



## **INFLAMMATORY BOWEL DISEASE**

### **1. Medical Condition**

Inflammatory Bowel Disease (IBD) specifically includes Crohn's disease and ulcerative colitis but also embraces colitis of indeterminate cause seen in about 10% of cases. It is well known that these conditions may have a familial tendency. IBD affects people of all ages but usually begins before age 30, with peak incidence from 14 to 24. IBD may have a second smaller peak between ages 50 and 70; consequently it is not uncommon for active young athletes to seek exemption to use prohibited substances including glucocorticoids for the long-term management of their bowel disease.

### **2. Diagnosis**

#### **A. Medical history**

Inflammatory bowel disease (IBD) carries a characteristic medical history that may include altered bowel habit, fever, abdominal pain, anorexia and weight loss. In the very young there may be a history of growth retardation. Toxic complications in ulcerative colitis are a common and serious complication. A family history is an important historical correlate.

#### **B. Diagnostic criteria**

Given a suspicious history and family history, the definitive diagnosis of IBD demands specific investigations carried out under the supervision of a specialist-gastroenterologist. Apart from routine laboratory screening to confirm the presence of inflammation and anaemia, imaging of the gastrointestinal tract is required to assess the extent, distribution and severity of Crohn's Disease. Direct imaging techniques such as gastroscopy, enteroscopy and colonoscopy permit the taking of biopsies that demonstrate specific pathological features at selected sites. Computerised Tomography (CT) scan or virtual colonoscopy may also be employed. Ulcerative colitis on the other hand requires stool examination, sigmoidoscopy to demonstrate typical mucosal changes and biopsy evidence of chronic inflammation and altered mucosal vascularity.

C. Relevant medical information

A relevant medical history of functional bowel disturbance and associated weight loss, anorexia and inappropriate fatigue is frequently obtained by the primary care/family physician. Where the patient is also an elite athlete there is added urgency to seek specialist opinion and diagnostic confirmation. Clearly during periods of acute exacerbation of IBD it is unlikely that an athlete would be fit for training or competition.

### 3. Medical best practice treatment

A. Name of prohibited substance

Glucocorticoids are a critical adjunct in the treatment of IBD.

B. Route

All systemic administration (intravenous, oral, rectal) are prohibited.

C. Frequency

Large doses of oral prednisone (40-60mg per day) may be necessary in the acute management of IBD tapering over a period of weeks to months. Acute ulcerative colitis may also require high dose systemic corticoids. Intravenous hydrocortisone 300 mg/day or methylprednisolone 60-80 mg/day by continuous drip or in divided doses may be used for severe disease. In hospital intravenous hydrocortisone would not require a TUE. Doses are individualized and demand specialist oversight in combination with other appropriate therapeutic agents. A small proportion of patients with IBD become corticoid-dependant and requires long-term maintenance.

D. Recommended duration of treatment

Given the chronic nature of IBD, the duration of treatment for athletes is likely to be lifetime or at least for the life of their exposure to high performance sport.

#### **4. Other non-prohibited alternative treatments?**

Permitted agents including immunomodulating drugs, 5-aminosalicylates, analgesics and antibiotics may be used in conjunction with glucocorticoids. No other permitted alternative drugs exist that provide the same effect as glucocorticoids.

#### **5. Consequences to health if treatment is withheld**

If untreated, IBD may run an undulating, unremitting course with a fatal outcome.

#### **6. Treatment monitoring**

During periods of remission from inflammatory bowel disease the athlete may be totally asymptomatic. Treatment is routinely monitored by the family physician with recommended review by the specialist - gastroenterologist at least annually or as clinically indicated.

Indices exist for scoring the activity of IBD and these may be applied to the initial assessment of acute exacerbations of the disease.

#### **7. TUE validity and recommended review process**

The recommended duration of a TUE for Inflammatory Bowel Disease is 4 years with an annual review by a specialist physician.. A common sense approach should always be adopted with respect to IBD, given the altered requirements of glucocorticoids during acute crises or periods of remission. Athletes must be able to provide documentation for any acute crises that requires the use of a prohibited substance.

#### **8. Any appropriate cautionary matters**

The sustained use of systemic glucocorticoids carries well- documented long-term risks.

## 9. References

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