



FIGURE 37-8 Computed tomographic enterography shows extensive Crohn's disease with fistula (arrow).

TABLE 37-3 TREATMENT OPTIONS

DISEASE SEVERITY	ULCERATIVE COLITIS	CROHN'S DISEASE
Mild	Oral and topical 5-ASA compounds	5-ASA compounds Antibiotics Elemental diet
Moderate	Oral and topical 5-ASA compounds Oral steroids or budesonide MMX Azathioprine, 6-MP Infliximab, adalimumab, golimumab	5-ASA compounds Antibiotics Oral steroids or budesonide EC Azathioprine, 6-MP Methotrexate Infliximab, adalimumab, certolizumab natalizumab
Severe	Intravenous steroids Cyclosporine Infliximab, adalimumab, golimumab Vedolizumab Surgery	Intravenous steroids Methotrexate Infliximab, adalimumab, certolizumab Natalizumab, vedolizumab Surgery

5-ASA, 5-Aminosalicylic acid; 6-MP, 6-mercaptopurine.

determine the extent and assess the severity of the disease. Patients with mild or moderate disease can be managed as outpatients. Patients with severe or fulminant disease—with abdominal pain, fever, tachycardia, anemia, and leukocytosis—require hospital admission and multidisciplinary team management. Because IBD is a chronic recurrent illness, treatment is centered on controlling the acute attack with induction of remission, followed by maintenance of remission. Treatment options for UC and Crohn's disease are summarized in [Table 37-3](#).

5-Aminosalicylic Acid

The aminosalicylates are given either orally or topically (suppository and enema). They are safe and effective for treatment (i.e., induction of remission) of mild to moderate UC and for maintenance of remission (Level of evidence III, A). The efficacy of the 5-aminosalicylic acid (5-ASA) agents in induction or maintenance of remission in Crohn's disease has not been clearly shown in studies, although they are commonly used off-label for this purpose (level of evidence III, A for induction and III, B for maintenance). This class of anti-inflammatory medications includes sulfasalazine (Azulfidine) at a dose of 4 to 6 g/day in divided doses. This drug consists of 5-ASA linked to a sulfapyridine moiety; the 5-ASA is released after bacterial lysis of an azo bond in the colon.

Side effects, including headache, nausea, and skin reactions, require discontinuation of sulfasalazine in about 30% of patients. Reversible oligospermia may occur, and rare serious side effects include pleuropericarditis, pancreatitis, agranulocytosis, interstitial nephritis, and hemolytic anemia. Patients who take sulfasalazine need folic acid supplementation. Derivatives of oral 5-ASA compounds include mesalamine (Pentasa, 4 g/day in divided doses; Delzicol, 2.4 g/day in divided doses; Asacol HD, 2.4 to 4.8 g/day in divided doses; Lialda, 2.4 to 4.8 g once daily; Apriso, 1.5 g once a day), olsalazine (Dipentum, 1 to 2 g/day in divided doses), and balsalazide (Colazal, 6.75 g/day in divided doses; Giazio 3.3 g/day in divided doses). Topical forms of mesalamine (Canasa suppositories, 1000 mg once daily; Rowasa enemas, 4 g once nightly) are commonly used because of a more favorable side-effect profile. In addition to their use in the primary treatment of IBD, several studies suggest that long-term use of 5-ASA medications may reduce the risk for colorectal cancer in patients with UC.

Corticosteroids

Corticosteroids may be used topically, orally, or intravenously. They are effective for controlling active disease but not for maintaining remission (level of evidence I,A for induction and III, A for maintenance). They are indicated for moderate or severe disease in UC patients for whom treatment with 5-ASA has failed. The most commonly used agent is oral prednisone, started in doses between 40 and 60 mg/day. Patients typically improve rapidly, and the medication is usually tapered down slowly (i.e., by 5 to 10 mg/week until discontinuation). Patients who do not improve after 1 week of oral treatment and those with more severe disease are best treated in the hospital with intravenous corticosteroids, such as intravenous hydrocortisone (300 mg/day), or methylprednisolone (which can be given either by continuous infusion or in three divided doses).

Corticosteroids have numerous side effects with long-term use. Controlled trials have shown that budesonide EC (Entocort EC) is more effective than placebo or oral 5-ASA and has similar efficacy to prednisolone for the induction of remission in Crohn's disease (level of evidence I, A). Entocort EC (9 mg given once daily) undergoes extensive first-pass hepatic metabolism, is available for inducing and maintaining remission of ileal and ileocolonic Crohn's disease (level of