

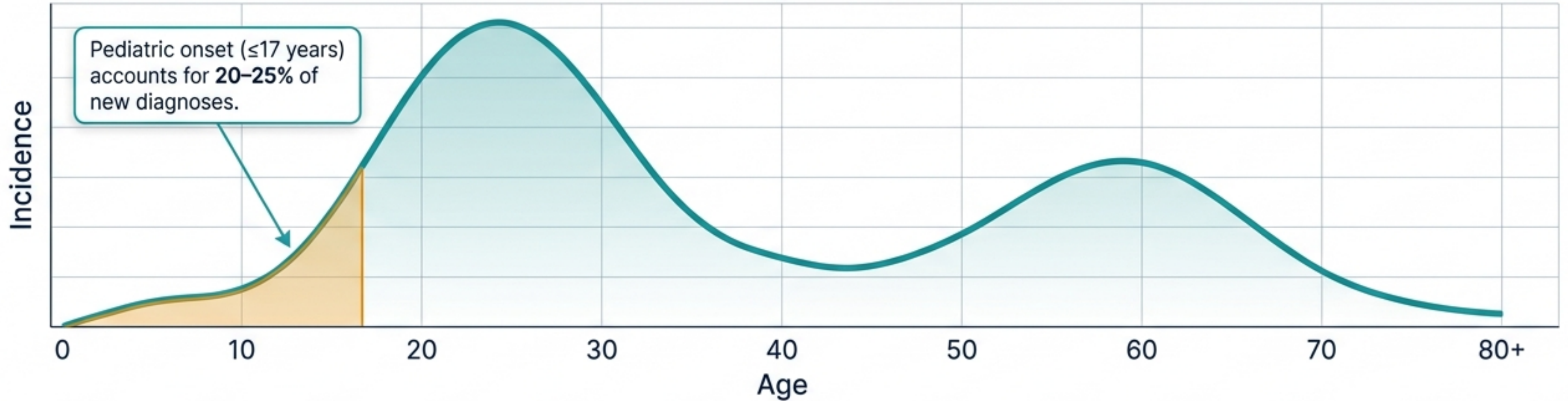
Suspected Inflammatory Bowel Disease

The Primary Care Protocol

An actionable clinical pathway for detection, investigation, triage, and interim management in the Australian healthcare context.

The Australian Burden Map

Bimodal Activation Curve



Prevalence:

85,000–100,000

Australians affected
(0.4–0.7% of the population).



Incidence Rates:

Ulcerative Colitis:
24–30 per 100k/yr.

Crohn's Disease:
15–17 per 100k/yr.



Economic Cost:

\$2.7 billion total
annual burden.



Diagnostic delay >12 months in Crohn's disease independently drives higher rates of stricturing and penetrating complications.

Primary care recognition is the defining factor in patient outcomes.

Differential Diagnosis: Crohn's vs. Ulcerative Colitis

Core Symptom	Crohn's Disease (CD)	Ulcerative Colitis (UC)	Clinical Significance
Chronic Diarrhea (>4 weeks)	Watery, loose, crampy pain	Frequent, small-volume, bloody	Nocturnal diarrhea highly suggests organic disease
Rectal Bleeding	Less common (unless colonic)	Present in >90% at diagnosis; hallmark	Exclude colorectal malignancy in >40 years
Abdominal Pain	Right iliac fossa most common; colicky	Diffuse/left-sided; improves with defecation	
Weight Loss	Common (malabsorption)	Less prominent unless severe	>5% in 3-6 months is a red flag
Tenesmus/Urgency	Tied to rectal/perianal disease	Very common with proctitis	
Perianal Disease	Fissures, fistulae, abscesses in 25-35%	Rare	Highly differentiating feature

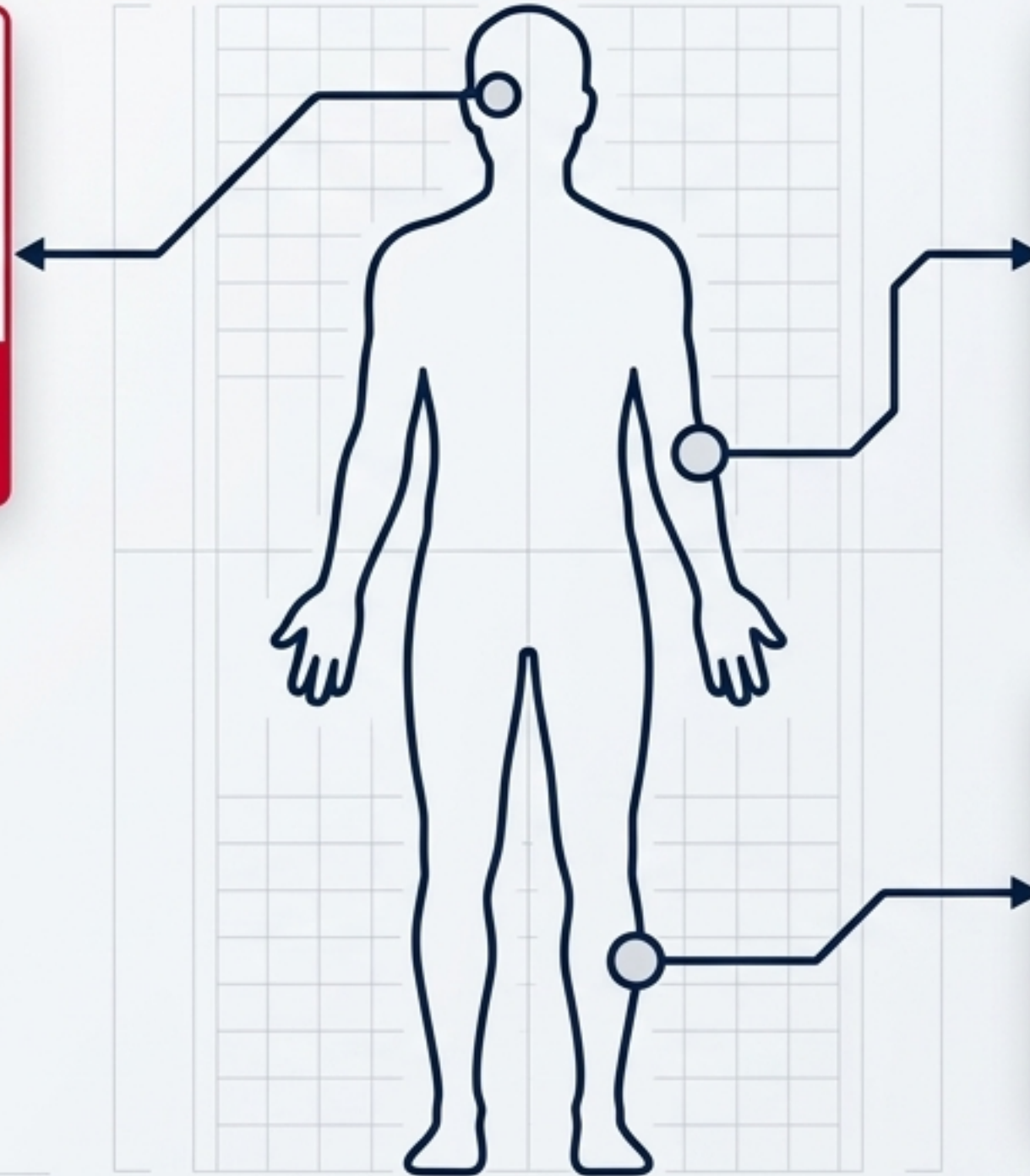
Extraintestinal Manifestations (EIMs): Systemic Impact

Ocular (Eyes)

Uveitis & Episcleritis

Uveitis presents with pain, photophobia, visual changes.

Sight-threatening emergency. Same-day ophthalmology review required.



Musculoskeletal (Joints)

Arthralgia & Arthritis (20-30%).

Peripheral large-joint pauciarticular arthritis tracks with disease activity. Axial spondyloarthropathy runs an independent course.

Action: Consider HLA-B27 and SI joint imaging.

Dermatological (Skin)

Erythema Nodosum & Pyoderma Gangrenosum.

Erythema nodosum (shins) tracks with activity. Pyoderma gangrenosum (deep limb ulcers) is independent.

Action: Requires urgent dermatology input.



Perianal Presentation: A young adult with recurrent perianal abscesses or fistulae-in-ano must be evaluated for underlying Crohn's disease.

Triage Logic: Distinguishing IBD from IBS

The IBS Baseline

IBS affects ~15% of Australian adults.

Symptoms overlap significantly with early IBD.

IBS is generally non-inflammatory, non-progressive, and presents before age 40.

Organic Red Flags (Rule out IBS)

- ⚠ Any rectal bleeding (IBS does not cause bleeding).
- ⚠ Nocturnal diarrhea or pain waking the patient from sleep.
- ⚠ Unintentional weight loss.
- ⚠ Fever or systemic symptoms.
- ⚠ Iron-deficiency anemia or elevated inflammatory markers.
- ⚠ Onset after age 50.



Never dismiss rectal bleeding as hemorrhoids without investigation. Faecal occult blood testing alone is insufficient to rule out IBD.

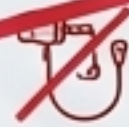
The Diagnostic Toolkit Breakdown

The Do Not's



CT Abdomen/Pelvis:

Exposes to unnecessary radiation; MRI enterography preferred via specialist.



Primary Colonoscopy:

Do not request independently; refer to gastroenterologist for planned biopsy mapping.



pANCA/ASCA Serology:

Insufficient utility for primary care diagnosis.

The Contextual Add-ons



Basic Metabolic Panel / LFTs / Iron Studies / B12 & Folate.



Coeliac Serology (MBS 66570) / TSH / HIV testing.

The Essentials (Primary Care Baseline)

Full Blood Count (MBS 66551):



Check for microcytic/normocytic anemia, leucocytosis.

CRP & ESR (MBS 66552):



CRP >5 mg/L or ESR >20 mm/hr. Note: Normal CRP does not exclude IBD (up to 20% of active CD have normal CRP).

Faecal Calprotectin (MBS 69234):



The definitive primary care differentiator.

Stool Microscopy & Culture (MBS 69300):



Must exclude *C. difficile*, *Salmonella*, *Shigella*, *Campylobacter*.

Faecal Calprotectin: The Primary Care Differentiator

Amber Zone (50–249 $\mu\text{g/g}$):

Borderline.

Intermediate result.
Requires clinical correlation
and repeat testing in 4–6 weeks.

Red Zone (≥ 250 $\mu\text{g/g}$):

Urgent.

Positive Predictive Value ~80-90%.
Highly suggestive of mucosal
inflammation. Warrants urgent
specialist referral.

Green Zone (<50 $\mu\text{g/g}$):

Unlikely.

Negative Predictive
Value ~99%. Active IBD
highly unlikely in adults.

Contextual Notes

- i** **Funded under Medicare (MBS item 69234).** Provide container at consultation to avoid 3-5 day lab delays.
- i** **False Positives Caution:** NSAIDs, PPIs, GI infections, and colorectal malignancy can elevate results.








Triage Algorithm: Specialist Referral Logic

Gastroenterology Referral




Emergency (Immediate ED Transfer)

Acute Severe Colitis.
Bloody diarrhea >6/day, fever, tachycardia >90 bpm, Hb drop, signs of peritonitis.
Action: Do not wait for outpatient referral.

Urgent Pathway (Target: 2-4 Weeks)

-  Weight loss >5% or Iron-deficiency anemia (Hb <100 g/L).
-  Significant/ongoing rectal bleeding.
-  Faecal calprotectin ≥ 500 $\mu\text{g/g}$ or CRP >50 mg/L.
-  Suspected perianal fistula/abscess or stricture.
-  Young patient (<16 years).

Routine Pathway (Target: 4-8 Weeks)

-  Mild, intermittent symptoms without alarm features.
-  Calprotectin 50–249 $\mu\text{g/g}$ with mild symptoms.
-  Chronic diarrhea >6 weeks with normal/mildly abnormal bloods.

Executing the Handover: Referral Data

Required Referral Inputs

- ✓ Duration and precise nature of symptoms (nocturnal waking, bleeding frequency).
- ✓ Extraintestinal features (joints, skin, eyes, mouth) and perianal symptoms.
- ✓ Smoking status (crucial: worsens CD, protective in UC).
- ✓ Family history (IBD, Coeliac, Colorectal cancer).
- ✓ Current medications (explicitly note NSAIDs, antibiotics, OCP).
- ✓ Quantitative lab results (FBC, CRP, ESR, exact Calprotectin value, stool MCS clearance).

Specialist Note: Patients with suspected perianal Crohn's require urgent surgical co-management (EUA with MRI pelvis) and should **not** be managed with simple incision and drainage in primary care.

Interim Management: The 2–8 Week Waiting Period



Pillar 1: Hydration

Encourage **>2L/day**.

Commercial **oral rehydration solutions** (ORS) preferred for **>4 loose stools/day**.

Avoid **high-sugar** carbonated drinks (worsens osmotic diarrhea).

Monitor elderly for AKI.



Pillar 2: Nutritional Optimization

Malnutrition affects **20-50%** at diagnosis.

Refer to Accredited **Practising Dietitian (APD)** early via GP Management Plan (MBS 10950–10970).

Target protein **1.0–1.5 g/kg/day**.



Pillar 3: Safety Netting

Schedule **GP follow-up** at **2-4 weeks** to check lab trajectory (recheck FBC/CRP).

Advise **immediate return** if new fever, constant pain, or worsening bleeding occurs.

Escalate referral if not seen by 8 weeks.

Primary Care Medication Pitfalls: DO NOT PRESCRIBE

Avoid NSAIDs



Non-steroidal anti-inflammatory drugs (ibuprofen, naproxen, diclofenac) are heavily associated with triggering disease flares, GI ulceration, and IBD-related hospitalizations.

Action: Use paracetamol for analgesia. Consult gastroenterologist if escalating.

Avoid Empirical Antibiotics



Do not prescribe blind antibiotics for suspected IBD. They disrupt gut microbiota and exacerbate symptoms. Antibiotics are only indicated for confirmed concurrent GI infections.

Action: If *C. difficile* is confirmed via stool MCS, prescribe oral vancomycin 125 mg QID for 10 days.

Safe Pharmacotherapy in Primary Care



Iron Supplementation (For Anemia)

Oral (Ferrous Sulphate 325mg):
Alternate-day dosing preferred for absorption/tolerance. **Worsens GI symptoms.**

IV (Ferric Carboxymaltose - Ferinject):
Up to 1000mg IV. Indicated if oral iron intolerant, Hb <90 g/L, or ongoing blood loss. Monitor for hypophosphatemia.



Antimotility Agents (Loperamide)

Dose: 2mg PO after loose stools (max 16mg/day).

Strict Indication: Symptomatic relief ONLY after infection (*C. difficile*) is fully excluded via stool culture.

Crimson Contraindication: Absolutely contraindicated in acute severe colitis due to high risk of toxic megacolon.

Clinical Modifiers: Special Populations



Pregnancy

Untreated disease poses greater fetal risk than medication. Urgent referral.

Mesalazine safe; Methotrexate **strictly contraindicated (teratogenic)**.



Paediatrics (<6yrs)

May present atypically (growth failure, delayed puberty).

Normal calprotectin is higher in <4 years (up to ~200 µg/g).

Refer to pediatric GI.



Elderly (≥65yrs)

UC > CD. High risk of dehydration/AKI.

Polypharmacy risk (NSAIDs).

Screen carefully for concurrent colorectal cancer.



Renal Impairment

Baseline U&E/eGFR required.

Mesalazine carries rare risk of interstitial nephritis. Watch for electrolyte derangement.



Hepatic Impairment

Primary Sclerosing Cholangitis (PSC) coexists with UC in 3-5%.

Elevated ALP/GGT requires MRCP and hepatology referral.



Immunocompromised

Rule out opportunistic infections (CMV colitis requires CMV PCR, MAC, C. difficile) before assuming IBD flare.

Aboriginal and Torres Strait Islander Health Considerations



Diagnostic Vigilance

Overlap with endemic infections (Giardia, Strongyloides) causes diagnostic overshadowing.

Do not attribute chronic diarrhea (>4 weeks) solely to infection without investigating for IBD.



Specialist Access & Geography

Utilize Telehealth (MBS 99200–99215) and activate Patient-Assisted Travel Schemes (PATS) early for remote patients requiring endoscopy.



Point-of-Care Testing

Utilize POC CRP testing (Afinion, i-STAT) at ACCHS.

Coordinate rapid specimen transport for Faecal Calprotectin to avoid 7-14 day delays in remote areas.



Cultural Safety & Access

Use clear language; involve Indigenous health workers. Ensure Closing the Gap PBS Co-Payment is applied, and coordinate S100 Highly Specialised Drugs via Remote Area Aboriginal Health Services.



The IBD Primary Care Protocol: Master Synthesis

