



A summary of prescribing recommendations from NICE guidance

This edition includes one guideline.

Crohn's disease: management

NICE NG129; May 2019

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.

Information and support - see [pathway](#).

**Pharmacological management – inducing remission
Monotherapy**

- ◆ Offer monotherapy with a conventional glucocorticoid (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.
- ◆ Consider enteral nutrition as an alternative to conventional glucocorticoid 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.
- ◆ Consider budesonide^{U1} for a first presentation or single inflammatory exacerbation in a 12-month period for people:
 - who have one or more of distal ileal, ileocaecal or right-sided colonic disease, **AND**
 - if conventional glucocorticoids are contraindicated, or if the person declines or cannot tolerate them.
 - Explain that budesonide is less effective than a conventional glucocorticoid, but may have fewer side effects.
- ◆ Consider aminosalicylate^{U2} treatment for a first presentation or single inflammatory exacerbation in a 12-month period if conventional glucocorticoids are contraindicated, or if the person declines or cannot tolerate them.
 - Explain that aminosalicylates are less effective than a conventional glucocorticoid or budesonide but may have fewer side effects than a conventional glucocorticoid.
- ◆ Do not offer budesonide or aminosalicylate treatment for severe presentations or exacerbations.
- ◆ Do not offer azathioprine, mercaptopurine or methotrexate as monotherapy to induce remission.

Add-on treatment

- ◆ Consider adding azathioprine^{U3} or mercaptopurine^{U3} to a conventional glucocorticoid or budesonide^{U1} to induce remission of Crohn's disease if:
 - there are 2 or more inflammatory exacerbations in a 12-month period, **OR**
 - the glucocorticoid dose cannot be tapered.
- ◆ 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^{U3} or mercaptopurine^{U3} at a lower dose if TPMT activity is below normal but not deficient (according to local laboratory reference values).

Please go to www.nice.org.uk to check for any recent updates to this guidance.

- ◆ Consider adding methotrexate^{U4} to a conventional glucocorticoid or budesonide^{U1} to induce remission in people who cannot tolerate azathioprine or mercaptopurine, or in whom TPMT activity is deficient, if:
 - there are 2 or more inflammatory exacerbations in a 12-month period, **OR**
 - the glucocorticoid dose cannot be tapered.
- ◆ Monitoring – see **Box 1**.

Box 1**Monitoring**

- ◆ Monitor the effects of azathioprine^{U3}, mercaptopurine^{U3}, methotrexate^{U4} and metronidazole^{U6} as advised in the BNF or BNFC. Monitor for neutropenia in people taking azathioprine or mercaptopurine even if they have normal TPMT activity.
- ◆ Ensure there are documented local safety monitoring policies and procedures (including audit) for people receiving treatment that needs monitoring. Nominate a member of staff to act on abnormal results and communicate with GPs, people with Crohn's disease and their family members or carers (as appropriate).

Box 2**Unlicensed prescribing**

- U1** – although use is common in UK clinical practice, budesonide is not specifically licensed for children and young people.
- U2** – although use is common in UK clinical practice, mesalazine, olsalazine and balsalazide are not licensed for this indication.
- U3** – although use is common in UK clinical practice, mercaptopurine and most preparations of azathioprine are not licensed for this indication.
- U4** – although use is common in UK clinical practice, not all formulations of methotrexate are licensed for this indication, and those that are, are licensed for adults.
- U5** – not all preparations of azathioprine are licensed for this indication.
- U6** – the combination of azathioprine and metronidazole is not licensed 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.

Infliximab and adalimumab

- ◆ These recommendations are from [NICE TA187](#).
- ◆ Infliximab and adalimumab, within their licensed indications, are recommended as treatment options for adults with severe active Crohn's disease 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.

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- ◆ 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 to determine whether ongoing treatment is still clinically appropriate.
- ◆ Treatment should normally be started with the less expensive drug (taking into account drug administration costs, required dose and price per dose). This may need to be varied for individuals due to differences in the method of administration and treatment schedules.
- ◆ When starting infliximab or adalimumab discuss options of:
 - monotherapy with one of these drugs, **OR**
 - combined therapy (either infliximab or adalimumab, combined with an immunosuppressant)
 - Tell the person there is uncertainty about the comparative effectiveness and long-term adverse effects of monotherapy and combined therapy.
- ◆ Infliximab, within its licensed indication, is recommended 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.
- ◆ Treatment with infliximab or adalimumab 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.
- ◆ Infliximab, within its licensed indication, is recommended for people aged 6 to 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.
- ◆ Treatment with infliximab or adalimumab should only be started and reviewed by clinicians with experience of TNF inhibitors and of managing Crohn's disease
- ◆ The definition of severe, active Crohn's disease used in this guidance is defined in the [full guideline](#).

Ustekinumab and vedolizumab

- ◆ For guidance on using ustekinumab, see [NICE TA456](#).
- ◆ For guidance on using vedolizumab, see [NICE TA352](#).

Maintaining remission

- ◆ Discuss with people with Crohn's disease and their family members or carers (as 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.
- ◆ Offer colonoscopic surveillance in line with [NICE CG 118](#).

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Follow-up for people who choose not to have maintenance treatment

- ◆ When people choose not to receive maintenance treatment:
 - discuss and agree with them and their family members or carers (as 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.

Maintenance treatment for people who choose this option

- ◆ Offer azathioprine^{U3} or mercaptopurine^{U3} as monotherapy to maintain remission when previously used with a conventional glucocorticoid or budesonide to induce remission.
- ◆ Consider azathioprine^{U3} or mercaptopurine^{U3} to maintain remission in people who have not previously received these drugs (particularly people with adverse prognostic factors such as early age of onset, perianal disease, glucocorticoid use at presentation and severe presentations)
- ◆ Consider methotrexate^{U4} 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).
- ◆ Do not offer a conventional glucocorticoid or budesonide to maintain remission.
- ◆ Monitoring – see **Box 1**.

Maintaining remission after surgery

- ◆ To maintain remission in people with ileocolonic Crohn's disease who have had complete macroscopic resection within the last 3 months, consider azathioprine^{U5} in combination with up to 3 months' postoperative metronidazole^{U6}.
- ◆ Consider azathioprine^{U5} alone for people who cannot tolerate metronidazole.
- ◆ Monitoring – see **Box 1**.
- ◆ Do not offer biologics to maintain remission after complete macroscopic resection of ileocolonic Crohn's disease.
- ◆ For people who have had surgery and started taking biologics before this guideline was published (May 2019), continue with their current treatment until both they and their NHS healthcare professional agree it is appropriate to change.
- ◆ Do not offer budesonide to maintain remission in people with ileocolonic Crohn's disease who have had complete macroscopic resection.

Surgery – see the [full guideline](#).

Monitoring for osteopenia and assessing fracture risk – see the [full guideline](#).

Conception and pregnancy – see the [full guideline](#).

Recommendations – wording used such as 'offer' and 'consider' denote the [strength of the recommendation](#).

Drug recommendations – the guideline assumes that prescribers will use a drug's [Summary of Product Characteristics \(SPC\)](#) to inform treatment decisions.