

Crohn's disease: management

Clinical guideline

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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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This guideline is the basis of QS81.

Overview

This guideline covers the management of Crohn's disease in children, young people and adults. It aims to reduce people's symptoms and maintain or improve their quality of life.

In May 2016, a new recommendation on [inducing remission](#) was added.

Who is it for?

- Healthcare professionals who care for people with Crohn's disease
- Providers of services for people with Crohn's disease
- People with Crohn's disease, their families and carers

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in [your care](#).

[Making decisions using NICE guidelines](#) explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

All recommendations relate to adults, children and young people unless otherwise specified. In this guideline, the term 'adults' is used to describe people who are aged 18 years or older, and 'children' those who are aged 11 years or younger. 'Young people' describes those who are aged 12 to 17 years.

1.1 *Patient information and support*

1.1.1 Ensure that information and advice about Crohn's disease:

- is age appropriate
- is of the appropriate cognitive and literacy level, and
- meets the cultural and linguistic needs of the local community. [2012]

1.1.2 Discuss treatment options and monitoring with the person with Crohn's disease, and/or their parent or carer if appropriate, and within the multidisciplinary team. Apply the principles outlined in [patient experience in adult NHS services](#) (NICE guideline CG138). [2012]

1.1.3 Discuss the possible nature, frequency and severity of side effects of drug treatment^[1] with people with Crohn's disease, and/or their parents or carers if appropriate. [2012]

1.1.4 Give all people with Crohn's disease, and/or their parents or carers if appropriate, information, advice and support in line with published NICE guidance on:

- smoking cessation
- patient experience

- medicines adherence

- fertility. [2012]

1.1.5 Give people with Crohn's disease, and/or their parents or carers if appropriate, additional information on the following when appropriate:

- possible delay of growth and puberty in children and young people
- diet and nutrition
- fertility and sexual relationships
- prognosis
- side effects of their treatment
- cancer risk
- surgery
- care of young people in transition between paediatric and adult services
- contact details for support groups. [2012]

1.1.6 Offer adults, children and young people, and/or their parents or carers, age-appropriate multidisciplinary support to deal with any concerns about the disease and its treatment, including concerns about body image, living with a chronic illness, and attending school and higher education. [2012]

1.2 *Inducing remission in Crohn's disease*

Monotherapy

1.2.1 Offer monotherapy with a conventional glucocorticosteroid (prednisolone, methylprednisolone or intravenous hydrocortisone) to induce remission in people with a first presentation or a single inflammatory exacerbation of Crohn's disease in a 12-month period. [2012]

1.2.2 Consider enteral nutrition as an alternative to a conventional glucocorticosteroid to induce remission for:

- children in whom there is concern about growth or side effects, and
- young people in whom there is concern about growth. [2012]

1.2.3 In people with one or more of distal ileal, ileocaecal or right-sided colonic disease^[2] who decline, cannot tolerate or in whom a conventional glucocorticosteroid is contraindicated, consider budesonide^[3] for a first presentation or a single inflammatory exacerbation in a 12-month period. Explain that budesonide is less effective than a conventional glucocorticosteroid but may have fewer side effects. [2012]

1.2.4 In people who decline, cannot tolerate or in whom glucocorticosteroid treatment is contraindicated, consider 5-aminosalicylate (5-ASA) treatment^[4] for a first presentation or a single inflammatory exacerbation in a 12-month period. Explain that 5-ASA is less effective than a conventional glucocorticosteroid or budesonide but may have fewer side effects than a conventional glucocorticosteroid. [2012]

1.2.5 Do not offer budesonide or 5-ASA treatment for severe presentations or exacerbations. [2012]

1.2.6 Do not offer azathioprine, mercaptopurine or methotrexate as monotherapy to induce remission. [2012]

Add-on treatment

1.2.7 Consider adding azathioprine or mercaptopurine^[5] to a conventional glucocorticosteroid or budesonide^[3] to induce remission of Crohn's disease if:

- there are two or more inflammatory exacerbations in a 12-month period, or
- the glucocorticosteroid dose cannot be tapered. [2012]

1.2.8 Assess thiopurine methyltransferase (TPMT) activity before offering azathioprine or mercaptopurine^[5]. Do not offer azathioprine or mercaptopurine if TPMT activity is deficient (very low or absent). Consider azathioprine or mercaptopurine at a lower dose if TPMT activity is below normal but not deficient (according to local laboratory reference values). [2012]

- 1.2.9 Consider adding methotrexate^{[6],[7]} to a conventional glucocorticosteroid or budesonide^[3] to induce remission in people who cannot tolerate azathioprine or mercaptopurine, or in whom TPMT activity is deficient, if:
- there are two or more inflammatory exacerbations in a 12-month period, or
 - the glucocorticosteroid dose cannot be tapered. [2012]
- 1.2.10 Monitor the effects of azathioprine, mercaptopurine^[5] and methotrexate^{[6],[7]} as advised in the current online version of the [British national formulary \(BNF\)](#)^[6] or [British national formulary for children \(BNFC\)](#). Monitor for neutropenia in those taking azathioprine or mercaptopurine even if they have normal TPMT activity. [2012]
- 1.2.11 Ensure that there are documented local safety monitoring policies and procedures (including audit) for adults, children and young people receiving treatment that needs monitoring. Nominate a member of staff to act on abnormal results and communicate with GPs and people with Crohn's disease and/or their parents or carers, if appropriate. [2012]

Infliximab and adalimumab

The recommendations in the following section (1.2.12 to 1.2.13 and 1.2.15 to 1.2.20) are from [infliximab and adalimumab for the treatment of Crohn's disease](#) (NICE technology appraisal guidance 187).

- 1.2.12 Infliximab and adalimumab, within their licensed indications, are recommended as treatment options for adults with severe active Crohn's disease (see 1.2.18) whose disease has not responded to conventional therapy (including immunosuppressive and/or corticosteroid treatments), or who are intolerant of or have contraindications to conventional therapy. Infliximab or adalimumab should be given as a planned course of treatment until treatment failure (including the need for surgery), or until 12 months after the start of treatment, whichever is shorter. People should then have their disease reassessed (see 1.2.16) to determine whether ongoing treatment is still clinically appropriate. [2012]
- 1.2.13 Treatment as described in 1.2.12 should normally be started with the less expensive drug (taking into account drug administration costs, required dose

and product price per dose). This may need to be varied for individual patients because of differences in the method of administration and treatment schedules. [2012]

1.2.14 When a person with Crohn's disease is starting infliximab or adalimumab (in line with recommendations 1.2.12, 1.2.15, 1.2.17 and 1.2.20), discuss options of:

- monotherapy with one of these drugs or
- combined therapy (either infliximab or adalimumab, combined with an immunosuppressant)

and tell the person there is uncertainty about the comparative effectiveness and long-term adverse effects of monotherapy and combined therapy. [new 2016]

1.2.15 Infliximab, within its licensed indication, is recommended as a treatment option for people with active fistulising Crohn's disease whose disease has not responded to conventional therapy (including antibiotics, drainage and immunosuppressive treatments), or who are intolerant of or have contraindications to conventional therapy. Infliximab should be given as a planned course of treatment until treatment failure (including the need for surgery) or until 12 months after the start of treatment, whichever is shorter. People should then have their disease reassessed (see 1.2.16) to determine whether ongoing treatment is still clinically appropriate. [2012]

1.2.16 Treatment with infliximab or adalimumab (see 1.2.12 and 1.2.15) should only be continued if there is clear evidence of ongoing active disease as determined by clinical symptoms, biological markers and investigation, including endoscopy if necessary. Specialists should discuss the risks and benefits of continued treatment with patients and consider a trial withdrawal from treatment for all patients who are in stable clinical remission. People who continue treatment with infliximab or adalimumab should have their disease reassessed at least every 12 months to determine whether ongoing treatment is still clinically appropriate. People whose disease relapses after treatment is stopped should have the option to start treatment again. [2012]

1.2.17 Infliximab, within its licensed indication, is recommended for the treatment of people aged 6–17 years with severe active Crohn's disease whose disease has not responded to conventional therapy (including corticosteroids,

immunomodulators and primary nutrition therapy), or who are intolerant of or have contraindications to conventional therapy. The need to continue treatment should be reviewed at least every 12 months. [2012]

- 1.2.18 For the purposes of this guidance, severe active Crohn's disease is defined as very poor general health and one or more symptoms such as weight loss, fever, severe abdominal pain and usually frequent (3–4 or more) diarrhoeal stools daily. People with severe active Crohn's disease may or may not develop new fistulae or have extra-intestinal manifestations of the disease. This clinical definition normally, but not exclusively, corresponds to a Crohn's Disease Activity Index (CDAI) score of 300 or more, or a Harvey-Bradshaw score of 8 to 9 or above. [2012]
- 1.2.19 When using the CDAI and Harvey-Bradshaw Index, healthcare professionals should take into account any physical, sensory or learning disabilities, or communication difficulties that could affect the scores and make any adjustments they consider appropriate. [2012]
- 1.2.20 Treatment with infliximab or adalimumab should only be started and reviewed by clinicians with experience of TNF inhibitors and of managing Crohn's disease. [2012]

1.3 *Maintaining remission in Crohn's disease*

- 1.3.1 Discuss with people with Crohn's disease, and/or their parents or carers if appropriate, options for managing their disease when they are in remission, including both no treatment and treatment. The discussion should include the risk of inflammatory exacerbations (with and without drug treatment) and the potential side effects of drug treatment. Record the person's views in their notes. [2012]
- 1.3.2 Offer colonoscopic surveillance in line with [colonoscopic surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas](#) (NICE guideline CG118). [2012]

Follow-up during remission for those who choose not to receive maintenance treatment

1.3.3 When people choose not to receive maintenance treatment:

- discuss and agree with them, and/or their parents or carers if appropriate, plans for follow-up, including the frequency of follow-up and who they should see
- ensure they know which symptoms may suggest a relapse and should prompt a consultation with their healthcare professional (most frequently, unintended weight loss, abdominal pain, diarrhoea, general ill-health)
- ensure they know how to access the healthcare system if they experience a relapse
- discuss the importance of not smoking. [2012]

Maintenance treatment for those who choose this option

1.3.4 Offer azathioprine or mercaptopurine^[5] as monotherapy to maintain remission when previously used with a conventional glucocorticosteroid or budesonide to induce remission. [2012]

1.3.5 Consider azathioprine or mercaptopurine^[5] to maintain remission in people who have not previously received these drugs (particularly those with adverse prognostic factors such as early age of onset, perianal disease, glucocorticosteroid use at presentation and severe presentations). [2012]

1.3.6 Consider methotrexate^{[6],[7]} to maintain remission only in people who:

- needed methotrexate to induce remission, or
- have tried but did not tolerate azathioprine or mercaptopurine for maintenance or
- have contraindications to azathioprine or mercaptopurine (for example, deficient TPMT activity or previous episodes of pancreatitis). [2012]

1.3.7 Do not offer a conventional glucocorticosteroid or budesonide to maintain remission. [2012]

See recommendations 1.2.10 and 1.2.11 for guidance on monitoring the effects of azathioprine, mercaptopurine and methotrexate.

See recommendation 1.2.16 for when to continue infliximab or adalimumab during remission.

1.4 *Maintaining remission in Crohn's disease after surgery*

1.4.1 Consider azathioprine or mercaptopurine^[5] to maintain remission after surgery in people with adverse prognostic factors such as:

- more than one resection, or
- previously complicated or debilitating disease (for example, abscess, involvement of adjacent structures, fistulising or penetrating disease). [2012]

1.4.2 Consider 5-ASA treatment^[4] to maintain remission after surgery. [2012]

1.4.3 Do not offer budesonide or enteral nutrition to maintain remission after surgery. [2012]

1.5 *Surgery*

Crohn's disease limited to the distal ileum

1.5.1 Consider surgery as an alternative to medical treatment early in the course of the disease for people whose disease is limited to the distal ileum, taking into account the following:

- benefits and risks of medical treatment and surgery
- risk of recurrence after surgery^[9]
- individual preferences and any personal or cultural considerations.

Record the person's views in their notes. [2012]

1.5.2 Consider surgery early in the course of the disease or before or early in puberty for children and young people whose disease is limited to the distal ileum and who have:

- growth impairment despite optimal medical treatment and/or

- refractory disease.

Discuss treatment options within the multidisciplinary team and with the person's parent or carer and, if appropriate, the child or young person. [2012]

Managing strictures

- 1.5.3 Consider balloon dilation particularly in people with a single stricture that is short, straight and accessible by colonoscopy. [2012]
- 1.5.4 Discuss the benefits and risks of balloon dilation and surgical interventions for managing strictures^[10] with:
- the person with Crohn's disease and/or their parent or carer if appropriate and
 - a surgeon and
 - a gastroenterologist. [2012]
- 1.5.5 Take into account the following factors when assessing options for managing a stricture:
- whether medical treatment has been optimised
 - the number and extent of previous resections
 - the rapidity of past recurrence (if appropriate)
 - the potential for further resections
 - the consequence of short bowel syndrome
 - the person's preference, and how their lifestyle and cultural background might affect management. [2012]
- 1.5.6 Ensure that abdominal surgery is available for managing complications or failure of balloon dilation. [2012]

1.6 *Monitoring for osteopenia and assessing fracture risk*

Refer to the NICE guideline on [osteoporosis: assessing the risk of fragility fracture](#) (NICE guideline CG146) for recommendations on assessing the risk of fragility fracture in adults. Crohn's disease is a cause of secondary osteoporosis.

- 1.6.1 Do not routinely monitor for changes in bone mineral density in children and young people. [2012]
- 1.6.2 Consider monitoring for changes in bone mineral density in children and young people with risk factors, such as low body mass index (BMI), low trauma fracture or continued or repeated glucocorticosteroid use. [2012]

1.7 *Conception and pregnancy*

- 1.7.1 Give information about the possible effects of Crohn's disease on pregnancy, including the potential risks and benefits of medical treatment and the possible effects of Crohn's disease on fertility. [2012]
- 1.7.2 Ensure effective communication and information-sharing across specialties (for example, primary care, obstetrics and gastroenterology) in the care of pregnant women with Crohn's disease. [2012]

^[1] Appendices L and M of the [full guideline](#) contain observational data on adverse events associated with 5-ASA treatment and immunosuppressives.

^[2] See recommendations 1.5.1 and 1.5.2 for when to consider surgery early in the course of the disease for people whose disease is limited to the distal ileum.

^[3] Although use is common in UK clinical practice, at the time of publication (October 2012), budesonide did not have a UK marketing authorisation specifically for children and young people. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Prescribing guidance: prescribing unlicensed medicines](#) for further information. Licensing arrangements remained unchanged when the guideline was updated (May 2016).

^[4] Although use is common in UK clinical practice, at the time of publication (October 2012) mesalazine, olsalazine and balsalazide did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Prescribing guidance: prescribing unlicensed medicines](#) for further information. Licensing arrangements remained unchanged when the guideline was updated (May 2016).

^[5] Although use is common in UK clinical practice, at the time of publication (October 2012) azathioprine and mercaptopurine did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Prescribing guidance: prescribing unlicensed medicines](#) for further information. Licensing arrangements remained unchanged when the guideline was updated (May 2016).

^[6] Although use is common in UK clinical practice, at the time of publication (October 2012) methotrexate did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Prescribing guidance: prescribing unlicensed medicines](#) for further information. Licensing arrangements remained unchanged when the guideline was updated (May 2016).

^[7] Follow BNF/BNFC cautions on prescribing methotrexate.

^[8] Advice on monitoring of immunosuppressives can be found in the BNF/BNFC. The gastroenterology chapter and other relevant sections should be consulted.

^[9] Appendix N of the [full guideline](#) contains observational data on recurrence rates after surgery.

^[10] Appendix O of the [full guideline](#) contains observational data on efficacy, safety, quality of life and time to recurrence for balloon dilation and surgery for stricture.

Context

Crohn's disease is a chronic inflammatory disease that mainly affects the gastrointestinal tract. The disease may be progressive in some people, and a proportion may develop extra-intestinal manifestations. There are currently at least 115,000 people in the UK with Crohn's disease. The causes of Crohn's disease are widely debated. Smoking and genetic predisposition are two important factors that are likely to play a role.

Typically people with Crohn's disease have recurrent attacks, with acute exacerbations interspersed with periods of remission or less active disease. Whether a relapse refers to a recurrence of symptoms or the appearance of mucosal abnormalities before the development of symptoms remains the subject of dispute. Treatment is largely directed at symptom relief rather than cure, and active treatment of acute disease (inducing remission) should be distinguished from preventing relapse (maintaining remission).

Management options for Crohn's disease include drug therapy, attention to nutrition, smoking cessation and, in severe or chronic active disease, surgery.

The aims of drug treatment are to reduce symptoms, promote mucosal healing, and maintain or improve quality of life, while minimising toxicity related to drugs over both the short- and long-term. Glucocorticosteroid treatment, 5-aminosalicylate (5-ASA) treatment, antibiotics, immunosuppressants and tumour necrosis factor (TNF)-alpha inhibitors are currently considered to be options for treating Crohn's disease. Enteral nutrition has also been used widely as first-line therapy in children and young people to facilitate growth and development, but its use in adults is less common. Between 50 and 80% of people with Crohn's disease will eventually need surgery for strictures causing symptoms of obstruction, other complications such as fistula formation, perforation or failure of medical therapy.

The routine surveillance review of CG152 highlighted evidence on the combined use of TNF-alpha inhibitor and immunosuppressant medications for inducing remission in people with severe active Crohn's disease. This update provides guidance on the combined use of TNF-alpha inhibitor biologics (infliximab or adalimumab) together with an immunosuppressant medication, compared with biologic medication given alone.

Considerations specific to children and young people

Up to a third of patients with Crohn's disease are diagnosed before the age of 21 but there is a lack of studies on treatment for children and young people. Paediatric practice is often based on

extrapolation from adult studies and in this guideline all recommendations relate to adults, children and young people unless otherwise specified. Inducing and maintaining remission as well as optimising nutritional status and growth, and minimising psychological concerns and possible side effects of treatment are fundamental to best practice for all people with Crohn's disease, whatever their age.

More information

You can also see this guideline in the NICE pathway on [Crohn's disease](#).

To find out what NICE has said on topics related to this guideline, see our web page on [inflammatory bowel disease](#).

See also the guideline committees' discussions and the evidence reviews (in the [addendum and full guideline](#)), and information about [how the guideline was developed](#), including details of the committees.

Recommendations for research

In 2012, the guideline committee made 5 recommendations for research.

As part of the 2016 update, the standing committee made an additional research recommendation on combined therapy (infliximab or adalimumab with an additional immunosuppressant). Details can be found in the [addendum](#).

1 *Azathioprine*

For patients with intestinal Crohn's disease, does the addition of azathioprine to glucocorticosteroid treatment at diagnosis improve the long-term outcome compared with glucocorticosteroid treatment alone?

Why this is important

Crohn's disease runs a relapsing and remitting course, with a significant inflammatory component during its early stages, and increasing degrees of fibrotic, stenosing or perforating disease later. Intervention during the inflammatory stage may affect disease progression while avoiding the side effects of glucocorticosteroid treatment – the current mainstay of treatment for exacerbations. Adults and children with a first presentation of intestinal Crohn's disease would be recruited once in remission and randomised to receive azathioprine or placebo for preventing relapse after an initial treatment with a glucocorticosteroid. Co-primary end points would be quality of life measures and maintaining glucocorticosteroid-free remission measured by the Crohn's Disease Activity Index (CDAI). Secondary end points would be mucosal healing at endoscopy, hospitalisation, side effects and surgery. Appropriate healthcare costs would also need to be assessed to inform a cost-effectiveness model. Follow-up should be at least 2 years, and ideally 5 years.

2 *Enteral nutrition*

What are the benefits, risks and cost effectiveness of enteral nutrition compared with glucocorticosteroid treatment in adults and children?

Why this is important

Previous studies in adults suggest that glucocorticosteroid treatment is more effective at inducing remission than enteral nutrition in adults with Crohn's disease, but some small paediatric studies suggest that growth and mucosal healing may be better following treatment with enteral nutrition.

In clinical practice enteral nutrition is often used to avoid the side effects of glucocorticosteroid treatment in children. There is little information about the relative effects on quality of life, bone density or cost effectiveness. Randomised controlled trials should be conducted in children and adults with an inflammatory exacerbation of Crohn's disease to compare the effects of enteral nutrition and glucocorticosteroid treatment on these parameters and also the effect on growth in children. Mucosal healing could also be assessed in a subgroup of participants. It is not ethical or practical to conduct a randomised controlled trial of enteral nutrition versus placebo.

3 5-ASA treatment

Following successful medical induction of remission of Crohn's disease of the colon, is mesalazine more clinically and cost effective than no treatment?

Why this is important

The evidence for use of this group of drugs for maintenance of remission in Crohn's disease is not clear, and in particular, there is very limited reporting of disease site. It is therefore possible that this might be a cost-effective treatment for maintenance of remission, with limited toxicity. Its use in this setting may therefore be associated with higher rates of successful maintenance of disease remission, reduced need for escalation of therapy, higher quality of life, and lower rates of hospital admissions and surgeries. The question is applicable to adults, young people and children, and trials in all are therefore required. A conventional glucocorticosteroid would be offered to induce remission in a first presentation of colonic Crohn's disease. Patients would be recruited once in remission and glucocorticosteroid-free and randomised to receive mesalazine or placebo, for maintenance of remission. Co-primary end points would be quality of life measures and maintenance of glucocorticosteroid-free remission measured by the Crohn's Disease Activity Index (CDAI). Secondary end points would be mucosal healing at endoscopy, need for escalation of therapy to azathioprine or biological therapy, adverse events, hospitalisation and surgery. The time frame for follow-up should be at least 12 months, but ideally 24–36 months.

4 Surgery versus medical treatment for the distal ileum

What is the effect on quality of life of medical treatment (immunosuppressive or biological therapy) compared with early surgery for Crohn's disease limited to the distal ileum?

Why this is important

Patients first presenting with Crohn's disease limited to the distal ileum are usually treated medically. When relapse occurs there is the option of further medical treatment or surgery.

Recurrence and reoperation rates are high after surgery, but most people with medically treated Crohn's disease require surgery at some time. There are no comparative studies reporting the quality of life associated with and long-term outcome of these management strategies. A multicentre trial is currently in progress in Holland in which patients with Crohn's disease limited to the distal ileum are randomised to treatment with a biological agent or laparoscopic surgical resection at the point at which initial medical treatment fails. A similar trial should be carried out in the UK, also considering the effectiveness of azathioprine as a medical treatment option.

5 Patient information and support

What are the information needs of people with Crohn's disease, as defined by people with the condition, and can education and support based on these needs lead to better clinical and quality of life outcomes?

Why this is important

Crohn's disease is a life-long condition that continues to have a significant impact on all aspects of life. The development of an educational and support programme could substantially reduce the cost of treatment and the social impact of the disease. Further research should be undertaken to determine the information and support needs of people with Crohn's disease. It should use qualitative techniques to identify the concerns of people with the condition and how they should be best addressed. Delphi techniques would ensure that the professional understanding of these needs was appropriate. From this work a randomised controlled trial would be designed to investigate the impact of a patient-originated programme on health outcomes, including frequency of relapse and need for surgery as well as quality of life issues.

6 Combined therapy with a tumour necrosis factor-alpha inhibitor and an immunosuppressant

Does combined therapy of a tumour necrosis factor (TNF)-alpha inhibitor with an immunosuppressant improve clinical outcomes and reduce the risk of serious adverse events in adults and children (6–17 years) with severe, active Crohn's disease who are starting a TNF-alpha inhibitor (infliximab or adalimumab) for the induction of remission, where previous conventional therapy has failed?

Why this is important

There is a current lack of directly applicable evidence of the comparative benefits and harms of the two treatment options in the populations specified to enable recommendations to be made.

Update information

May 2016

A new recommendation has been added on inducing remission in people with Crohn's disease. This is marked as [new 2016].

Where recommendations end [2012], the evidence has not been reviewed since the original guideline.

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Accreditation

