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What every GP needs to know about IBD

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Making the diagnosis

- FCP is your and our best friend

Symptoms vs Inflammation

- These are not the same thing! They don't even go hand-in-hand.
- Objective monitoring of inflammation i.e. fecal calprotectin, endoscopy, or imaging is required, no matter what the clinical picture is

Goals of treatment in IBD

- Mucosal healing
- Treating symptoms

Prednisone is a major red flag

- We don't use Prednisone for maintenance therapy. We don't use Prednisone for 5 days. Why? Prednisone does not cause mucosal healing.
- If used, it is to buy time i.e. control symptoms until a new therapy kicks in.
- But we almost never use it. Why? Because we have targeted-release budesonide (Entocort = TI and right colon; Cortiment = colon). And other effective therapies.

Flare management

- UC: Concurrently assess for C difficile (and other infectious triggers), CRP, optimize PO/PR 5ASA therapy, consider Cortiment or Prednisone, and let GI know urgently
- CD: Concurrently assess for C difficile (and other infectious triggers), CRP, consider Entocort or Prednisone, and let GI know urgently
- If known to us, our offices have flare protocols and we can do this. If not known to us, we will see urgently.

Preventative health is key

- Vitamin D and bone health
- Cancer screening (Pap yearly, colon cancer q3-5 years, skin check yearly)
- Vaccinations (Shingrix, Prevnar, Pneumovax, Twinrix, TdP, Gardasil, Flu vaccine)