



Following the publication of research in the LANCET on 10th February 2010, about an increased risk of blood clotting for people who have Inflammatory Bowel Disease, NACC's Medical Advisers have produced the following explanatory statement for journalists and patients.

Risk of venous thromboembolism in inflammatory bowel disease

Venous thromboembolism (VTE) is a condition in which clotting occurs in a vein, usually in the legs. This often causes little in the way of symptoms, but many patients will get pain or swelling in the affected leg (deep venous thrombosis, DVT). In a minority of patients, small pieces of clot in the leg veins can break off and go to the lung circulation (pulmonary embolus, PE), where they can cause shortness of breath and chest pain. Patients with these symptoms need to go urgently to hospital for appropriate tests and treatment with anticoagulants.

It has long been known that patients with IBD are at increased risk of VTE when they are ill in hospital with active disease. For this reason, all patients with IBD admitted to hospital should routinely be given preventive treatment with injections of the anticoagulant drug, heparin, often with compression/support stockings to improve the circulation through the leg veins.

The study published in the Lancet compared the rate of VTE in about 13000 patients with IBD with that in appropriate matched control patients (without IBD) over the years 1987-2001. Active IBD was defined by the need to use steroids. The study confirmed that the risk of getting a deep venous thrombosis (DVT) or pulmonary embolus (PE) is increased about three-fold in hospitalised patients with IBD. For the first time, however, it showed that the risk was also raised in patients with active IBD who are not in hospital.

The increase in risk of VTE in non-hospitalised patients with active IBD was about 16 times that of the controls.

A few points should be made to put these apparently alarming figures into perspective for people with IBD:

- While the VTE risk seems high when expressed as a ratio, the rate of VTE in the controls was of course extremely low: indeed the absolute risk in non-hospitalised patients with active IBD was only about 1 in 500 flares.
- Many flares of IBD are not severe enough to need steroid treatment and patients with such lesser relapses have not been shown by this report to have an increased risk of VTE.

- Much of the period used for collection of these results preceded the widespread use of azathioprine or other immunomodulator drugs, or, for Crohn's disease, infliximab and adalimumab: it is possible that the risk of VTE if assessed now would be lower than it was in 1987-2001 because patients with active disease may conceivably now have less complex and extensive disease when they flare up.
- In 1987-2001, heparin was much less widely used as a preventive measure than it is now when patients with active IBD are admitted to hospital.

What is the practical significance of these findings for patients with IBD?

1. Patients should be reassured in knowing that if they are admitted to hospital with active IBD they will be given injections of heparin often with the addition of support stockings.
2. If patients do have severe flare ups needing intensification of their IBD treatment while not in hospital, they should keep as mobile as possible, drink plenty of fluids and wear support stockings: all these measures reduce the risk of DVT. They should also not smoke (another risk factor for VTE).
3. If patients with active IBD outside hospital do get pain or swelling in the legs (particularly in the calf), or develop chest pain or shortness of breath, they should tell their GP, IBD nurse or IBD consultant IMMEDIATELY; if this is not possible, they should go to their local A & E straight away, so as to get instant investigation and if necessary treatment for VTE if it is found to have occurred.

NACC
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