Healthier Together

Improving health and care in Bristol, North Somerset and South Gloucestershire

Crohn's Disease (Moderate to Severe)

BNSSG Recommended Biologic Commissioning Pathway

1st Line Treatment options — Adalimumab or Infliximab (TA 187)

2nd Line Treatment option — Upadacitinib (TA 905)

3rd Line Treatment option — Ustekinumab (TA 456) or Risankizmab* (TA 888)
*After discussion at an MDT

4th Line Treatment option — Vedolizumab (TA 352) or Risankizmab (TA 888)

4th Line treatments are the end of the commissioned pathway

NICE Criteria to start treatment

Patients with severe active CD, which has responded inadequately to conventional therapy, or who cannot take/tolerate, or have medical contraindications for these are eligible for treatment with a biologic.
Severe CD is defined as very poor general health & 1 or more symptoms e.g. weight loss, fever, severe abdominal pain and usually frequent (3–4 or more) diarrhoeal stools daily. This normally, but not exclusively, corresponds to a Crohn's Disease Activity Index (CDAI) score of 300 or more, or a Harvey- Bradshaw score of 8 to 9 or above.

Choosing which biologic treatment

NICE does not make specific recommendations on the sequential use of biologics in CD
The choice of treatment should be made on an individual basis, between the patient and clinician. If treatments are found to be equally suitable for the patient the drug with the lowest overall costs should be used. This is reflected in this pathway document.

Use of Biologics Post Surgery

Routine use of biologics as post-surgery prophylaxis in CD is not recommended. For further details see BGS Guidance: https://www.bsg.org.uk/wp-content/uploads/2019/12/BSG-IBD-Guidelines-2019.pdf

Continuation of Biologic Treatment

Treat for 12 months or until treatment failure (including the need for surgery), whichever is shorter, then review and discuss the risks and benefits of continued treatment.
Continue only if there is evidence of response as determined by clinical symptoms, biological markers and investigation, including endoscopy if necessary.
Reassess at least every 12 months to determine whether ongoing treatment is still clinically appropriate.
Consider a trial of withdrawal for patients who are in stable clinical remission. If disease relapses after treatment is stopped patients should have the option to start treatment again.

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