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COMMENTARY

The second European evidence-based consensus on the diagnosis and management of Crohn's disease (part 4)

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''The second European evidence-based Consensus on the diagnosis and management of Crohn's disease'' was recently published in the *Journal of Crohn's and Colitis* by a working group of the European Crohn's and Colitis Organisation (ECCO) [1—3].

Three previous articles have discussed: the first and second part of the guidelines devoted to definitions and diagnosis of Crohn's disease (CD) [1], patient management [2], and certain special situations (post-operative recurrence, fistulating CD) [3]. This fourth article focuses on the other special situations described in the third part of the ECCO consensus on CD [3]: CD in children and adolescents, CD and pregnancy, CD and psychological factors, extra-intestinal manifestations of CD, alternative therapies.

Crohn's disease in children and adolescents

Growth failure can be the unique inaugural sign of CD. Surrogate markers of inflammation may be normal (although inflammation of the lower gastrointestinal tract is unlikely if the faecal levels of calprotectin and lactoferin are normal). The initial investigation should include a colonoscopy with ileal intubation and an upper gastrointestinal endoscopy, with systematic biopsies. For the small bowel investigation, entero-MRI imaging should be preferred to limit radiation exposure.

First-line treatment for ileal or ileocaecal involvement is exclusive enteral nutrition, rather than corticosteroids. There are fewer side effects and the impact on growth is favourable. If corticosteroids are given for ileocaecal involvement, budesonide is preferred. Corticosteroids, including budesonide, should not be used for maintenance therapy. Thiopurines can maintain remission effectively. They should be introduced early in patients with severe or extensive CD. In the event of resistance or intolerance to thiopurines, methotrexate is effective. Infliximab (IFX) is effective for CD refractory to first-line treatment. Regular perfusions can maintain remission. IFX can also be effective at closing fistulae. Biotherapies, especially when combined with immunosuppression, carry a risk of opportunistic infection and the development of hepatosplenic T-cell lymphoma, which is rare but potentially fatal. Therapeutic decisions should be discussed with the patient and family. If resistance to medical treatment occurs, surgery should be considered, especially in the event of growth failure in a patient with localised disease.

Crohn's disease and pregnancy

In male patients, rectal excision may lead to impotence or ejaculatory problems. Sulfasalizine is a reversible cause of infertility.

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In female patients, active CD decreases fertility. Surgery can have a deleterious effect on tubal function.

It is advisable to achieve remission before conception. CD is a risk factor for pre-term delivery and low birth weight. Excepting methotrexate (and thalidomide), medical treatment for CD should be continued during pregnancy (the expected benefits are superior to risks). Patients free of perianal disease or rectal involvement can deliver vaginally.

Crohn's disease and psychosocial factors

Psychological manifestations appear to be more a consequence of CD than its cause. Their impact on the disease course is controversial. It has nevertheless been noted that most patients consider that stress affects their illness. It is recommended to inform the patient about CD, its associations with other illnesses, and to evaluate quality of life and the psychological impact of the disease in order to refer the patient for specialised care if needed.

Extra-intestinal manifestations of Crohn's disease

Extra-intestinal manifestations are variable and common, affecting up to 35% of patients. The ECCO guidelines concerning arthropathy and cutaneous manifestations are summarised in Table 1.

Episcleritis is the most common ocular manifestation of CD. Local corticosteroids should be used if treatment is needed. Uveitis is rare, but potentially serious; in case of doubt, referral to an ophthalmologist for a slit-lamp examination is wise. Topical, or if needed systemic, corticosteroids should be used; thiopurines, methotrexate and IFX can be effective.

Diagnosis of hepatobiliary disorders in association with CD follows the standard investigatory pathways prompted by abnormal liver function tests. MRI is the first-line exploration for the diagnosis of primary sclerosing cholangitis (PSC). PSC increases the risk of cholangiocarcinoma and colonic cancer.

PSC appear to respond to ursodiol (20 mg/kg) with improved liver function, improved prognosis and reduced risk of colonic cancer. In the event of dominant biliary strictures, endoscopic retrograde cholangiography enables dilatation and/or stenting. Liver transplantation may be necessary for advanced disease.

Patients with inflammatory bowel disease are at increased risk of thromboembolism. The ECCO recommends prophylaxis for hospitalized patients.

Alternative therapies

None of the alternative therapies have proven efficacy for CD. Complementary investigations would be warranted for certain propositions.

Comments

The ECCO working methods and evidence levels as well as the recommendations according to the Oxford Centre for Evidence-Based Medicine have not been detailed here to avoid unnecessary lengthening of the text.

Special guidelines established at the world congress in London for paediatric, adolescent, and pregnant patients were also published later in 2010 [4]. That article focused on precautions concerning live vaccines (rotavirus) or BCG as a function of biotherapy (IFX) received during pregnancy and/or childhood [4]. It also indicated that IFX and adalimumab (ADA) are effective for inducing and maintaining remission in children and that ADA can be effective after IFX has lost efficacy. Guidelines concerning the use of biotherapies during pregnancy are given. Use of anti-TNF in male or female patients is compatible with conception and appears to carry little risk during pregnancy, at least during the first two trimesters. IFX and certolizumab pegol are compatible with breastfeeding [4].

Table 1 The ECCO guidelines concerning arthropathy and cutaneous manifestations.

Rheumatismal manifestations	
Peripheral arthropathies Type I[a] et II[b]	Non-steroid anti-inflammatory drugs (NSAID), short-term Local injections of corticosteroids Physiotherapy Sulfasalazine in the event of persistent arthritis Treatment of the underlying CD
Axial arthropathy[c]	Physiotherapy + NSAID (long-term treatment should be avoided) Anti-TNF if intolerance or inefficacy of NSAID
Metabolic bone disease	Supplementation with calcium and vitamin D in patients taking corticosteroids or with reduced bone density Exercise and cessation of smoking Biphosphonates in the event of fracture
Cutaneous manifestations	
Erythema nodosum	Systemic corticotherapy
Pyoderma gangrenosum	Systemic corticotherapy, anti-calcineurins or infliximab
Sweet's syndrome	Systemic corticotherapy

[a] Type I: pauci-articular (< 5), large joints, flare ups concomitantly with Crohn's disease.
[b] Type II: poly-articular, small joints (hand), flare ups independently of Crohn's disease.
[c] Includes sacro-ileitis and spondylodiscitis. MRI provides early diagnosis.

Furthermore, the Montreal classification concerning specific features of inflammatory bowel disease in children has recently been modified by an expert group which met in Paris [5].

Disclosure of interest

The author declare that he has no conflicts of interest concerning this article.

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