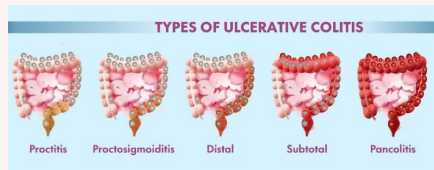


ULCERATIVE COLITIS



ULCERATIVE COLITIS

Ulcers in the colon & rectum. Starting in rectum & works up

Periods of inflammation & remission

S/S: cannot store contents, cannot distinguish between gas & solids, fatigue, low energy, small stools

Montreal classification

E1: Ulcerative proctitis (distal to the rectosigmoid junction)

E2: left sided UC (distal to the splenic flexure)

E3: Extensive UC (proximal to the splenic flexure)

Causes (both)

not known exactly - genetics, smoking, abnormal immune system, bacteria, environmental triggers, low fibre

Risk factors (both)

genetics	smoking
infections	antibiotics
dysregulated immune response	

Diagnosis (both)

Exclude infections and gastroenteritis

Stool test – faecal calprotectin (measures inflammation)

Endoscopy, colonoscopy, sigmoidoscopy, CT/MRI

Biopsies UC vs DC

Biochem

↓ RBC

↑ WBC

↑ CRP

UC – ↑ pANCA

CD – ↑ ASCA

Medications

Aminosalicylates (Sulfa-salazine, Mesalazine) (UC ONLY) Long-term to maintain remission in mild-to-moderate UC. Nausea, ↓ appetite, diarrhoea, folate deficiency

Corticosteroids (Prednisolone, Prednisone, budesonide) Reduce inflammation quickly; short term. ↑ d appetite, weight gain, fluid retention, bone loss → Ca & Vit D supp

Antibiotics (Metronidazole, ciprofloxacin) Nausea, ↓ appetite, diarrhoea, ↓ Vit K

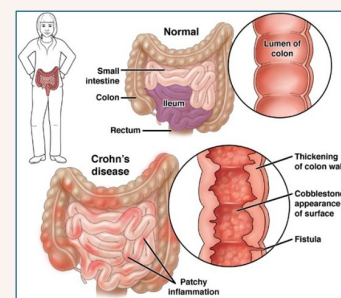
Immunomodulators (azathioprine (Imuran), mercaptopurine (Purine-thol), thioguanine (Lanvis)) suppress the immune system. Up to 3 months to work

Biologics (infliximab (Remicade), adalimumab (Humira), vedolizumab (Entyvio)) Target specific inflammation pathways for moderate-severe-IBD. Fatigue, weight changes, ↑ d infection risk, altered gut absorption

Methotrexate ↓ growth of cells and suppress the immune system. Causes low folate levels. Nausea, ↓ appetite, liver toxicity

Steroids Reduce inflammation. Stimulates appetite. Swelling, weight gain, hair growth and acne. Often need Ca & Vit D supp.

CROHN'S DISEASE



By Michellephillips02

Not published yet.
Last updated 11th July, 2025.
Page 1 of 2.

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CROHN'S DISEASE

Chronic inflammation - affect Entire GIT – commonly end of S.I (ilium) & start of L.I

immune system upregulated – not able to turn itself off again

Characteristics: Fat wrapping around bowel. Muscle hypertrophy. Fissures (small tears). Strictures (narrowing of part of the intestine because of scar tissue). Fistulas (opening, connection forms between two organs/skin)

S/S: Abdominal pain, diarrhoea, weight loss, loss of appetite, anal skin tags, stunted growth (children), mouth ulcers, blood in stools

CROHN'S DISEASE

Montreal classification

Age of diagnosis A1 <16 yr

A2 17-40 yr

A3 >40 years

Location L1 ileal

L2 colonic

L3 ileocolonic

L4 isolated upper disease

Behaviour B1 non-stricturing, non-penetrating

B2 stricturing

B3 penetrating

P perianal disease

Nut Reqs

E: 125-145kj/kg (active), 100-125 kj/kg (remission)

P: 1.2-1.5kj/kg (active), 0.8-1g/kg (remission)

Intervention

Remission = varied healthy diet

No evidence to restrict fibre unless strictures or an obstruction

ONS/EN if indicated

Screen for malnutrition

CROHNS ONLY DURING FLARE - Exclusive Enteral Nutrition

(EEN): nutritionally complete formula as sole source of nutrition – no food, but water allowed (6-8 weeks)

PAEDS CHRON'S ONLY - Crohn's Disease Exclusion Diet (CDED) +

partial enteral nutrition (PEN). Reduces dairy, wheat, animal fat, emulsifiers, pre-packaged foods, alcohol, coffee, artificial sweeteners

Consider

Strictures, avoid "stringy" = avoid – celery, pineapple, organs, mangoes, gristly meats

Dairy products – transient lactose intolerance during flares

Patients mental health – draining, painful condition

PN – if ileus, ischemia, high output fistula

Example PESS

Chronic disease or condition related malnutrition (NC-4.1.2)

Guidelines & References

Bishoff et al. ESPEN practical guideline: Clinical nutrition in inflammatory bowel disease

Forbes et al. ESPEN guideline: Clinical nutrition in inflammatory bowel disease



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Page 2 of 2.

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