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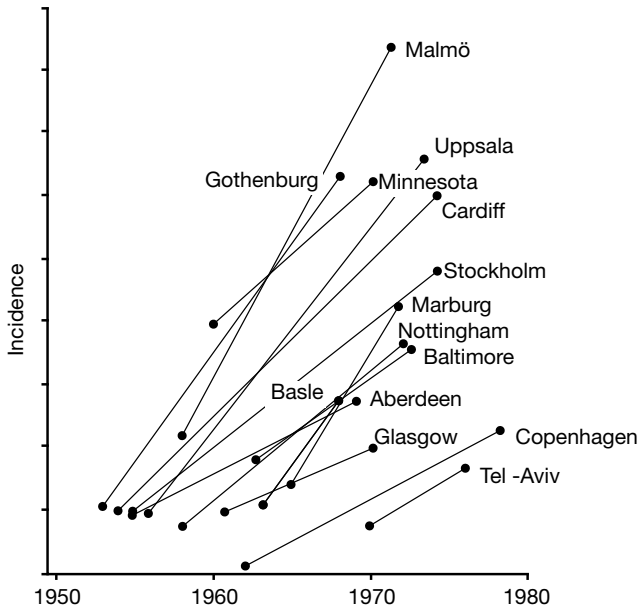


Figure 2.1 Rising incidence of Crohn's disease per 10^5 population. Langman in *Inflammatory Bowel Diseases* (Allan *et al.* 1990). Reproduced with permission

led to a delayed and transient exposure to a common agent which triggered an inappropriate and chronic disease process. This fascinating observation raised the possibility that something similar might be happening in Crohn's disease. Therefore, 133 patients who had Crohn's disease and 231 with ulcerative colitis were studied and compared with controls selected from the general population and matched for age and sex. A series of known risk factors for poor hygiene were investigated in all subjects. Crohn's disease was found to be significantly more common in subjects whose first houses had main drainage, a hot tap and a bath in the first five years of life. Ulcerative colitis showed no relationship with household amenities in infancy. Thus it was concluded that these findings might explain why the incidence of Crohn's disease had increased in developed countries over the past 50 years (Gent *et al.* 1994).

Racial and ethnic variations are well recognised in Crohn's disease. In general there is a higher incidence in Anglo-Saxons, those from northern European races and in the Jewish population. A low incidence is seen in Orientals, Latin Americans, those from southern Europe and in black races.

The prevalence of Crohn's disease is in the region of 50 cases per 10^5 . However, it seems probable that this is a considerable underestimate and that the true prevalence may be in excess of 100 per 10^5 (Table 2.5).

Crohn's disease: evidence and opinion for first-line therapy

Stephen M Evans and Jeremy D Sanderson

Introduction

First-line therapy for active Crohn's disease still relies heavily on the use of corticosteroids and aminosalicylates. In this chapter, the evidence for continuing this practice is explored and the merits of alternative strategies examined. Where evidence is lacking or inconclusive, an opinion is offered. In so doing, the authors hope to provide a rational framework with which to manage active Crohn's disease as effectively as possible.

All available treatments for Crohn's disease have as their goal the amelioration of symptoms, improvement of quality of life, and the prevention of relapse and complications. Ideally, treatments should be safe and well tolerated but, in this regard, current treatments are far from ideal. Healing of the intestinal mucosa has been suggested as an ultimate goal, but few therapies can justifiably claim to achieve this. The treatment of Crohn's disease should be evidence based and established by data from quality randomised controlled trials, yet the reality falls well short of this. Furthermore, compromises are inevitable given the nature of the disease and the need to take the wishes and fears of patients (and their doctors) into account.

'No treatment' options

Any approach to treating Crohn's disease should include 'no-treatment' options. Perhaps most important among these is stopping smoking. Cigarette smoking is the strongest predictor of relapse in Crohn's disease (Figure 5.1) (Yamamoto & Keighley 2000), yet this simple advice to patients is often neglected. Non-steroidal anti-inflammatory drugs may provoke exacerbations of Crohn's disease symptoms and should be stopped where possible. Aminosalicylates can themselves cause diarrhoea (Chakraborty 1987) (especially olsalazine – Goerg 1987) and improvement may result from stopping them. It is important to remember that symptoms may not be caused by active Crohn's disease: bile salt malabsorption (Nyhlin *et al.* 1994), lactose intolerance (Mishkin *et al.* 1997) and bacterial overgrowth (Castiglione *et al.* 2000) should always be considered.

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