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Current follow-up standards for patients with inflammatory bowel disease

To the Editor: I was recently consulted by a patient requesting an annual follow-up colonoscopy for colitis. After a single bout of diarrhoea, this had been recommended to avoid developing colon cancer, and had been diligently followed for over 10 years. This excess by a colleague is disappointing, but not that rare.

The standard follow-up recommendations for patients with ulcerative colitis and Crohn's disease depend on the patient's status:[1]

(*i*) An asymptomatic patient on biological therapy with normal intestinal mucosa, faecal calprotectin and C-reactive protein is the target situation that our therapy is aimed at. In these patients who are <45 years of age, an annual calprotectin and a review of their therapy is all that is needed. In older patients, the possibility of colon cancer needs to be considered. A reasonable recommendation is a 5-yearly colonoscopy with mucosal biopsies. This frequency may be variable depending on other factors, but has been well studied.[2]

(*ii*) Patients with diarrhoea or other symptoms do not need follow-up; they need better treatment. Unfortunately, they sometimes have a colonoscopy and are told to increase their mesalamine.

(*iii*) Currently asymptomatic patients with a past history of intermittent symptoms need re-assessment. This would include history, calprotectin, C-reactive protein and possibly endoscopy. This could be a sigmoidoscopy or even colonoscopy. Patients should not have occasional symptoms. They need a review and modification of their therapy.

(*iv*) Patients with even mild chronic active disease need biological or so-called small-molecule therapy. In the past, mesalamine-based medication or immunosuppression were the standard therapy, but these are being replaced by modern options. When carefully monitored, these reduce the main risks associated with these inflammatory conditions, such as colon cancer and stricture formation.[3,4] If patients do not have access to this therapy, they need to be referred to a research unit where they can be offered disease-modifying therapy.

To keep patients in remission, planned follow-up with regard to medication and occult inflammation is more important than routine frequent expensive endoscopy.

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