Crohn’s disease: management in adults and children

NICE guideline
Draft for consultation, May 2012

If you wish to comment on this version of the guideline, please be aware that all the supporting information and evidence is contained in the full version.
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Introduction

Crohn's disease is a chronic inflammatory disease that mainly affects the gastrointestinal tract. 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 factors that are likely to play a role. 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).

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.

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 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 and immunosuppressives form the basis of drug treatment. Studies suggest that tumour necrosis factor (TNF) alfa inhibitors are effective in inducing and maintaining remission. 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 limited. 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.

Considerations specific to children

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 and children 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.

**Use of drugs**

The guideline will assume that prescribers will use a drug’s summary of product characteristics to inform decisions made with individual patients.

This guideline recommends some drugs for indications for which they do not have a UK marketing authorisation at the date of publication, if there is good evidence to support that use. Informed consent should be obtained and documented. Where recommendations have been made for the use of drugs outside their licensed indications ('off-label use'), these drugs are marked with a footnote in the recommendations.
Patient-centred care

This guideline offers best practice advice on the care of adults and children with Crohn’s disease.

Treatment and care should take into account patients’ needs and preferences. People with Crohn’s disease should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If patients do not have the capacity to make decisions, healthcare professionals should follow the Department of Health’s advice on consent and the code of practice that accompanies the Mental Capacity Act. In Wales, healthcare professionals should follow advice on consent from the Welsh Government.

If the patient is under 16, healthcare professionals should follow the guidelines in the Department of Health’s ‘Seeking consent: working with children’. Good communication between healthcare professionals and patients is essential. It should be supported by evidence-based written information tailored to the patient’s needs. Treatment and care, and the information patients are given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.

Families and carers should also be given the information and support they need.

Care of young people in transition between paediatric and adult services should be planned and managed according to the best practice guidance described in the Department of Health’s ‘Transition: getting it right for young people’.

Adult and paediatric healthcare teams should work jointly to provide assessment and services to young people with Crohn’s disease. Diagnosis and management should be reviewed throughout the transition process, and
there should be clarity about who is the lead clinician to ensure continuity of care.
Key priorities for implementation

The following recommendations have been identified as priorities for implementation.

Patient information and support

• 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. [1.1.1]

• Discuss treatment options and monitoring with the person with Crohn’s disease, and/or their carer if appropriate, and within the multidisciplinary team. Apply the principles outlined in ‘Patient experience in adult NHS services’ (NICE clinical guideline 138). [1.1.2]

• Give people with Crohn’s disease, and/or their carer if appropriate, additional information on the following when appropriate:
  – possible delay of growth and puberty in children
  – diet and nutrition
  – fertility and sexual relationships
  – prognosis
  – side effects of their treatment
  – cancer risk
  – surgery
  – contact details for support groups. [1.1.5]

• Offer children and young people, and their carers, professional support from a multidisciplinary team to deal with concerns about the disease and its treatment, including concerns about body image, living with a chronic illness, and attending school and higher education. [1.1.6]
Inducing remission in Crohn's disease

- Assess thiopurine methyltransferase (TPMT) activity before offering azathioprine or mercaptopurine\(^1\). 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).

\[1.2.6\]

- Monitor the effects of azathioprine, mercaptopurine and methotrexate as advised in the most recent version of the 'British national formulary' (BNF)\(^3\) or 'British national formulary for children' (BNFC). Monitor for neutropenia in those taking azathioprine or mercaptopurine even if they have normal TPMT activity. \[1.2.8\]

- Ensure that local safety monitoring policies and procedures (including audit) are in place and documented for adults and children receiving treatment that needs monitoring. Nominate a person/s to take responsibility for acting on results. \[1.2.9\]

Maintaining remission in Crohn's disease

- Discuss with people with Crohn's disease, and/or their carer 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. \[1.3.1.\]

- Do not offer a conventional glucocorticosteroid or budesonide to maintain remission. \[1.3.8\]

\(^1\) Although use is common in UK clinical practice, at the time of consultation (May 2012) azathioprine, mercaptopurine, methotrexate, mesalazine, olsalazine and balsalazide did not have UK marketing authorisation for inducing remission in Crohn's disease. Informed consent should be obtained and documented.

\(^2\) Follow BNF/BNFC cautions on prescribing methotrexate.

\(^3\) Advice on monitoring of immunosuppressives can be found in the BNF/BNFC. The gastroenterology chapter and other relevant sections should be consulted.
1 Guidance

The following guidance is based on the best available evidence. The full guideline gives details of the methods and the evidence used to develop the guidance.

All recommendations relate to adults and children unless otherwise specified.

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.

1.1.2 Discuss treatment options and monitoring with the person with Crohn's disease, and/or their carer if appropriate, and within the multidisciplinary team. Apply the principles outlined in 'Patient experience in adult NHS services' (NICE clinical guideline 138).

1.1.3 Discuss the possible nature, frequency and severity of side effects of drug treatment (see appendices M and N of the full guideline) with people with Crohn's disease, and/or their carer if appropriate.

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

- smoking cessation
- patient experience
- medicines adherence
- fertility.

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

- possible delay of growth and puberty in children
- diet and nutrition
- fertility and sexual relationships
- prognosis
- side effects of their treatment
- cancer risk
- surgery
- contact details for support groups.

1.1.6 Offer children and young people, and their carers, professional support from a multidisciplinary team to deal with concerns about the disease and its treatment, including concerns about body image, living with a chronic illness, and attending school and higher education.

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 an inflammatory exacerbation of Crohn’s disease.

1.2.2 Consider the following in a first presentation or an inflammatory exacerbation and in people who decline, cannot tolerate or in whom a conventional glucocorticosteroid is contraindicated:

- budesonide for one or more of isolated distal ileal\(^4\), ileocaecal or right-sided colonic disease, or
- 5-aminosalicylate\(^5\) (5-ASA) treatment.

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\(^4\) See recommendation 1.6.1 for when to consider surgery early in the course of the disease for people whose disease is limited to the distal ileum.
Explain that both budesonide and 5-ASA treatment are less effective than a conventional glucocorticosteroid but have fewer side effects.

1.2.3 Do not offer budesonide or 5-ASA treatment for severe presentations or exacerbations.

1.2.4 Do not offer azathioprine, mercaptopurine or methotrexate as monotherapy to induce remission.

**Add-on treatment**

1.2.5 Consider adding azathioprine or mercaptopurine to a conventional glucocorticosteroid to induce remission of Crohn’s disease if there are two or more inflammatory exacerbations within a 12-month period, or the glucocorticosteroid dose cannot be tapered.

1.2.6 Assess thiopurine methyltransferase (TPMT) activity before offering azathioprine or mercaptopurine. 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).

1.2.7 Consider adding methotrexate to a conventional glucocorticosteroid to induce remission in people who cannot tolerate azathioprine or mercaptopurine, or in whom TPMT activity is deficient.

1.2.8 Monitor the effects of azathioprine, mercaptopurine and methotrexate as advised in the most recent version of the ‘British

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5 Although use is common in UK clinical practice, at the time of consultation (May 2012) azathioprine, mercaptopurine, methotrexate, mesalazine, olsalazine and balsalazide did not have UK marketing authorisation for inducing remission in Crohn's disease. Informed consent should be obtained and documented.

6 Follow BNF/BNFC cautions on prescribing methotrexate.
Ensure that local safety monitoring policies and procedures (including audit) are in place and documented for adults and children receiving treatment that needs monitoring. Nominate a person/s to take responsibility for acting on results.

**Infliximab and adalimumab**

The recommendations in the following section are from 'Infliximab and adalimumab for the treatment of Crohn’s disease' ([NICE technology appraisal guidance 187](#)).

1.2.10 Infliximab and adalimumab, within their licensed indications, are recommended as treatment options for adults with severe active Crohn’s disease (see 1.2.15) 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 1.2.13) to determine whether ongoing treatment is still clinically appropriate.

1.2.11 Treatment as described in 1.2.10 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.

1.2.12 Infliximab, within its licensed indication, is recommended as a treatment option for people with active fistulising Crohn’s disease.

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7 Advice on monitoring of immunosuppressives can be found in the BNF/BNFC. The gastroenterology chapter and other relevant sections should be consulted.
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 1.2.13) to determine whether ongoing treatment is still clinically appropriate.

1.2.13 Treatment with infliximab or adalimumab (see 1.2.10 and 1.2.12) 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.

1.2.14 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.

1.2.15 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.

1.2.16 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.

1.2.17 Treatment with infliximab or adalimumab should only be started and reviewed by clinicians with experience of TNF inhibitors and of managing Crohn’s disease.

1.3 Maintaining remission in Crohn’s disease

1.3.1 Discuss with people with Crohn's disease, and/or their carer 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.

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 clinical guideline 118).

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 carer 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 (for example, unintended weight loss, abdominal pain, diarrhoea, general ill-health).

1.3.4 Discuss the following:
• the importance of lifestyle factors, such as not smoking
• the effect of nutrition and diet on disease activity
• how to access the healthcare system if they experience a relapse.

Maintenance treatment for those who choose this option
1.3.5 Offer azathioprine or mercaptopurine\(^8\) as monotherapy to maintain remission when previously used with a conventional glucocorticosteroid to induce remission.

1.3.6 Consider azathioprine or mercaptopurine\(^8\) 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).

1.3.7 Only consider methotrexate\(^8,9\) to maintain remission 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).

\(^8\) Although use is common in UK clinical practice, at the time of consultation (May 2012), azathioprine, mercaptopurine, methotrexate, olsalazine, balsalazide, sulfasalazine, budesonide did not have UK marketing authorisation for maintaining remission in Crohn’s disease. Informed consent should be obtained and documented. Some forms of mesalazine (Octasa MR, Mesren MR, Asacol MR) are licensed for maintaining remission in Crohn’s disease.

\(^9\) Follow BNF/BNFC cautions on prescribing methotrexate.
1.3.8 Do not offer a conventional glucocorticosteroid or budesonide to maintain remission.

See recommendation 1.2.13 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\textsuperscript{10} 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).

1.4.2 Do not offer 5-ASA treatment, budesonide or enteral nutrition to maintain remission after surgery.

1.5 Enteral nutrition

1.5.1 For children in whom there is concern about growth or side effects, consider enteral nutrition as an alternative to a conventional glucocorticosteroid to induce remission.

1.6 Surgery

Crohn’s disease limited to the distal ileum

1.6.1 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

\textsuperscript{10} Although use is common in UK clinical practice, at the time of consultation (May 2012), azathioprine, mercaptopurine, methotrexate, olsalazine, balsalazide, sulfasalazine, budesonide did not have UK marketing authorisation for maintaining remission in Crohn’s disease. Informed consent should be obtained and documented. Some forms of mesalazine (Octasa MR, Mesren MR, Asacol MR) are licensed for maintaining remission in Crohn’s disease.
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- risk of recurrence after surgery (see appendix O of the full guideline)
- individual preferences and any personal or cultural considerations.

Record the person’s views in their notes.

1.6.2 Consider surgery early in the course of the disease or before or early in puberty for children 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 child’s carer and, if appropriate, the child.

Managing strictures

1.6.3 Consider balloon dilation particularly in people with a single stricture that is short, straight and accessible by colonoscopy.

1.6.4 Discuss with the person, a surgeon and a gastroenterologist the benefits and risks of balloon dilation and surgical interventions for managing strictures (see appendix O in the full guideline).

1.6.5 Take into account the following factors when assessing options for managing a stricture:

- number and extent of previous resections
- rapidity of past recurrence (if appropriate)
- potential for further resections
- the consequence of short bowel syndrome
- the person’s preference, and how their lifestyle and cultural background might affect management.
1.6.6 Ensure that abdominal surgery is available for managing complications or failure of balloon dilation.

1.7 Monitoring for osteopenia

Refer to the (forthcoming) NICE clinical guideline on ‘Osteoporosis: assessing the risk of fragility fracture’ for recommendations on assessing the risk of fragility fracture (publication expected June 2012).

1.7.1 Do not routinely monitor for changes in bone mineral density in children and young people under 18.

1.7.2 Consider monitoring for changes in bone mineral density in children and young people under the age of 18 with risk factors, such as low body mass index (BMI) or continued or repeated glucocorticosteroid use.

1.8 Conception, pregnancy and breastfeeding

1.8.1 Give information about the possible effects of Crohn's disease on pregnancy, including the potential risks and benefits of medical treatment and the effects of the Crohn’s disease on fertility and pregnancy outcomes.

1.8.2 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.

2 Notes on the scope of the guidance

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover.
How this guideline was developed

NICE commissioned the National Clinical Guideline Centre to develop this guideline. The Centre established a Guideline Development Group (see appendix A), which reviewed the evidence and developed the recommendations.

There is more information about how NICE clinical guidelines are developed on the NICE website. A booklet, ‘How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS’ is available.

3 Implementation

NICE has developed tools to help organisations implement this guidance.

Note: these details will apply when the guideline is published.

4 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future.

4.1 Induction of remission

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 maintaining remission 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 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.

4.2 **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.

4.3 **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.

4.4 Patient information and support

What information do people with Crohn’s disease want, and can support based on these information 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.

5 Other versions of this guideline

5.1 Full guideline

The full guideline, 'Crohn's disease' contains details of the methods and evidence used to develop the guideline. It is published by the National Clinical Guideline Centre, and is available from our website. Note: these details will apply to the published full guideline.
5.2 **NICE pathway**

The recommendations from this guideline have been incorporated into a NICE pathway. Note: these details will apply when the guideline is published.

5.3 **‘Understanding NICE guidance’**

A summary for patients and carers (‘Understanding NICE guidance’) is available.

For printed copies, phone NICE publications on 0845 003 7783 or email publications@nice.org.uk (quote reference number N[XXXX]). Note: these details will apply when the guideline is published.

We encourage NHS and voluntary sector organisations to use text from this booklet in their own information about Crohn’s disease.

6 **Related NICE guidance**

6.1 **Incorporated guidance**

This guideline incorporates the following NICE guidance:


6.2 **Other related NICE guidance**

**Published**


Under development

NICE is developing the following guidance (details available from the NICE website):

• Osteoporosis: fragility fracture risk. NICE clinical guideline. Publication expected June 2012.

7 Updating the guideline

NICE clinical guidelines are updated so that recommendations take into account important new information. New evidence is checked 3 years after publication, and healthcare professionals and patients are asked for their views; we use this information to decide whether all or part of a guideline needs updating. If important new evidence is published at other times, we may decide to do a more rapid update of some recommendations. Please see our website for information about updating the guideline.
Appendix A: The Guideline Development Group, National Collaborating Centre and NICE project team

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