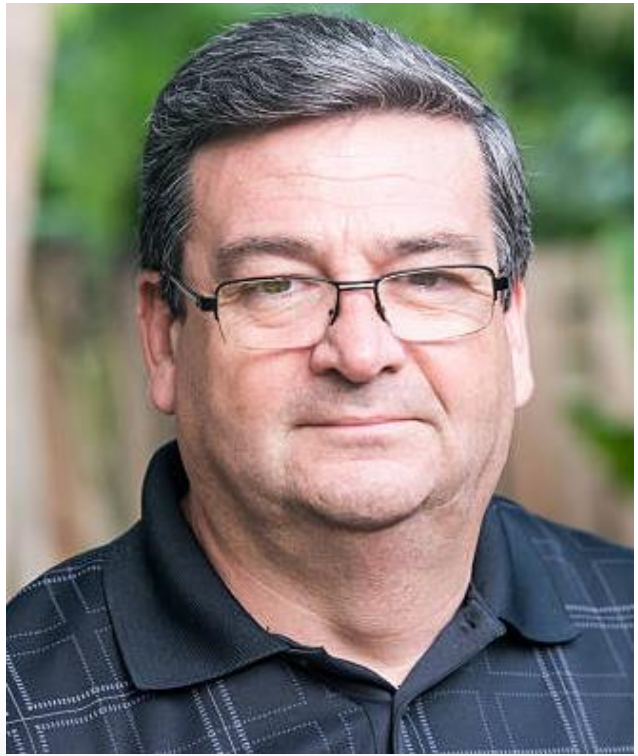
IBD MEDICATION SAFETY DURING PREGNANCY AND LACTATION

Mediation	Use in pregnancy	Use in breastfeeding	Comments
Sulfasalazine (SSZ) and 5-ASA	Safe	Safe	2mg/day folate required with SSZ.
Steroids- prednisolone and budesonide	Safe	Safe	Increased maternal risks of gestational diabetes, hypertension and pre-eclampsia.
Thiopurines (azathioprine and 6 mercaptopurine)	Safe	Safe	Potential concerns regarding neonatal anaemia not confirmed with recent studies.
Allopurinol	Safety uncertain	Safe	Consider original indication and current disease activity. Alternatives include split dosing to reduce shunting, or reduced dose thiopurine monotherapy if on biologics.
Anti TNF antibodies Infliximab (IFX) Adalimumab (ADA) Golimumab	Safe	Safe	No safety reason to cease early. Continued therapy recommended due to risk of relapse and small risk of failure to recapture response. Women in deep remission may elect to stop at 32 weeks (IFX) or 36 weeks (ADA). No live vaccinations for infant until 12 months of age.
Combination therapy thiopurine/anti TNF	Safe	Safe	Increase in neonatal childhood infections e.g. chickenpox.
Vedolizumab	Limited data but likely to be safe	Limited data but likely to be safe	Use only in patients with no alternatives.
Ustekinumab	Limited data but likely to be safe	Limited data but likely to be safe	Use only in patients with no alternatives.
Metronidazole	Safe in short course	Safe - may cause diarrhoea in infant	Safe in meta-analysis. Use in short course. Alternative Augmentin DF.
Ciprofloxacin	Safe in short course	Safe - may cause diarrhoea in infant	Safe in meta-analysis. Use in short course.
Tacrolimus	Limited data from transplant registries Appears safe	Avoid- baby may have therapeutic levels which may lower seizure threshold	Monitor carefully for hypertension.
Cyclosporine	Limited data from transplant registries Appears safe	Avoid- baby may have therapeutic levels which may lower seizure threshold	Monitor carefully for hypertension.
Methotrexate	Teratogen Do not use	Unsafe - excreted in breast milk and accumulates in neonate	Cease 6 months prior to pregnancy ideally, but minimum of one ovulatory cycle.

A link to download this resource is provided at the end of the presentation

MEET DAVID

- David is 49 years old. He was diagnosed with ulcerative colitis 2 years ago.
- Prescribed a combination of oral and topical mesalazine. Discontinued liquid enemas after 2 weeks but continued with 1.5 g/day oral mesalazine.
- 1 flare 6 months ago.
- Worsening symptoms, with nocturnal diarrhoea, blood in stools, and a mild fever.



MEET DAVID

Medical history

- Gout
- Hypertension

Allergies

- Nil

Medicines

- Mesalazine 1.5g/day
- Allopurinol 200mg/day
- Perindopril 4mg/day

Social history

- David is a divorced, father of 2 children. Works full-time as a warehouse supervisor and lives alone.
- He has 2 – 3 standard drinks/day and smokes 6 cigarettes/day.
- His diet consists largely of take-away food and pre-prepared meals.
- He does no regular physical activity.

CASE QUESTION 1

What steps would you take to manage David's IBD flare?

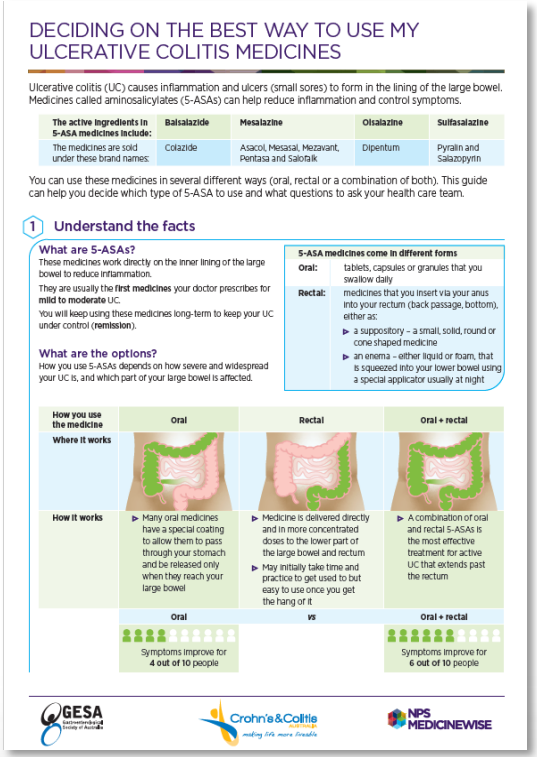
IBD FLARE MANAGEMENT

1. Optimise use of rectal 5-ASA
2. Optimise oral 5-ASA dose
3. More than 1 flare/year:

✓ Refer back to gastroenterologist for additional treatment (immunomodulator)

✗ Recurrent use of steroids

5-ASAS FOR ULCERATIVE COLITIS



DECIDING ON THE BEST WAY TO USE MY ULCERATIVE COLITIS MEDICINES

Ulcerative colitis (UC) causes inflammation and ulcers (small sores) to form in the lining of the large bowel. Medicines called aminosalicylates (5-ASAs) can help reduce inflammation and control symptoms.

The active ingredients in 5-ASA medicines include:	Balsalazide	Mesalazine	Olsalazine	Sulfasalazine
The medicines are sold under these brand names:	Colazide	Asacol, Mesasal, Mezavant, Pentasa and Salofalk	Dipentum	Pyralin and Salazopyrin

You can use these medicines in several different ways (oral, rectal or a combination of both). This guide can help you decide which type of 5-ASA to use and what questions to ask your health care team.

1 Understand the facts

What are 5-ASAs?

These medicines work directly on the inner lining of the large bowel to reduce inflammation.

They are usually the **first medicines** your doctor prescribes for **mild to moderate** UC.

You will keep using these medicines long-term to keep your UC under control (**remission**).

What are the options?

How you use 5-ASAs depends on how severe and widespread your UC is, and which part of your large bowel is affected.

5-ASA medicines come in different forms	
Oral:	tablets, capsules or granules that you swallow daily
Rectal:	medicines that you insert via your anus into your rectum (back passage, bottom), either as: ▶ a suppository – a small, solid, round or cone shaped medicine ▶ an enema – either liquid or foam, that is squeezed into your lower bowel using a special applicator usually at night

How you use the medicine	Oral	Rectal	Oral + rectal
Where it works			
How it works	▶ Many oral medicines have a special coating to allow them to pass through your stomach and be released only when they reach your large bowel	▶ Medicine is delivered directly and in more concentrated doses to the lower part of the large bowel and rectum ▶ May initially take time and practice to get used to but easy to use once you get the hang of it	▶ A combination of oral and rectal 5-ASAs is the most effective treatment for active UC that extends past the rectum
	Oral	*vs*	Oral + rectal
	Symptoms improve for **4 out of 10** people		Symptoms improve for **6 out of 10** people

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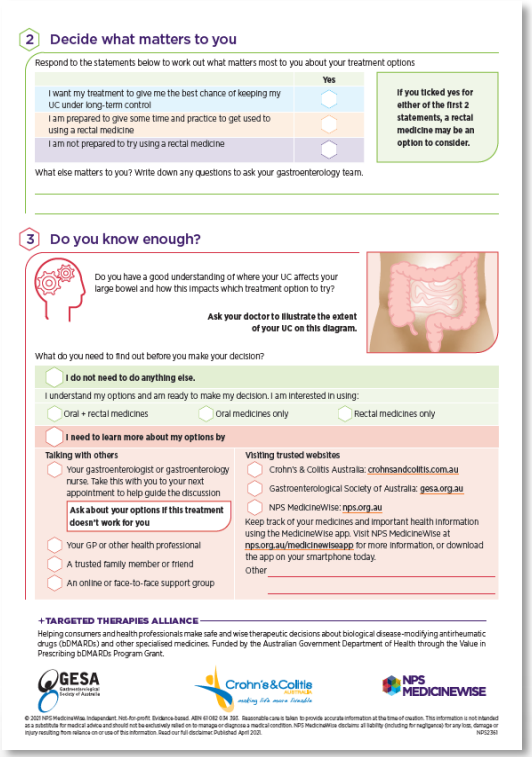

2 Decide what matters to you

Respond to the statements below to work out what matters most to you about your treatment options

	Yes
I want my treatment to give me the best chance of keeping my UC under long-term control	☐
I am prepared to give some time and practice to get used to using a rectal medicine	☐
I am not prepared to try using a rectal medicine	☐

If you ticked yes for either of the first 2 statements, a rectal medicine may be an option to consider.

What else matters to you? Write down any questions to ask your gastroenterology team.

3 Do you know enough?

Do you have a good understanding of where your UC affects your large bowel and how this impacts which treatment option to try?

Ask your doctor to illustrate the extent of your UC on this diagram.

What do you need to find out before you make your decision?

☐ **I do not need to do anything else.**

I understand my options and am ready to make my decision. I am interested in using:

☐ Oral + rectal medicines ☐ Oral medicines only ☐ Rectal medicines only

☐ **I need to learn more about my options by**

Talking with others

☐ Your gastroenterologist or gastroenterology nurse. Take this with you to your next appointment to help guide the discussion

Ask about your options if this treatment doesn't work for you

☐ Your GP or other health professional

☐ A trusted family member or friend

☐ An online or face-to-face support group

Visiting trusted websites

☐ Crohn's & Colitis Australia: crohnsandcolitis.com.au

☐ Gastroenterological Society of Australia: gesa.org.au

☐ NPS MedicineWise: nps.org.au

Keep track of your medicines and important health information using the MedicineWise app. Visit NPS MedicineWise at nps.org.au/medicinewiseapp for more information, or download the app on your smartphone today.

Other _____

+TARGETED THERAPIES ALLIANCE

Helping consumers and health professionals make safe and wise therapeutic decisions about biological disease-modifying antirheumatic drugs (bDMARDs) and other specialised medicines. Funded by the Australian Government Department of Health through the Value in Prescribing bDMARDs Program Grant.

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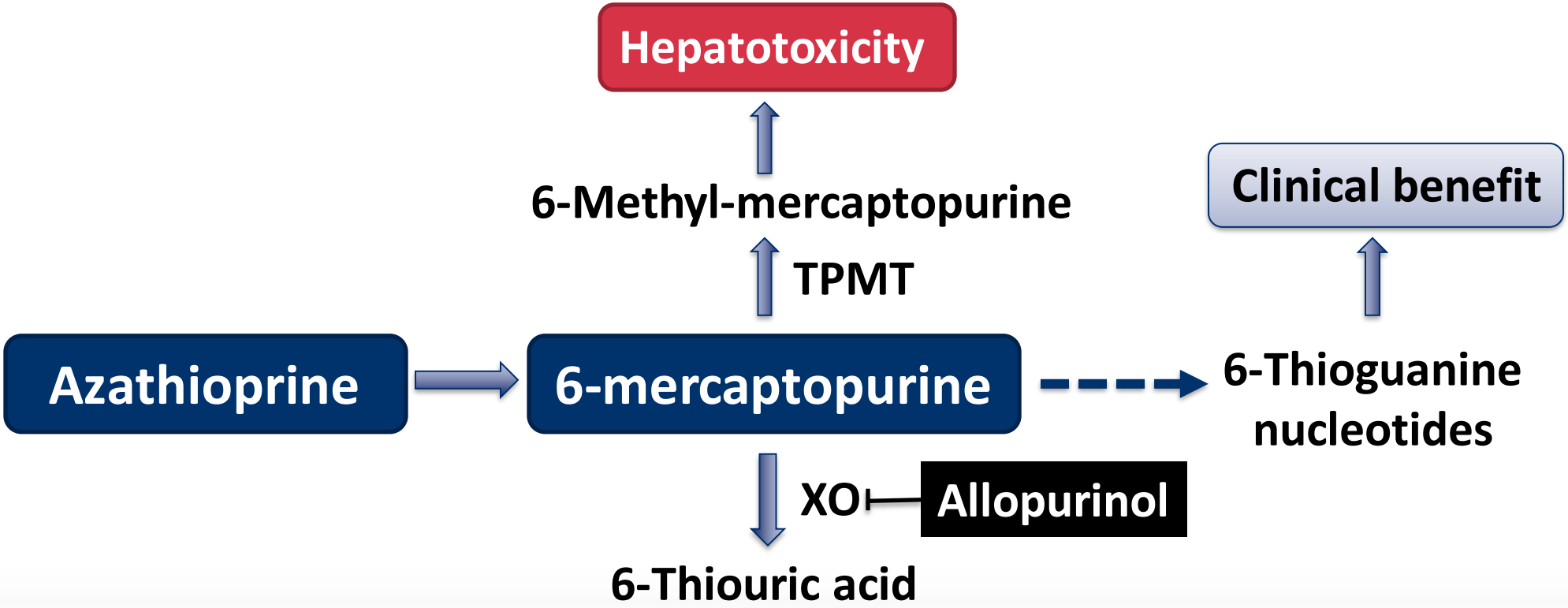
NPS2361

A link to download this resource is provided at the end of the presentation

THIOPURINE METABOLISM



CASE QUESTION 2

What non-pharmacological treatments should David also consider?

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FACT SHEET

Diet in Inflammatory Bowel Disease (IBD)

Introduction

The term inflammatory bowel disease (IBD) is used to describe chronic conditions that cause inflammation of the digestive system. The two major types of IBD are **Crohn's Disease** and **Ulcerative Colitis**. The cause of these conditions is still unknown; however the environment, genes and the gut bacteria are thought to be involved.

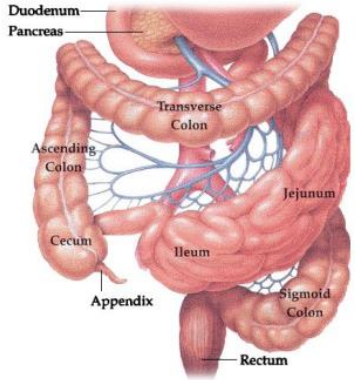
Ulcerative Colitis is a chronic inflammatory condition that can affect any part of the large bowel. The inflammation only involves the lining of the bowel.

Crohn's disease involves chronic inflammation of any part of the digestive system from the mouth to the anus. It can involve the full thickness of the bowel wall.

Both conditions can cause pain, nausea, fever and diarrhoea. These symptoms can cause loss of appetite, reduced dietary intake and poor nutrition.

Symptoms and severity vary from person to person and may flare or improve over time (remission).

Nutrition plays an important role in the management of IBD and referral to a specialist Dietitian may be recommended to ensure your diet is nutritionally adequate during periods of flare and remission.



1. What are general dietary recommendations for people with IBD?

- Promote normal growth and development in children

Periods of remission are good times to make up for inadequate nutrient intake during flares. Low nutrient intake during a flare may result from increased nutritional needs or symptoms that reduce oral intake (poor appetite, abdominal pain, nausea and/or vomiting).

Excluding certain foods can cause deficiencies in energy,

A link to download this resource is provided at the end of the presentation

CASE QUESTION 3

David’s symptoms continue to worsen. How do you escalate his treatment?

QUESTIONS

RESOURCES

For your patients

- **GESA** gesa.org.au
  - Fact sheet: Inflammatory Bowel Disease
  - Fact sheet: Diet in Inflammatory Bowel Disease
  - Fact sheet: Pregnancy, Fertility and Inflammatory Bowel Disease
- **Crohn's & Colitis Australia** crohnsandcolitishub.com.au
  - Crohn's and Colitis Hub: Understanding and living with Crohn's and Colitis
- **NPS MedicineWise** nps.org.au
  - Patient action plan: Thiopurines for inflammatory bowel disease
  - Patient action plan: Low-dose methotrexate for Crohn's disease
  - Patient decision aid: Deciding on the best way to use my ulcerative colitis medicines

Health professionals

- **GESA** gesa.org.au
  - Australian Guidelines for General Practitioners and Physicians: Inflammatory Bowel Disease 4th Edition (updated 2018)
  - Fact sheet for gastroenterologists: Pregnancy, Fertility and Inflammatory Bowel Disease
  - Fact sheet for GPs and obstetricians: Pregnancy, Fertility and Inflammatory Bowel Disease
  - Fact sheet: Medication (Pregnancy, Fertility and Inflammatory Bowel Disease)
- **Crohn's & Colitis Australia** gutsmart.com.au
  - GutSmart: Online education platform for health professionals
- **NPS MedicineWise** nps.org.au/bdmards

DISCLOSURES

Susan Connor

- Advisory Boards: Abbvie/BMS/Celgene/Celltrion/Chiesi/DrFalk/Ferring/Fresenius Kabi/Gilead/Janssen/MSD/Novartis/Pfizer/Takeda
- Speaker fees: Abbvie/Aspen/Ferring/Janssen/Pfizer/Takeda
- Educational Support: DrFalk/Pfizer/Takeda
- Research Grants to Liverpool IBD Service and *Crohn's Colitis Cure*: Abbvie/ACI/DrFalk/Ferring/Janssen/MSD/Pfizer/SWSLHD/Takeda/Vifor

Michael De Gregorio

- Michael De Gregorio has received research support grants from Janssen

THANK YOU