Evidence-based Medicine

Tra ipotesi di lavoro ed applicazione

Ferrara, 29-30 settembre 2000

Sessione Clinica

Evidence-based Clinical Problem Solving

1. Gastroenterologia

Scenario Clinico (1)

• Il signor Saverio è un agente di polizia tributaria di 28 anni, fumatore, con una lunga storia di malattia di Crohn.

Scenario Clinico (2)

4-87 comparsa di fistola perianale; alvo regolare

88 appendicectomia elettiva (!)

88 recidiva di fistola perianale

92 curettage chirurgico di fistola perianale

4-93 1° episodio di subocclusione intestinale

8-93 2° episodio di subocclusione intestinale
La colonscopia evidenzia una flogosi a livello ileo-colico. L'esame istologico conferma la diagnosi endoscopica di malattia di Crohn

Scenario Clinico (3)

93-97 Periodiche riaccensioni della malattia con caratteristiche prevalentemente infiammatorie trattate con steroidi o mesalazina

7-97 3° episodio subocclusivo

11-97 riacutizzazione della malattia di base a cui segue l'ileo con anastomosi latero-laterale di ansa ileale al tratto di passaggio tra cieco ed ascendente, sul profilo interno. Le anse digiunali e la porzione residua dell'ileo appaiono normodistribuite, con pareti soffici e normale rilievo valvolare. Buona opacizzazione dell'ansa anastomotica.

Scenario Clinico (4)

12-98 Rx Clisma opaco
Stenosi tubulariforme dell'estremo distale del sigma (diametro max 1,5 cm) e dell'ampolla rettale di 10 cm. Assenza di formazioni ascessuali.
Conclusioni: riacutizzazioni cliniche della malattia di base su stenosi serrata del giunto retto-sigmoideo

CLINICAL QUESTIONS

?

• Quali, tra le seguenti opzioni farmacologiche, sono efficaci nella malattia di Crohn sia per indurre la remissione, che per mantenerla?

- Steroidi
- Mesalazina
- Immunosoppressori
- Anticorpi monoclonali

• Qual ruolo hanno le diete liquide?

• La chirurgia può essere risolutiva ?

Hanauer SB, Meyers S

Treatment Guideline
Crohn's Disease in Adults

Am J Gastroenterol 1997;92:599-66

BRITISH SOCIETY OF GASTROENTEROLOGY
CLINICAL GUIDELINES

Inflammatory Bowel Disease

1996

Sandborn W, Sutherland L, Pearson D, May G, Modigliani R, Prantera C.

Azathioprine or 6-Mercaptopurine for inducing remission of Crohn's disease

(Cochrane Review)

The Cochrane Library, Issue 3, 2000. Oxford: Update Software.

Pearson DC, May GR, Fick G, Sutherland LR.

Azathioprine for maintaining remission of Crohn's disease

(Cochrane Review)

The Cochrane Library, Issue 3, 2000. Oxford: Update Software.

Steinhart AH, Ewe K, Griffiths AM, Modigliani R, Thomsen OO.

Corticosteroids for maintaining remission of Crohn's disease

(Cochrane Review)

The Cochrane Library, Issue 3, 2000. Oxford: Update Software.

Cochrane Inflammatory Bowel Disease Group Protocols

- 5-aminosalicylate for maintaining remission of Crohn's disease
- Antibiotics for inducing remission of Crohn's disease
- Budesonide for inducing remission of Crohn's disease
- Budesonide for maintaining remission of Crohn's disease
- Cyclosporine for inducing remission of Crohn's disease
- Cyclosporine for maintaining remission of Crohn's disease
- Enteral nutritional therapy for inducing remission of Crohn's disease

Camma C, Giunta M, Rosselli M, Cottone M.

Mesalamine in the maintenance treatment of Crohn's disease: a meta-analysis adjusted for confounding variables.

Gastroenterology 1997;113:1465-73.

- Mesalamine may be recommended for maintaining remission of quiescent Crohn's disease.
- The benefit is mainly observed in the postsurgical setting, in patients with ileitis and with prolonged disease duration.

Camma C, et al. Gastroenterology 1997

Bell S, Kamm MA.

Antibodies to tumour necrosis factor alpha as treatment for Crohn's disease.

Lancet. 2000 Mar 11;355(9207):858-60.

Placebo-controlled double-blind randomised trials of antibodies to TNF-α in Crohn's disease

Trial	Drug	Patient Group	Follow-up	Clinical response	Remission or all fistula closed
Stack et al[3] (n=31)	CDP571 5 mg /kg (1 dose)	CDAI 150-400	8 weeks	*Fall in median CDAI after 2 weeks* 96 points (CDP571) 6 points (placebo)	*CDAI<150 after 2 weeks* 29% CDP571 Placebo not reported
Targan et al[4] (n=108)	Infliximab 5 mg/kg 10 mg/kg (1 dose)	CDAI 220–400 (37% on azathioprine)	12 weeks	*Fall in CDAI>70 points after 4 weeks* 65% infliximab 17% placebo	*CDAI<150 after 4 weeks* 33% infliximab 4% placebo
Present et al[5] (n=94)	Infliximab 5 mg/kg 10 mg/kg (1 dose)	Draining perianal or abdominal fistula	14 weeks	*>50% reduction number of fistulae* 62% infliximab 26% placebo	*All fistula closed* 46% infliximab 13% placebo
Rutgeerts et al[6] (n=73)	Infliximab 10 mg/kg 8 weekly (4 doses)	Patients who had responded to a single dose of 5 mg/kg	36 weeks	*Fall in CDAI>70 points after 8 weeks* 62% infliximab 37% placebo	*CDAI<150 after 8 weeks* 53% infliximab 20% placebo

Bell S, et al. Lancet 2000

Korelitz BI

The role of liquid diet in the management of small bowel Crohn's disease

Inflamm Bowel Dis 2000;6:66-7

Yamamoto T, Keighley MR

Smoking and disease recurrence after operation for Crohn's disease

Br J Surg. 2000 Apr;87(4):398-404

- Smoking significantly increases the risk of recurrence of disease after operation for Crohn's disease, especially in women and heavy smokers.
- Encouraging patients to stop smoking is an important part of the management of Crohn's disease.

Yamamoto T, et al. Br J Surg 2000

Lochs H, Mayer M, Fleig WE, et al.

Prophylaxis of postoperative relapse in Crohn's disease with mesalamine
European Cooperative Crohn's Disease Study VI.

Gastroenterology 2000 Feb;118(2):264-73

Ewe K, Bottger T, Buhr HJ, Ecker KW, Otto HF

Low-dose budesonide treatment for prevention of postoperative recurrence of Crohn's disease
A multicentre randomized placebo-controlled trial.
German Budesonide Study Group.

Eur J Gastroenterol Hepatol 1999 Mar;11(3):277-82

Hellers G, Cortot A, Jewell D, et al.

Oral budesonide for prevention of postsurgical recurrence in Crohn's disease.
The IOIBD Budesonide Study Group.

Gastroenterology 1999 Feb;116(2):294-300