This fact sheet has been created for you by the American Osteopathic Association as an overview of the diagnosis and treatment of inflammatory bowel disease (IBD). As you read this fact sheet, jot down any questions you’d like to discuss with your physician. In addition, consult a few of the Web sites listed at the conclusion of this handout. Many offer information, resources and news on the latest developments in IBD.

What It Is
Inflammatory bowel disease (IBD) is a chronic gastrointestinal illness which causes swelling and inflammation in the walls of the gut. There are two types of IBD: Ulcerative Colitis (UC) and Crohn's disease (CD). Although these are separate and distinct diseases, they can cause similar symptoms and sometimes make it difficult to distinguish between the two when determining the diagnosis.

Ulcerative colitis causes inflammation and sometimes ulcers in the top layers of the lining of the large intestine, or colon, including the rectum. The main symptom is bloody diarrhea and, depending on the extent of the disease, patients may have other symptoms.

If the disease is only located in the rectum, patients have urgency to have bowel movements and frequent trips to the toilet, but pass only very small amounts of mucus or blood. Half of UC patients have the disease only in the lowest part of the colon or rectum.

When it is extensive, involving the entire colon, patients have larger bowel movements that are still bloody and may have diffuse abdominal pain, weight loss, fever, joint pain and dehydration.

Crohn's disease, on the other hand, can involve any segment of the gastrointestinal system from the mouth to the anus. CD leads to ulcers that extend deeper in the digestive tract wall and "skip lesions." This means that inflamed tissue “skips” to various areas in the GI tract, with healthy tissue in between.

The most common site of involvement is the small bowel, although any segment of the gut can be involved. Patients usually have abdominal pain, weight loss, diarrhea, poor appetite, and abdominal bloating or distention, especially after meals. CD patients may develop fistulas (tunnels that lead from one loop of intestine to another, or that connects the intestine to the bladder, vagina or skin) or abscesses because of the deep ulcerations in the gut wall, which may require surgery.

Both illnesses do have one strong feature in common. They are marked by an abnormal response by the body's immune system. Although the exact cause of IBD is unknown, the immune system plays a large role. The immune system is composed of various cells and proteins. Normally, these protect the body from infection.

In people with Crohn's disease, however, the immune system reacts inappropriately. Researchers believe that the immune system mistakes microbes, such as bacteria that is normally found in the intestines, for foreign or invading substances, and launches an attack. In the process, the body sends white blood cells into the lining of the intestines, where they produce chronic inflammation. These cells then generate harmful products that ultimately lead to ulcerations and bowel injury. When this happens, the patient experiences the symptoms of IBD.

IBD vs. IBS
Many times people confuse Inflammatory Bowel Disease (IBD) with Irritable Bowel Syndrome (IBS). Often referring to IBS as “colitis.” The main difference is that IBS is a “functional disease.” It is a problem with how the bowel contracts and relaxes. There is not a significant inflammatory component to it, which causes the bleeding with bowel movements, weight loss, fever, bowel movements at night and anemia.

IBS is very common and usually has intermittent episodes of diarrhea and
Other Options
When medical treatment does not work or when IBD patients develop serious complications such as blockage of the intestine, abscesses or large fistulas, physicians may recommend some type of surgery.

In ulcerative colitis, generally the entire colon is removed and this is considered a curative procedure. Surgeons can leave a small internal pouch from the small bowel and attach it to the anal muscle. This allows patients to pass bowel movements through the new pouch. In CD though, only the diseased portion of the GI tract is removed. Often, disease recurs where it was previously removed.

Although all of the information about IBD can be overwhelming and scary for patients, there are tremendous advances being made in the area of IBD. Visit some of the Web resources for more information and detail about these advances.

Patient Profile
More than 1 million Americans have IBD.
IBD is more common in young people. CD is most frequently diagnosed in late adolescence or early adulthood, with a median age of diagnosis in the third decade. The average age at diagnosis of UC is in the fourth decade.

Most studies show a “bimodal” age distribution of incidence in CD and UC, meaning that a large peak in incidence is seen in the second or third decades, followed by a smaller peak in incidence later in life. Men and women get the disease in equal numbers. Some groups, such as Jews of Eastern European ancestry, are more vulnerable to the disease than others. The disease also seems to run in families.

Colon Cancer Risk and IBD
Studies have shown as much as a five-fold risk of colon cancer in people with IBD compared to the general population. Physicians will recommend screening colonoscopies usually starting 8-10 years after diagnosis to detect early stages of cell wall changes, polyps or cancer. There are small studies that suggest that Mesalamine products can help reduce the risk of colon cancer in patients with IBD.

Diagnosis
The diagnosis of IBD is based on symptoms and test results. Your physician will need to do a complete history and physical assessment with a strong emphasis on gastrointestinal symptoms. If the disease is suspected, the physician can order several tests including:

1) Blood work to test for anemia, inflammation, low protein or infection.
2) Stool samples to look for blood or signs of parasites or infection.
3) Special X-rays including an upper GI and/or barium enema.
4) Endoscopy of the large intestine which allows the doctor to look inside the rectum and colon using a thin lighted flexible scope.

Treatment for IBD
While there’s no cure for IBD, the goal of medical treatment is to suppress the inflammatory response and relieve symptoms of diarrhea, abdominal pain, and rectal bleeding.

Once the symptoms are brought under control (this is known as inducing remission), medical therapy is continued to decrease the frequency of disease flares (this is known as maintaining remission, or maintenance).

Several groups of drugs are used to treat IBD today. Your physician will be able to help you explore the types of drugs used to treat IBD and can also explain to you some of the short- and long-term benefits and side effects.

Be sure to discuss your drug treatment plan with your physician so you understand the process and the approach that is being taken.
Important Questions to Ask Your Physician About IBD

Following are some questions you might consider the next time you visit your physician.

1. Could any condition other than IBD be causing my symptoms?
2. Do I have ulcerative colitis or Crohn’s disease?
3. Do I have an increased risk of cancer and what can I do to prevent it?
4. What medications are best for me and what are the side effects?
5. How soon should I expect relief?
6. What symptoms are considered an emergency?
7. What can I do to help my disease such as diet, nutritional supplements, drug treatments and lifestyle changes?
8. Will I be able to work, travel and exercise?
9. How will the disease change my life and where can I get support?
10. As a woman, what special considerations do I need to take in such areas as fertility, pregnancy and menopause?