2023 Chinese national clinical practice guideline on diagnosis and management of Crohn's disease

Inflammatory Bowel Disease Group, Chinese Society of Gastroenterology, Chinese Medical Association; Inflammatory Bowel Disease Quality Control Center of China

Inflammatory bowel disease (IBD) is a complex condition, for which standardized diagnostics and treatment are paramount to enhance medical efficacy. Chinese consensus/guidelines for IBD management were formulated in 1978, 1993, 2001, 2007, 2012, and 2018, and markedly standardized and improved the clinical management of IBD in China. Recently, given the rising incidence of IBD in China,[1] related clinical and basic research has received much attention. The depth of evidence is increasing, which has laid a solid foundation for updating the consensus guideline. Additionally, novel diagnostic methods and treatment modalities are being developed and updated rapidly. In this context, by incorporating the latest international consensus statements[2–6] and integrating Chinese research findings and clinical practice approaches, the Inflammatory Bowel Disease Group of the Chinese Society of Gastroenterology, Chinese Medical Association, has revised the *2018 Consensus on inflammatory bowel disease management*.[7] This revision differs from previous guidelines in that the guideline for ulcerative colitis management and that for Crohn's disease (CD) management have been formulated and completed separately. This allows the new guidelines to fully reflect the research progress in each field, and to offer standardized, comprehensive, and feasible guidance for clinical practice. This text comprises the guideline for CD management.

Methodology

The 2011 Oxford Center for Evidence-based Medicine (OCEBM) Levels of Evidence has been adopted for evidence quality evaluation and rating of the research included. The quality of recommendations was evaluated in accordance with the Grading of Recommendations, Assessment, Development, and Evaluation system. Additionally, content that the expert group considered important but inappropriate to recommend on the basis of the evidence level and recommendation strength is described with a Best Practice Statement (BPS) designation, with no separate classification. The guideline is offered to the target users, who are clinical physicians and nurses engaged in IBD diagnostics and treatment, and applies to Chinese CD patient populations. The full text of this guideline appears in Supplementary File 1, http://links.lww.com/CM9/C85.

Recommendations on diagnostics and assessment

Recommendation 1: No gold standard has been established for the diagnosis of CD. The diagnosis comprises comprehensive evaluations of clinical manifestations, with laboratory, imaging, and endoscopic and histopathologic findings. (BPS)

Recommendation 2: Fecal calprotectin concentration could be used to evaluate intestinal inflammation in patients with CD. (Level 1 evidence, Weak recommendation)

Recommendation 3: Routine colonoscopy is recommended for the diagnosis and surveillance of CD. Advancing the scope into the terminal ileum is strongly advised, and multiple biopsies should be obtained in patients with suspected CD. (Lever 2 evidence, Strong recommendation)

Recommendation 4: Gastroduodenoscopy with biopsies is recommended routinely for patients who are diagnosed with probable CD, to evaluate whether the disease affects the upper gastrointestinal tract. (Level 2 evidence, Strong recommendation)

Recommendation 5: Capsule endoscopy is suggested mainly for patients with suspected CD. However, evidence collected through colonoscopy and radiographic examination can be insufficient to support a diagnosis of CD. Intestinal stricture assessment before capsule endoscopy

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is advised to lower the risk of capsule retention. (Level 1 evidence, Weak recommendation)

Recommendation 6: Balloon-assisted enteroscopy with biopsy is recommended for patients with suspected CD with positive findings on computed tomographic enterography (CTE)/magnetic resonance enterography (MRE)/small bowel capsule endoscopy for whom a confirmed diagnosis of CD cannot be made from colonoscopy. (Level 2 evidence, Strong recommendation)

Recommendation 7: It is recommended that patients with probable or newly diagnosed CD undergo MRE or CTE to assess the range of lesions and complications. MRE and CTE are similar in the diagnostic evaluation of small bowel lesions in CD. (Level 1 evidence, Strong recommendation)

Recommendation 8: Perianal MRI is the first choice for the diagnosis of perianal fistula in CD, and should be routinely performed for patients with suspected CD and those with concurrent perianal lesions. Perianal ultrasonography is an alternative to perianal MRI. (Level 2 evidence, Strong recommendation)

Recommendation 9: Intestinal ultrasonography could be used for disease surveillance in patients with CD. (Level 2 evidence, Weak recommendation)

Recommendation 10: The diagnosis of CD requires the exclusion of intestinal inflammation or damage due to other causes, such as intestinal tuberculosis, intestinal Behcet's disease, and lymphoma. (BPS)

Recommendation 11: A complete diagnosis of CD should include disease classification, disease activity, and complications. (Level 1 evidence, Strong recommendation)

Recommendation 12: Assessment of risk factors for CD progression is necessary before a CD diagnosis, and risk factors include young age at onset, smoking history, extensive intestinal involvement, penetrating or stricturing phenotype, and perianal lesions. (Level 2 evidence, Strong recommendation)

Recommendations on treatment

Recommendation 13: The treatment principle of CD is to induce and maintain remission. The immediate goals are to relieve clinical symptoms and normalize serum/fecal inflammatory indicators. The long-term goals are to relieve clinical symptoms, normalize serum/fecal inflammatory indicators, and achieve mucosal healing. (Level 2 evidence, Weak recommendation)

Recommendation 14: Early and active use of biologics or glucocorticoids is recommended for remission induction in patients with high-risk factors. (Level 2 evidence, Strong recommendation)

Remission induction

Recommendation 15: Local or systemic glucocorticoids can be considered to induce remission for patients with mildly active CD. (Level 2 evidence, Strong recommendation)

Recommendation 16: Biologics are suggested for remission induction in patients with mildly active CD and high-risk factors or failure of traditional medication. (Level 2 evidence, Strong recommendation)

Recommendation 17: Systemic glucocorticoids are recommended for remission induction in patients with moderately and severely active CD. (Level 1 evidence, Strong recommendation)

Recommendation 18: Anti-tumor necrosis factor monoclonal antibodies are recommended for remission induction in patients with moderately and severely active CD. (Level 2 evidence, Strong recommendation)

Recommendation 18a: When infliximab (IFX) is administered to induce CD remission, in the absence of contraindications, the addition of azathioprine (AZA) or methotrexate (MTX) is suggested. (Level 2 evidence, Weak recommendation)

Recommendation 18b: When adalimumab (ADA) is administered as a second-line biologic to induce CD remission, adding AZA or MTX is an option. (Level 4 evidence, Weak recommendation)

Recommendation 19: Vedolizumab can be used for remission induction in patients with moderately and severely active CD. (Level 2 evidence, Strong recommendation)

Recommendation 20: Ustekinumab is recommended for induction remission in patients with moderately and severely active CD. (Level 2 evidence, Strong recommendation)

Recommendation 21: Selective Janus kinase inhibitors can be used for remission induction in patients with moderately and severely active CD who fail to respond to anti-tumor necrosis factor therapy. (Level 2 evidence, Strong recommendation)

Recommendation 22: Exclusive enteral nutrition facilitates remission induction in patients with active CD. (Level 1 evidence, Strong recommendation)

Recommendation 23: Antibiotics are recommended for CD patients with concurrent infections or complex perianal fistulas. (Level 1 evidence, Strong recommendation)

Recommendations on maintenance of remission

Recommendation 24: Glucocorticoids should not be used for maintenance therapy in CD. (Level 1 evidence, Strong recommendation)

Recommendation 25: AZA and MTX can be used for maintenance therapy in CD. (Level 1 evidence, Strong recommendation)

Recommendation 26: Patients with CD who have achieved remission with biologics should continue with the same

biologic agent for maintenance therapy. (Level 2 evidence, Strong recommendation)

Recommendation 27: For patients with CD who have achieved remission with selective Janus kinase inhibitors, continuation of the same agent for maintenance therapy is recommended. (Level 2 evidence, Strong recommendation)

Recommendation 28: For patients with CD with intestinal strictures of <5 cm in length, endoscopic balloon dilation or endoscopic stricturotomy could be considered. (Level 3 evidence, Weak recommendation)

Recommendations on management principles for CD with concomitant perianal disease/fistulizing CD

Recommendation 29: For patients with CD complicated with perianal abscesses or complex anal fistulas, a collaborative assessment and treatment approach by gastroenterologists and surgeons is recommended. (Level 2 evidence, Strong recommendation)

Recommendation 30: Monotherapy with antibiotics or thiopurines is not recommended for the treatment of CD with anal fistulas. (Level 2 evidence, Strong recommendation)

Recommendation 31: IFX is recommended for the treatment of CD with anal fistulas. (Level 2 evidence, Strong recommendation)

Recommendation 32: ADA and/or ustekinumab is recommended for the treatment of CD with anal fistulas. (Level 2 evidence, Strong recommendation)

Recommendation 33: Vedolizumab is considered a viable option for the treatment of CD with anal fistulas. (Level 2 evidence, Weak recommendation)

Recommendations on perioperative management and prevention of postoperative recurrence in CD

Recommendation 34: Surgical intervention is indicated for severe complications in CD. The consideration of surgery is advised when medical therapy proves ineffective. (Level 2 evidence, Strong recommendation)

Recommendation 35: For elective surgical CD patients, preoperative assessment and perioperative management are recommended, including nutritional support and pharmacological management. (BPS)

Recommendation 36: For patients with CD with risk factors for recurrence, proactive preventive treatment is recommended post-intestinal resection. (Level 2 evidence, Strong recommendation)

Recommendation 37: Thiopurines are effective in preventing both clinical and endoscopic postoperative recurrence in CD. (Level 2 evidence, Weak recommendation)

Recommendation 38: Biologics are effective in both preventing and treating postoperative CD recurrence and can be continued postoperatively if they were effective preoperatively. (Level 2 evidence, Strong recommendation)

Recommendation 39: It is advisable to perform an endoscopic evaluation 6 months post-surgery or upon the emergence of symptoms in patients with CD to assess for potential recurrence. If endoscopy is not tolerable, alternate evaluation methods, such as fecal calprotectin testing in conjunction with CTE or MRE, are recommended. (Level 2 evidence, Strong recommendation)

Recommendations on treatment monitoring and patient management

Recommendation 40: Pre-treatment *NUDT15* genotyping is suggested before initiating thiopurine therapy. Monitoring 6-thioguanine nucleotide levels to guide dosage adjustments could be considered if this testing is available. (Level 2 evidence, Weak recommendation)

Recommendation 41: Therapeutic drug monitoring is recommended for patients who receive IFX therapy. (Level 2 evidence, Strong recommendation)

Recommendation 42: Screening colonoscopy should be performed in patients with CD with colonic involvement 8 years after disease onset to exclude colorectal cancer. The frequency of colonoscopy can be determined by the stratification of cancer risk. Currently, there is little evidence supporting routine screening for CD-associated small bowel and perianal malignancies. (Level 3 evidence, Strong recommendation)

Recommendation 43: Nutritional assessment and monitoring are recommended for patients with CD, and appropriate nutritional support should be supplied. (Level 2 evidence, Strong recommendation)

Recommendation 44: Assessing the mental health status of patients with CD is recommended, and timely intervention for psychological disorders should be provided. (Level 2 evidence, Strong recommendation)

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Conflicts of Interest

None.

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