Inflammatory Bowel Disease (IBD)

What is the difference between ulcerative colitis and Crohn's Disease?

Ulcerative colitis and Crohn's disease are two types of Inflammatory Bowel Disease (IBD). The large intestine (colon) is inflamed in ulcerative colitis, and this involves the inner lining of the colon. In Crohn's disease the inflammation extends deeper into the intestinal wall. Crohn's disease can also involve the small intestine (ileitis), or can involve both the small and large intestine (ileocolitis).

How is IBD different from Irritable Bowel Syndrome?

IBD develops due to inflammation in the intestine which can result in bleeding, fever, elevation of the white blood cell count, as well as diarrhea and cramping abdominal pain. The abnormalities in IBD can usually be visualized by cross-sectional imaging (for instance a CT scan) or colonoscopy. Irritable Bowel Syndrome (IBS) is a set of symptoms resulting from disordered sensation or abnormal function of the small and large bowel. Irritable Bowel Syndrome is characterized by crampy abdominal pain, diarrhea, and/or constipation, but is not accompanied by fever, bleeding or an elevated white blood cell count. Examination by colonoscopy or barium x-ray reveals no abnormal findings.

What is the cause of IBD?

There is no single explanation for the development of IBD. A prevailing theory holds that a process, possibly viral, bacterial, or allergic, initially inflames the small or large intestine and, depending on genetic predisposition, results in the development of antibodies which chronically "attack" the intestine, leading to inflammation. Approximately 10 percent of patients with IBD have a close family member (parent, sibling or child) with the disease, which lends support to a genetic predisposition in some patients.

Is IBD caused by stress?

Emotional stress due to family, job or social pressures may result in worsening of the Irritable Bowel Syndrome but there is little evidence to suggest that stress is a major cause for ulcerative colitis or Crohn's disease. Although IBD is not caused by stress recent studies show that there may be a relationship between the two--stressful periods in life may lead to a flare of disease activity in persons with the underlying diagnosis of IBD.

How is IBD diagnosed?

There is no single test that can make the diagnosis of IBD or completely rule out its existence reliably. Colonoscopy, cross-sectional imaging studies of the colon or the upper GI tract, along with newer blood tests that detect markers that are commonly associated with IBD, along with a patient's history and physical exam, can all be useful in helping your doctor establish a diagnosis of IBD.

What are the complications of IBD?

Ulcerative colitis and Crohn's disease can lead to diarrhea, bleeding, anemia, weight loss, fevers, malnutrition and fistulae. IBD can also have extra-intestinal manifestations where areas other than your gastrointestinal system such as your skeletal system, your skin or your eyes may be involved.

What medical treatments are available for IBD?

Various formulations of 5-ASA, a drug which has been used to treat IBD for over 50 years, are available as oral preparations, suppositories and enemas. These are often one of the first drugs used to treat IBD.

Corticosteroid therapies, such as prednisone or hydrocortisone, are given when the 5-ASA products are insufficient to control inflammation. These drugs can be given orally, rectally as suppositories or enemas, or intravenously.

Drugs which suppress the body's immune response in IBD (known as immunomodulators) are used. Azathioprine and 6-mercaptopurine (6-MP) are the two most commonly used immunomodulators for anti-immune therapy.

Finally, a newer class of medications called "biologics" is used for patients with moderate to severe disease. Biologics include medications like infliximab (Remicade®), a medication given thru an IV infusion, and adalimumab (Humira®) and certolizumab pegol (Cimzia®), medications given via subcutaneous injection.

Are there complications from the medical treatments?

Sulfasalazine, a 5-ASA product first used to treat IBD in the 1940s, may cause nausea, indigestion or headache in about 15 percent of patients and worsening diarrhea in about 4 percent of patients. The newer drugs have fewer side effects. Chronic corticosteroid therapy can lead to fluid retention and high blood pressure, some rounding of the face and softening of the bones similar to osteoporosis. These complications usually prompt attempts to discontinue corticosteroid treatment as soon as possible. The anti-immune drugs require periodic monitoring of the blood count since some patients will develop a low white blood cell count. These drugs, however, are usually well-tolerated in many patients. Biologics can alter a patient's ability to respond to any stressors to their immune system and in some patients may make it harder for their body to fight off infections.

Is diet management important for patients with IBD?

Physicians prefer to maintain good nutrition for those diagnosed with IBD. If you are responding well to medical management you can often eat a reasonably unrestricted diet. A low-roughage diet is often suggested for those prone to diarrhea after meals. If you appear to be milk sensitive (lactose intolerant), you are advised to either avoid milk products or use milk to which the enzyme lactase has been added.

How successful is medical therapy?

With early and proper treatment the majority of patients with IBD lead healthy and productive lives. Some patients may require surgery for treatment of complications of IBD such as an abscess, bowel obstruction or inadequate response to treatment.

What are surgical options for IBD?

Crohn's disease of the small or large intestine can be treated surgically for complications such as obstruction, abscess, fistula or failure to respond adequately to treatment. The disease may recur at some time after the operation.

Ulcerative colitis is curable with removal of the entire colon. This may require creating an "ileostomy" (with attachment of the ileum to the external abdominal wall with an external application pouch) or may involve the direct attachment of the small intestine (ileum) to the anus. This type of surgery, known as "IPAA surgery," does not require an external application pouch.