IBD management in 2010: highlight report from the annual meeting of the BSG, Liverpool 2010

Keith Leiper

Correspondence to

Dr K Leiper, Link 5Z, Royal Liverpool University Hospital, Prescot Street, Liverpool L7 8XP, UK; keith.leiper@rlbuht.nhs.uk

Accepted 23 April 2010

A refreshingly iconoclastic view of the ECCO guidance was delivered by Professor Stange (Stuttgart), all the more impressive as he is a principle author of the guidance. His thoughtful interpretation was particularly useful in the minefield of when to start anti-tumour necrosis factors (TNFs). The ECCO consensus strongly recommends budesonide as firstline therapy in mild to moderately active disease and anti-TNFs if relapse occurs. However, all patients with Crohn's disease (CD) will eventually relapse and only a proportion of these will require anti-TNFs. He recommended "use what worked last time" and this includes antibiotic and dietary therapy (neither of which are endorsed by ECCO). His general recommendations as indications for anti-TNFs were: those refractory to oral steroids and those in whom there is a predictable poor response to conventional therapy (early

age at onset, extensive small bowel disease, perianal disease, smokers).

Dr Craig Mowat (Dundee) presented the, yet to be ratified, new BSG guidelines for the management of inflammatory bowel disease (IBD) in adults. It is heartening to see that service delivery and IBD standards are embedded in the new guidance. The UK guidance differs from ECCO in several other respects: auditable features, rejection of oral 5-aminosalicylic acid (5-ASA) for CD, step up approach and measurement of thiopurine methyltransferase recommended prior to starting thiopurines and for postoperative therapy in CD the only evidence based recommendation is for stopping smoking.

Professor Louis (Liege) provided a timely review of exit strategies for biological therapy in CD. He first addressed 'why would you want to stop?'—patient choice, avoidance of adverse effects and cost. He presented data from the STORI

trial, an open label trial of stopping infliximab in patients with CD in stable remission for at least 6 months and treated with infliximab for at least 1 year. Relapse rate was 50% at 1 year but the relapse rate was low thereafter. The concept of 'deep remission' was introduced, as those with no symptoms and no laboratory abnormalities and mucosal healing who are unlikely to relapse on withdrawing anti-TNFs. Data from rheumatoid arthritis studies suggest that those who relapse have a good response to retreatment.

Professor Vermeire (Leuven) discussed pregnancy in IBD, stressing that the key is to attempt to establish remission prior to conceiving. We need to discuss the risks and benefits of each therapy but in the knowledge that data are sparse. Azathioprine is class D teratogenic in animals but there is no evidence of this in human studies. Several studies have shown no increase in the rate of congenital abnormalities for patients on azathioprine. Infliximab and adalimumab are IgG antibodies and cross the placenta in the third trimester. The recommendation is to stop these drugs after 20–22 weeks' gestation. The data are reassuring in pregnancy from the TREAT register, published studies (*Am J Gastroenterol* 2009) and unpublished data from the Leuven Group. However, there are some lingering concerns about the risk of congenital abnormalities. Professor Vermeire recommended using steroids and 5-ASA in the event of relapse in the third trimester. Pregnant patients with severely active ulcerative colitis who failed to respond to steroids can be treated with ciclosporin or infliximab for ulcerative colitis.

Data on outcome in acute severe colitis from the National IBD Audit were presented by Dr Ian Arnott (Edinburgh). Overall mortality was 1.2% and only slightly increased in those fulfilling Travis criteria, at

Take home messages

- ▶ Consider stopping treatment with TNF inhibitor after 1 year in patients with Crohn's disease in 'deep remission': no symptoms; no laboratory abnormalities; and mucosal healing.
- ▶ During pregnancy, treatment with thiopurine, corticosteroid and 5-ASA appear safe. Infliximab or ciclosporin may be used to treat steroid refractory acute severe ulcerative colitis.
- ▶ Mortality associated with acute severe ulcerative colitis is age related: it increases from about 1.5% to 11% in patients over 80 years of age. Failure to respond to corticosteroids doubles the risk of death.

1.9%. A striking association exists with age, with a mortality of 11% in those over 80 years. Sixty-one per cent responded to steroids; those who do not respond to steroids have a doubling of mortality. J F Rahier (Yvoir) presented a persuasive argument for immunisation in IBD, stating that "death from preventable disease should not occur". Although there are no trials on cost effectiveness, the recommendation is to check vaccination history, check serology (for hepatitis B virus and varicella zoster virus) and immunise if negative before starting immunosuppression (see *Gut* 2009;58:1313–15).

Finally, J Hunter (Southampton) presented data on a novel way of following up people with quiescent disease (*Gut* 2010;59(Suppl 1):A3). This methodology resulted in high levels of patient satisfaction. As is commensurate with an innovative 21st century method, you should look up the details online.

Competing interests None.

Provenance and peer review Commissioned; not externally peer reviewed.

Frontline Gastroenterology 2010;1:67–68.
doi:10.1136/fg.2010.001693