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My IBD Worksheet

Name ___________________________  Date of Birth _____/_____/_____

Physician(s) ____________________________________________________

IBD History:

What type of IBD do I have?
☐ Ulcerative colitis  ☐ Crohn’s disease  ☐ Indeterminate colitis  ☐ I don’t know

Where is my IBD located?
☐ Small intestine  ☐ Colon  ☐ Rectum  ☐ Colon  ☐ I don’t know  ☐ Other __________

Date of diagnosis? _____/_____/_____

My Surgeries:

<table>
<thead>
<tr>
<th>SURGERY</th>
<th>DATES</th>
<th>HOSPITAL</th>
<th>WHY WAS THE SURGERY DONE?</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

My Medications:

What are your medications? Please list the dosages and how often you take them.

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________
Preparing for My Next Visit

**Recordkeeping:**
It is very important that you update your IBD health care team about any new health problems you have or any ER visits or hospital stays. Please try to bring records for discharge summaries and reports of any tests, such as endoscopies, CT scans, MRIs, stool tests and blood tests that were not done through UF. If you cannot obtain these records on your own, call our patient navigator to obtain the records for you.

**Preparing a list of questions:**
Generating a list of questions to ask your IBD health care team before your visit will make sure that you do not forget to ask any of your burning questions. Your care team will not be able to answer your questions unless you ask. Please use the chart below to generate a list of questions before your next visit.

<table>
<thead>
<tr>
<th>QUESTIONS AND CONCERNS</th>
<th>ANSWERS AND COMMENTS</th>
</tr>
</thead>
<tbody>
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</table>
Welcome!

Welcome to the UF Inflammatory Bowel Disease Clinic

We are glad you have chosen us to help you manage your inflammatory bowel disease. This binder is a resource that will help you take an active role in your medical care. It will also help you understand inflammatory bowel disease and how it will impact your life. We have included our contact information, as well as pages to record your questions and current medicines. You will also find information about treatment options and other helpful resources.

The quality of your care is our number one goal. We are a team of physicians, clinical pharmacists, registered nurses, and patient navigators. We want to partner with you to make sure you have the best quality of life possible. To do this, we ask you to come to all of your visits and take your medicines as prescribed by your gastroenterologist.

We need to see you at least once every 6 to 12 months and maybe more often, if necessary. Your well-being is our number one concern. If it is easier, you may have some blood tests done at a lab close to your home. Please ask the lab to fax us the results. If you are not able to attend your scheduled clinic visits or have lab tests done as needed, we are not able to care for you safely and your health can be affected. We look forward to getting to know you. We will work together toward your goals so that you can live your life to the fullest.
Meet Your Care Team!

Gastroenterologists

Naeun Chaudhry, MD
Angela Pham, MD
Devi Saroja Rampertab, MD
Ellen Zimmermann, MD

Colorectal Surgeons

Johan Nordenstam, MD
Thomas Read, MD
Krista Terracina, MD

Rheumatologists

Blas Betancourt, MD
Michael Bubb, MD
Wesley Reeves, MD
Catalina Sanchez, MD
Eric Sobel, MD
Meet Your Care Team!

**Immunologists**
- Lyda Cuervo Pardo, MD
- Misu Paul, MD

**IBD Dermatologist**
- Marie Longo, MD

**Additional IBD Staff**
- Tim Edminister, PharmD
  IBD Clinical Pharmacist
- Nell Wade, RN
  IBD Triage Nurse
- Karen Yung
  IBD Patient Navigator

**Clinical Psychologist**
- Lori Waxenberg, PsyD

**ECHO Staff**
- Manavii Kumar
  IBD Health Coach
- Avery Weisman
  IBD Health Coach
What is inflammatory bowel disease?

Inflammatory Bowel Disease (IBD) is a chronic disease, which means that it is lifelong and always present, even if the symptoms come and go. While there is no cure yet, proper disease management helps many patients successfully reach and stay in remission, or a stage where their symptoms are under control.

IBD causes inflammation in the gastrointestinal tract (Figure 1), such as the stomach, the small intestine and the large intestine, but it can also affect other regions of the body including the skin, joints and eyes. Inflammation can suddenly increase, often unpredictably, leading to an increase in symptoms that are commonly called “flares.” Having IBD affects your ability to absorb nutrients that your body needs every day.

The cause of IBD is not completely understood, but is believed to be related to a combination of genetic, bacterial (microbiome) and immune system factors. Current theories suggest that individuals with IBD have an immune system that has developed an aggressive response to harmless intestinal bacteria. Several genes have been linked to an increased risk or severity of IBD, however no single gene is clearly causative. There are three types of IBD, ulcerative colitis, Crohn’s disease and indeterminate colitis.
What is ulcerative colitis?

Ulcerative colitis (UC) causes inflammation and ulcers in the large intestine including the colon and the rectum. An ulcer is an open sore that fails to heal. The inflammation from ulcerative colitis is continuous, which means that it does not stop and then start again in a different part of the colon. Further, the inflammation is limited to the innermost lining of the colon, helping to separate ulcerative colitis from Crohn's disease. Ulcerative colitis is different from irritable bowel syndrome, infectious colitis and ischemic colitis because it is caused by chronic immune-mediated inflammation.

What is Crohn’s disease?

Crohn’s disease can affect any part of the digestive tract: mouth, esophagus, stomach, small intestine or the colon. The most common area affected is at the end of the small intestine, called the terminal ileum. The inflammation usually occurs in segments, with healthy segments in between inflamed segments. This patchy, “skip lesion” behavior of Crohn’s disease is different from ulcerative colitis. In addition, Crohn’s disease can affect deep layers of the intestine, further distinguishing it from ulcerative colitis. Crohn’s disease can be called Crohn’s ileitis when only the ileum is affected, Crohn’s colitis when only the colon is affected or Crohn’s ileocolitis when both the ileum and the colon are affected.

What is indeterminate colitis?

Indeterminate colitis is when features of both Crohn’s disease and ulcerative colitis are present. Indeterminate colitis only affects the colon, but it is not the same as ulcerative colitis. IBD may be called indeterminate colitis when biopsy cells under the microscope look more like cells from a person with ulcerative colitis, but with the naked eye, the inflammation in the colon looks more like that of Crohn’s disease — with isolated segments of inflammation and deep, long ulcerations.

What are the symptoms of IBD?

The severity of IBD symptoms varies greatly between patients. In general, as the lining of the intestine becomes inflamed, it may lose its ability to process food and absorb water, resulting in diarrhea and weight loss. Other common symptoms of IBD include bloody stools, abdominal pain, cramping, urgency (the need to have a bowel movement quickly) and tenesmus (frequent urges to have a bowel movement, but passing very little stool). IBD may also affect other body systems causing dental, eye, and joint problems among many.
Complications of Inflammatory Bowel Disease

- **Structures**: A scar that is your body’s attempt at healing prolonged severe inflammation of the intestine; in the process this causes a narrowing of the intestine. Narrowing of a region of your intestine can make it more difficult for solids, liquid, and gas to pass. This can cause symptoms of bloating with distension of the abdomen, nausea, and sometimes vomiting, especially after meals.

- **Bowel obstruction**: Occurs when a stricture develops where contents are unable to pass through your intestine. A long-term obstruction raises the pressure in the part of the intestine upstream of the blocked area. This pressure can cause the intestinal wall to burst. This is quite painful and requires immediate surgery.

- **Fistula**: A tunnel between the intestine and another close structure like the skin, pelvis, bladder, or another section of bowel. It is often the result of deep inflammation. They often occur in the perianal area (the internal and external region of the anus).

- **Abscess**: A collection of infected pus that can occur in the abdomen or anus which requires urgent medical attention. They lead to abdominal pain and fever. Abscesses can form when a fistula is not able to drain.

- **Joint and bone problems**: People with IBD also often have decreased vitamin D, which can lead to bone loss (osteopenia or osteoporosis). In addition, prolonged high-dose steroid use can also accelerate bone loss. Some individuals with IBD will develop an inflammatory arthritis of large or small joints; this occurs in approximately 15-20% of the IBD population.

- **Malnutrition**: Many patients with IBD have vitamin and mineral deficiencies. Iron deficiency is one of the most common, which can lead to anemia with resulting fatigue. Iron stores are often checked by your physician. Iron levels can be easily restored through oral or IV iron supplements.

- **Colon cancer**: Long-term inflammation of the colon can lead to precancerous changes called dysplasia; this is different from typical colon polyps which occur in everyone. When dysplasia is present the risk of developing colon cancer increases substantially. For these reasons, patients with UC or Crohn’s disease affecting the colon require frequent colonoscopies to prevent the development of colon cancer.
Surgeries for Ulcerative Colitis

Ulcerative colitis
People with complications of severe ulcerative colitis such as perforation (hole in lining of intestine) or severe bleeding need surgery right away. People who have ulcerative colitis for a long time, have a higher risk for colon cancer. Pre-cancerous changes or colon cancer are other reasons for surgery. Because ulcerative colitis only affects the colon, once the colon is removed, symptoms are much better. The surgery can be done either openly (a large cut) or laparoscopically (a few small cuts). Sometimes, two or three separate operations are needed.

Common types of surgeries for ulcerative colitis:
- **Proctocolectomy**: This type of surgery removes the colon and the rectum. It is sometimes called a colectomy. A permanent ileostomy may need to be done. Other times an ileal pouch — anal anastomosis (connection) is done.
- **Ileostomy**: This is done after a proctocolectomy. It involves bringing the end of the small intestine (ileum) through a hole (stoma) in the wall of the abdomen. This allows the intestinal contents (waste) to drain into an ostomy bag worn outside the body.
- **Ileal pouch — anal anastomosis**: This is also called a restorative proctocolectomy. This allows a person to pass stool through the anus. It is done by removing the colon and rectum, then turning the ileum into a pouch and connecting it to the anus. An ostomy bag is worn for about 12 weeks so that the internal pouch can heal.
- **Subtotal colectomy**: This involves removing only part of the colon. The rectum or the rectum and part of the sigmoid colon (last 10-20 cm) is not removed.
Crohn’s disease

Surgery cannot cure Crohn’s disease, but it may greatly improve symptoms and quality of life. However, the disease often reappears in another area of the intestines. This is mostly likely to occur where the surgery was done. About two-thirds to three-quarters of people with Crohn’s disease will need surgery at some point.

Common types of surgeries for Crohn’s disease:

- **Fistulotomy**: The most common surgery to repair a fistula is a resection (removal of affected part) and anastomosis (reconnecting healthy parts).
- **Treating abscesses**: An abscess may be treated in one of two ways: It may be drained by inserting a needle in the skin, or the abscess may be removed.
- **Resection**: This is the most common type of surgery done for Crohn’s disease. The affected part of the intestine is removed and the two healthy ends of the intestine are attached. Putting the two ends together is called an anastomosis.
- **Strictureplasty**: This is done to widen a stricture (narrowing) in the small intestine. A cut is made along the narrowed area, the two ends of the cut are pushed together, and then the intestine is sewn together.
- **Colectomy**: This involves removing the entire colon. Sometimes a permanent ileostomy is done. Other times an ileal pouch – anal anastomosis (connection) is performed.
- **Proctocolectomy**: This involves the removal of both the colon and the rectum. Sometimes a permanent ileostomy is done. Other times an ileal pouch–anal anastomosis (connection) is performed.
- **Ileostomy**: This is done most commonly after a proctocolectomy. It involves bringing the end of the small intestine (ileum) through a hole (stoma) in the wall of the abdomen. This allows the intestinal contents (waste) to drain into an ostomy bag worn outside the body.
There are many different medications that will help you with your IBD. Oftentimes patients are prescribed multiple medications at once for the best effect. Additionally, combining these medications with diets and other supplements will further enhance your quality of life and bring you closer to the goal of remission. Currently there are four classes of medications designed to help patients with IBD, these are: Aminosalicylates, Steroids, Immunomodulators and Biologics.

- **Aminosalicylates**: Aminosalicylates are anti-inflammatory drugs that contain 5-aminosalicylic acid (5-ASA). These drugs work by inhibiting the production of biological factors responsible for the acute inflammatory response. In other words, these drugs act specifically at the site of inflammation to decrease the cell’s inflammatory response. These drugs have a higher success rate in ulcerative colitis patients than Crohn’s disease patients.

- **Steroids**: Steroids are used during flare-ups to put you into or towards remission because they reduce inflammation relatively quickly. Steroids are not commonly used as a medicine to maintain remission because of the long-term side effects. The two most commonly prescribed steroids for IBD are prednisone and budesonide (Entocort and Uceris). Budesonide just works in the bowel, while prednisone can affect the whole body. Budesonide also has fewer side effects than prednisone, because it becomes inactive once it is absorbed by the body. For this reason budesonide can be a good choice to control disease flares for people who cannot tolerate prednisone. Prednisone may be chosen over budesonide because it will work faster to prevent your flare from getting out of control so that you do not need to be in the hospital or have surgery.

- **Immunomodulators**: Immunomodulators are a chemical agent that modify the immune response or function of your immune system in order to stop inflammation. These medications often weaken or suppress your immune system. The goal of immunomodulators is to limit your immune system’s ability and desire to attack its own healthy cells.

- **Biologics**: Biologics are the newest form of treatment for IBD patients. They are a solution of genetically-engineered proteins made from human genes. They are designed to stop specific components of the immune system that play a role in attacking the healthy cells of your digestive tract. This will in turn limit the inflammation that your intestines are experiencing. Biologics are usually only recommended for people with moderate to severe disease that have not responded well to other therapies.
Below is a chart of the most commonly prescribed medications for IBD:

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>DRUG CATEGORY</th>
<th>ROUTE TAKEN</th>
<th>AVERAGE DOSE</th>
<th>EFFECTS BEGIN</th>
<th>COMMON SIDE EFFECTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mesalamine (Pentasa™, Asacol™ and Lialda™)</td>
<td>Aminosalicylates</td>
<td>Pill</td>
<td>400-800 mg 3x/day</td>
<td>2-4 weeks</td>
<td>Headaches, abdominal pain, belching, nausea, diarrhea and sore throat</td>
</tr>
<tr>
<td>Prednisone</td>
<td>Steroid</td>
<td>Pill</td>
<td>40-60 mg/day followed by a taper</td>
<td>Within a few days</td>
<td>Increased hunger, weight gain, trouble sleeping, mood changes, acne, slow wound healing, dry skin, menstrual problems and impotence</td>
</tr>
<tr>
<td>Controlled Ileal-Release Budesonide (Entocort™)</td>
<td>Steroid</td>
<td>Pill</td>
<td>9 mg/day followed by a taper</td>
<td>Within a week</td>
<td>Headache, nausea, diarrhea, respiratory infection and joint pain</td>
</tr>
<tr>
<td>Extended-Release Budesonide (Uceris™)</td>
<td>Steroid</td>
<td>Pill</td>
<td>9 mg/day</td>
<td>2 weeks</td>
<td>Acne, mood changes, sleep changes and rounding of face</td>
</tr>
<tr>
<td>Azathioprine</td>
<td>Immuneomodulator</td>
<td>Pill or Injection</td>
<td>1.5-3 mg/kg/day</td>
<td>2-4 months</td>
<td>Nausea, vomiting, gastritis, fever, malaise, diarrhea, low white blood cell count, low platelet count, liver toxicity and muscle pain</td>
</tr>
<tr>
<td>Methotrexate</td>
<td>Immuneomodulator</td>
<td>Pill or Injection</td>
<td>10-25 mg/week</td>
<td>4-8 weeks</td>
<td>Increased risk of infection, skin reactions, liver and kidney damage, mouth sores and bone marrow suppression</td>
</tr>
<tr>
<td>Tofacitinib (Xeljanz™)</td>
<td>Immuneomodulator</td>
<td>Pill</td>
<td>22 mg/day for 8 weeks followed by 11 mg/day maintenance dose</td>
<td>2 weeks</td>
<td>Increased risk of infection, nasal congestion, sore throat, increased cholesterol levels, headache, increased muscle enzyme levels, rash, diarrhea and shingles</td>
</tr>
<tr>
<td>Ozanimod (Zeposia™)</td>
<td>Immuneomodulator</td>
<td>Pill</td>
<td>0.23mg on Days 1-4, 0.46mg on Days 5-7 and 0.92mg/Day maintenance dose</td>
<td>10 weeks</td>
<td>Increased risk of infection, elevated liver enzymes, low blood pressure, painful and frequent urination, back pain, high blood pressure and headache</td>
</tr>
<tr>
<td>Infliximab (Remicade™)</td>
<td>Biologic (Anti-TNFα)</td>
<td>Intravenous</td>
<td>5 mg/kg at weeks 0, 2 and 6 followed by a maintenance dose every 8 weeks</td>
<td>6 weeks</td>
<td>Increased risk of infections, headaches, lightheadedness, joint and muscle aches, rash, flushing and nausea</td>
</tr>
<tr>
<td>Adalimumab (Humira™)</td>
<td>Biologic (Anti-TNFα)</td>
<td>Injection</td>
<td>160 mg at week 0, 80 mg at week 2, and then 40 mg every 2 weeks for maintenance dose</td>
<td>3 months</td>
<td>Increased risk of infections, injection site swelling and redness, headaches, fatigue, joint pain, nausea and sinusitis</td>
</tr>
<tr>
<td>Certolizumab (Cimzia™)</td>
<td>Biologic (Anti-TNFα)</td>
<td>Injection</td>
<td>400 mg at weeks 0, 2 and 4 followed by a maintenance dose every 4 weeks</td>
<td>3 months</td>
<td>Increased risk of infections, injection site swelling and redness, headaches, fatigue, joint pain, nausea and sinusitis</td>
</tr>
</tbody>
</table>
Inflammatory Bowel Disease Medications *(continued)*

Below is a chart of the most commonly prescribed medications for IBD:

<table>
<thead>
<tr>
<th>DRUG NAME</th>
<th>DRUG CATEGORY</th>
<th>ROUTE TAKEN</th>
<th>AVERAGE DOSE</th>
<th>EFFECTS BEGIN</th>
<th>COMMON SIDE EFFECTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Golimumab (Simponi™)</td>
<td>Biologic (Anti-TNFα)</td>
<td>Injection</td>
<td>200 mg at week 0, 100 mg at week 2, and then 100 mg every 4 weeks for</td>
<td>3 months</td>
<td>Increased risk of infections, injection site swelling and redness, headaches,</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>maintenance dose</td>
<td></td>
<td>fatigue, joint pain, nausea and sinusitis</td>
</tr>
<tr>
<td>Vedolizumab (Entyvio™)</td>
<td>Biologic (Anti-Integrin)</td>
<td>Intravenous</td>
<td>300 mg at weeks 0, 2 and 6 followed by a maintenance dose every 8 weeks</td>
<td>12 weeks</td>
<td>Increased risk of infections, common cold symptoms, headache, joint pain, fever,</td>
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<td></td>
<td></td>
<td>fatigue, rash, itching and throat pain</td>
</tr>
<tr>
<td>Ustekinumab (Stelara™)</td>
<td>Biologic (Anti-IL-12/IL-23)</td>
<td>Intravenous and injection</td>
<td>260-520 mg via IV at week 0 followed by a 90 mg injection maintenance dose every 8 weeks</td>
<td>3-6 weeks</td>
<td>Increased risk of infection, nasal congestion, sore throat, fatigue, redness at injection site, vaginal yeast infections, joint pain, urinary tract infections, nausea and vomiting</td>
</tr>
</tbody>
</table>

![Image of a pill organizer with a pill]
Vaccines and IBD

Vaccines are used to reduce our risk for infections. Some vaccines are made with a live virus and others are made with an inactivated form of the virus. Vaccines that are made with a live virus may cause some symptoms of the virus. However, they lower your risk for getting a more serious form of the infection. Many vaccines work better if they are alive but weak. They cause a better immune response. However, if you are taking immunosuppressive medications, these vaccines can cause infections. It is VERY IMPORTANT to avoid active virus vaccines while taking immunosuppressive medicines.

The five vaccines that only come in live forms should be given at least 2 months before starting to take immunosuppressive medication (for example, prednisone, methotrexate, Remicade®, Humira®, etc). Live vaccines should not be given while you are taking immunosuppressive medications, or within 2 months after these medicines are stopped. The inactivated form should be used instead whenever possible. If you are taking immunosuppressive medications, tell your primary care doctor before you get any shots.

Important vaccines include:

- The pneumonia vaccine (Pneumovax®) can protect people against 23 of the most aggressive types of pneumonia with just one shot. It is not a live vaccine and will not give you pneumonia. This vaccine is advised for all adults age 65 and older and also for anyone who is taking immunosuppressive medicines (including prednisone). A booster is given at 5 years.

- The flu vaccine can prevent the flu or shorten the time the flu lasts and ease its symptoms. A flu shot is advised each fall for all people with IBD. Anyone who takes immunosuppressive medicines should get the shot and avoid the nasal spray. The shot is made of inactivated virus and the nasal spray is made of the live virus.

- The hepatitis B vaccine is given to prevent severe infections of the liver. These infections can be more serious, and even fatal, among people who are taking anti-TNF medicines. This vaccine is now a part of the routine childhood shots. It is a good idea for everyone with IBD to get it because anti-TNF medications may be needed in the future. You need three (3) shots over 6 months for the vaccine to work. It often comes in a form that combines both hepatitis A and hepatitis B vaccines in a single shot (although it is still three [3] shots total). This vaccine is inactivated and safe to get while taking immunosuppressive medicines.

- The human papilloma virus (HPV) vaccine (Gardasil® and Cervarix®) is recommended for young women between ages 11 and 26 to reduce their risk for cervical cancer. It is a good idea for young women with IBD to have this vaccine because taking an immunosuppressive medicine can increase your risk of HPV infection. A total of three (3) shots are required over 6 months for the vaccine to work. This vaccine is inactivated and safe to get while taking immunosuppressive medicines.

- Chickenpox and shingles are caused by the same virus – varicella zoster. This virus lives on in the body after chickenpox and can occur again as shingles. Having the vaccine for both chickenpox and shingles is advised for adults. However, the chickenpox vaccine is made of the live virus, which is not safe for someone who is taking immunosuppressive medicines. It is best to have the chickenpox vaccine at least 2 months after stopping an immunosuppressive medicine, and to not start taking immunosuppressive medicine for about 2 months after having the chickenpox vaccine. Shingrix® is a new recombinant zoster vaccine for shingles that is inactive, and thus safe for immunocompromised patients. It is recommended for adults 50 years and older or on a case-by-case basis for immunocompromised individuals. It is a two-shot series, given two months apart, and no more than 6 months apart.
Important vaccines include *(continued)*:

- **Injectable polio vaccine** is not a live virus, and will not cause polio. This vaccine is advised for children. The oral form is a live vaccine and is not considered safe for people who take immunosuppressive medicines.

**Typical vaccination plan:**

- **Childhood**: MMR, polio, rotavirus, Hib, TdaP, chickenpox, and hepatitis A and B long before immune suppressed

- **Adolescence**: meningitis, tetanus, diphtheria, pertussis (TdaP), hepatitis B, and Gardasil® (for females)

- **At diagnosis of IBD**: flu shot. If immunosuppressive medicine is not needed right away, consider pneumonia vaccine and shingles vaccine
Testing with IBD

Endoscopic procedures:

- **Colonoscopy**: A colonoscopy is a procedure where a long, flexible tube (colonoscope) is inserted into the rectum. A tiny video camera at the tip of the tube allows the doctor to view the inside of the entire colon. Starting the day before the procedure you will have to take a colon cleansing preparation or “prep”. This is a special laxative that helps clear away the stool so the lining of the colon can be inspected. You will be given a sedative through an intravenous (IV) line before the procedure. Colonoscopies are used to make the diagnosis of Crohn’s disease or ulcerative colitis. A colonoscopy can also assess the symptoms of IBD flares and the response to treatment. Another important use of a colonoscopy is to screen for early colon cancer or to look for abnormal cells that may turn into cancer cells. If necessary, polyps or other types of abnormal tissue can be removed through the scope. Tissue samples (biopsies) can be taken during a colonoscopy as well.

- **Flexible sigmoidoscopy**: A flexible sigmoidoscopy is a procedure similar to a colonoscopy but the scope is smaller and only inserted a short way into the colon. The bowel preparation usually requires taking two enemas before the exam. A flexible sigmoidoscopy typically causes less discomfort than a colonoscopy. Most people do not need a sedative beforehand.

- **Upper endoscopy**: An upper endoscopy is an exam of the upper gastrointestinal (GI) tract — esophagus, stomach, and duodenum (first part of the small intestine). You will not be able to eat any solid food the day of your procedure and will be given a sedative through an intravenous (IV) line before the procedure. Unlike a colonoscopy, which is usually required for everyone with IBD, an upper endoscopy is used only if you have upper abdominal pain, problems swallowing, or nausea. Crohn’s disease may affect the upper GI tract and biopsies taken during an upper endoscopy can confirm this.

Laboratory tests:

Laboratory tests are blood and stool tests that are used to monitor how severe your disease is, your response to treatment, and the effects of your medications.

Common blood tests:

- **White blood cell count (WBC)**: This test shows the number of white blood cells in your body. White blood cells help your body fight against disease and infection. High WBC can be an indicator that you might have an infection, while low WBC can be a sign of bone marrow suppression and possible difficulty in fighting off an infection. A low count may also be a side effect of a medication, which means your dose may need to be decreased or stopped. A normal range for all individuals is between 5,000-10,000 cells.

- **Platelet count**: A platelet count is a lab test to measure how many platelets you have in your blood. Platelets are parts of the blood that help the blood clot. A high platelet count can be a sign of inflammation while a low count increases your risk for bleeding. A low platelet count may be a side effect of a medication, which means your dose may need to be decreased or stopped.

- **Hemoglobin (Hgb)**: Hemoglobin is the part of the red blood cell that carries oxygen throughout the body. Low hemoglobin can indicate anemia and excess bleeding. Males should range from 14-18 g/dL, while women should range from 12-16 g/dL.
Testing with IBD (continued)

Common blood tests (continued):

- **AST/SGOT**: These abbreviations stand for different types of liver enzymes, aspartate aminotransferase (AST) and serum glutamic oxaloacetic transaminase (SGOT) respectively. When elevated, these levels can show a sign of liver problems such as inflammation. A normal range should be between 10-36 Units/Liter.

- **Erythrocyte sedimentation rate (ESR)**: This blood test that measures how quickly your red blood cells settle at the bottom of a test tube that contains a blood sample. Normally, red blood cells settle relatively slowly. A faster-than-normal rate may indicate inflammation in the body because inflammation increases the level of blood proteins. This test assesses how severe your disease is and also measures your response to treatment. The normal range is below 20 mm/hr.

- **C-Reactive protein (CRP)**: C-Reactive Protein is a substance that is produced in the liver as a response to the presence of inflammation in the body. Any disease that brings about an inflammatory response of any tissue will be seen in the results of this test. This test assesses how severe your disease is and also measures your response to treatment. The normal range is 1-3 mg/L.

- **Medication levels**: Many times your doctor will test your blood to check on your medication levels to evaluate the effectiveness of your current drug therapy regimen. Many of these medications need to be in a target range inside your body to be considered optimally working. Sometimes your body may be metabolizing, or breaking down, your medication too quickly and will leave you with lower than ideal levels of medication. This would be a cause to call for an increase in your medication. These blood tests often vary from medication to medication so consult your doctor for further information on your specific medication levels.

Common stool tests:

- **Fecal calprotectin**: This test measures the amount of white blood cells in your stool. Elevated levels on this test indicate inflammation is occurring in your intestine. A normal range is from 0-110 µg/g (micrograms per gram of stool).

- **Stool culture**: A stool culture is used to detect the presence of disease-causing bacteria and help diagnose other infections in the digestive tract. This test looks for infections including *salmonella*, *shigella* and *campylobacter*.

- **C. Diff**: C. Diff stands for *Clostridium Difficile*. This bacterium typically appears in patients with IBD. The C. Diff test tests for the *C. Difficile* toxin or the presence of the bacteria itself. Infection with C. Diff can cause diarrhea and needs antibiotic treatment.
Imaging tests:

- **Abdominal X-ray series**: An abdominal X-ray is a picture of structures and organs in the belly. The cause of pain in the abdomen or the cause of ongoing nausea and vomiting may show up on the X-ray. In IBD, an X-ray is helpful to look for a dilated or perforated intestine, which can be a complication of the disease. An abdominal X-ray can show if there is air in the abdomen, which is a sign of a perforation.

- **Computed tomography enterography (CTE)**: This test is similar to a routine CT scan except you drink the contrast material (dye) before the CT scan is started. The contrast material allows for the small intestine to be seen more clearly. Contrast material may also be given through an intravenous (IV) line, which shows the small intestine even more clearly. This has become useful to study diseases, such as Crohn’s disease. While a routine CT can detect the complications of Crohn’s disease, such as fistula and abscess, CTE clearly shows the small bowel inflammation that occurs in Crohn’s disease. As a result, CTE is becoming the first-line of testing for IBD, and is also being used to monitor the disease over time.

- **Magnetic resonance enterography (MRE)**: This is often used instead of a CTE so that you are not exposed to radiation. An MRE involves a powerful but harmless magnetic field and radio waves like the kind that transmit your favorite FM music. The radio waves combine with the magnetic field to produce very clear pictures of parts of the body such as the small intestine. Contrast material is given through an intravenous (IV) line so that your small intestine can be seen more clearly. Because the MRE scan involves the use of a powerful magnet, you will be asked questions about whether you have any implanted devices such as a cardiac pacemaker, a cerebral aneurysm clip, a neurostimulator, or a hearing aid. You will also be asked if you have any metal shrapnel in your body or any metal fragments in your eyes.

- **Dual-energy X-ray absorption (DEXA)**: Many IBD patients have taken steroids, which can lower bone density. DEXA measures bone density to find out if you have osteopenia (abnormally low bone density) or osteoporosis (severely low bone density). This test can help predict your chances of having a broken bone. There are no known risks from having a DEXA.
Digestion and Diet

Digestion is the process of breaking down food into smaller pieces so it can be used by the body or eliminated as waste. When the food you eat goes into your stomach, it is mixed with acid and enzymes that break it down into small pieces. Just past the stomach, in the small intestine, water is added as well as enzymes and digestive fluids from the pancreas and liver, which break these pieces down even more. The nutrients your body needs are absorbed through the lining of the small intestine into the blood vessels, where they travel through the bloodstream to the cells throughout the body. What cannot be digested in the small intestine moves into the large intestine, which is also called the colon. The colon absorbs and recycles much of the water that is left over. The food residue is now solid (stool) and is passed from the large intestine as a bowel movement through the anus.

When the small intestine is inflamed in Crohn’s disease, it is less able to fully digest and absorb the nutrients from food. This can lead to malnutrition because the nutrients pass through to the colon, causing watery diarrhea. When the large intestine is also inflamed, the diarrhea may become more severe. In ulcerative colitis, the colon is inflamed and the small intestine continues to work normally. However, because the inflamed colon does not recycle water as it should, the diarrhea can be severe. If the colon is very inflamed, proteins can leak out from the bloodstream into the stool.

Eating a well-balanced and healthy diet is a very important aspect of managing IBD. A healthy diet full of fruits, vegetables, lean meats and unprocessed grains will fuel your body with the necessary nutrients it needs. While diets cannot cure IBD, they can be very useful in reducing disease-related symptoms.

There is no universal diet for IBD since each person’s disease is unique. It is important to pay attention and monitor the foods you can and cannot tolerate. It may be beneficial for you to keep a food diary so that you can identify trigger foods. Even if dietary changes are successfully helping you manage your symptoms, it is important to keep taking your medications as prescribed by your doctor.
Digestion and Diet (continued)

Three diets that have been found helpful for IBD include:

Low-Residue Diet

What is a low-residue diet?
A low-residue diet limits the amount of fiber and other material that cannot be digested as it passes through your small intestine. This diet can reduce the size and number of your stools and help relieve abdominal pain and diarrhea. A low-residue diet can be very helpful when you are suffering from a flare up, stricture, bowel obstruction, or after surgery when your gastrointestinal tract needs time to heal.

What foods should I eat and what foods should I avoid?
Below is a brief list of foods to eat and foods to avoid. To find out more, please contact your health care team.

<table>
<thead>
<tr>
<th>FOODS TO EAT</th>
<th>FOODS TO AVOID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refined breads, cereals and pasta</td>
<td>Whole grain breads, pastas and cereals</td>
</tr>
<tr>
<td>(with less than 1 gram of fiber</td>
<td>Nuts and seeds</td>
</tr>
<tr>
<td>in each serving)</td>
<td></td>
</tr>
<tr>
<td>White rice</td>
<td>Most fruits and vegetables including:</td>
</tr>
<tr>
<td>Fruit and vegetable juices</td>
<td>dried fruit and coconut</td>
</tr>
<tr>
<td>Bananas and applesauce</td>
<td>Brown rice and quinoa</td>
</tr>
<tr>
<td>Tender meat, poultry, fish and eggs</td>
<td>Popcorn</td>
</tr>
<tr>
<td>Oil, margarine, butter and mayonnaise</td>
<td>Anything with more than</td>
</tr>
<tr>
<td>Broth-based soups (strained)</td>
<td>1-2 grams of fiber</td>
</tr>
<tr>
<td>Jelly, honey, syrup</td>
<td></td>
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</tbody>
</table>
Specific Carbohydrate Diet

What is the specific carbohydrate diet (SCD)?

The Specific Carbohydrate Diet is a diet that is widely studied for its effects on treating individuals with IBD by healing one’s digestive tract and restoring proper absorption. The goal of the SCD diet is to bring one’s intestinal bacteria back to a proper balance by controlling what the individual takes in. This is primarily achieved by eliminating many of the carbohydrates that an individual eats every day. Simple Carbohydrates (monosaccharides) are easy for the body to absorb and use as energy. These simple carbohydrates are allowed in the diet. However, many carbohydrates are Complex Carbohydrates (disaccharides or polysaccharides), which require digestive enzymes to break them apart for your body to be able to use. These types of carbohydrates are avoided in the diet due to their complex structures and not being readily available for absorption. Since they are not easily absorbed, complex carbohydrates feed harmful bacteria within your digestive tract. By limiting your carbohydrate intake, these harmful bacteria may begin to starve and die, which may help restore your body’s proper bacterial balance.

Another key component to the Specific Carbohydrate diet is eliminating the processed foods that have become a staple in the diets of many. Processed foods are often high in fats and complex carbohydrates that negatively affect one’s digestive tract. There are certain foods that depending on preparation can be harmful or helpful for your digestive tract. For example store-bought yogurt is typically filled with preservatives that will be harmful to your digestive tract, however there are many recipes for homemade yogurt that will be free of preservatives and packed with good bacteria that will be beneficial to your digestive system.
Specific Carbohydrate Diet (continued)

What foods should I eat and what foods should I avoid?
The list of foods approved to eat and those to avoid are extensive. There are books and recipe collections available; if you are interested in learning more, talk with your IBD team.

Below is a brief list of foods to eat and foods to avoid.

<table>
<thead>
<tr>
<th>FOODS TO EAT</th>
<th>FOODS TO AVOID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most vegetables</td>
<td>Grains (i.e. wheat, rice, corn, oats, rye, quinoa)</td>
</tr>
<tr>
<td>Unprocessed meats, poultry and fish</td>
<td>Most dairy products (i.e. milk, cream)</td>
</tr>
<tr>
<td>Fresh, frozen or dried fruit without preservatives</td>
<td>Starches (i.e. potatoes)</td>
</tr>
<tr>
<td>Eggs</td>
<td>Processed meats</td>
</tr>
<tr>
<td>Honey</td>
<td>Canned fruits and vegetables</td>
</tr>
<tr>
<td>Homemade yogurt</td>
<td>Sweets and candy</td>
</tr>
<tr>
<td>Most nuts and nut flours</td>
<td>Sweetened drinks, beer and juices with preservatives</td>
</tr>
<tr>
<td>Unprocessed cheeses low in lactose (i.e. aged cheddar)</td>
<td>Refined oils (i.e. vegetable oil, canola oil)</td>
</tr>
<tr>
<td>Healthy fats (i.e. ghee, “grass-fed” butter, coconut oil)</td>
<td>Condiments with added sugars (i.e. ketchup, margarine, mayonnaise)</td>
</tr>
<tr>
<td>Unprocessed drinks (i.e. almond milk)</td>
<td></td>
</tr>
<tr>
<td>Homemade dressings with approved ingredients</td>
<td></td>
</tr>
</tbody>
</table>

Who should do the SCD diet?
Some patients benefit from the specific carbohydrate diet. It is not for everyone, but if you are interested in trying it, you should do this under the guidance of your doctor and dietician to ensure you are doing it properly and safely.
**Mediterranean Diet**

**What is the Mediterranean diet?**

The Mediterranean diet is based on a pyramid that provides information on what foods you should be eating and how often you should be eating them. The pyramid includes all of the different food groups, but following the diet’s proportions and frequencies is what makes this diet so effective. The bottom of the pyramid, which is what should be eaten the most often, incorporates plant-based foods. Eating a lot of plant-based foods helps provide a lot of key nutrients to patients. Since the Mediterranean diet incorporates all of the different food groups, it minimizes the chance of developing nutrient deficiencies. The Mediterranean diet has been linked to many health benefits and has proven to have a protective effect against chronic diseases.¹

**What should I eat on the Mediterranean diet?**

**Your three main meals should include:**

1. One or two servings of whole grain cereals, such as bread, pasta, couscous and rice.

2. Two or more servings of vegetables with one serving being a raw vegetable.

3. One or two servings of fruit. Fruit should be the dessert you eat after most meals.

It is also important for you to drink 1.5-2.5 liters of water per day, eat low fat dairy products daily, always use olive oil as your main source of fat, eat olives, nuts and seeds as snacks and limit the amount of alcohol you drink. Traditionally, animal protein is not the main ingredient of meals on the Mediterranean diet, but instead should be used as a tasty source of added protein. A wide variety of plant and animal proteins should be incorporated into your diet each week. Each week you should be eating two or more servings of fish, two servings of white meat, and two to four servings of eggs. It is important to limit the amount of red meat to less than two servings a week on this diet.

**If you are interested in learning more about this diet, please reach out to your IBD health care team.**

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Smoking and IBD

There is no doubt that smoking will make your Crohn’s disease much worse. It makes your symptoms worse and can make it harder for medicines to work. If you smoke and you have Crohn’s disease or ulcerative colitis, stopping is one of the best things you can do for yourself. It is hard to quit, but there is help. Talk to your doctor or attend a smoking cessation program for help in quitting. If you have ulcerative colitis you may have a flare when you quit smoking. Using a nicotine patch can help to prevent or relieve the flare.
Mental Health and IBD

Living with a chronic disease like IBD can take a toll on one’s mental and emotional well-being. Due to the unpredictable nature of IBD, patients may feel angry, anxious and scared. IBD flare-ups often lead to increased levels of stress. Additionally, stress can also be a trigger of IBD flare-ups. Stress can come from all aspects of life, school, family, friends, relationships, even things you enjoy can cause you stress. Along with causing IBD flare-ups, having a lot of stress also decreases your immune response by decreasing the production of cells that fight infection, leaving you vulnerable to getting sick.

Being able to manage your stressors, take a step back and calm yourself down is very important and will keep you healthy. Deep breathing can help you calm your body and mind from whatever stressful situation you might be in at the time. When you find yourself in a stressful situation or in a place where you feel overwhelmed, you should take a step back from whatever you are doing and follow the six sides of breathing. Start by taking a deep breath in, holding it, then breathing out and repeating this cycle until you feel that you are calm and in a better, less stressed state.

Regular exercise is another way to destress and help improve your mental well-being. Trying to stay active in whatever way you can will help improve many of your bodily functions, including your gut health. However, do remember that you are dealing with an illness that can cause chronic fatigue. It is important to listen to your body and rest when you feel that you need to.

Many people with IBD feel isolated and alone, but it is important to remember that there are a lot of other individuals out there with IBD. Depression is a serious mental illness that can affect IBD patients. Do not be afraid to get help from a mental health provider if you feel that you need to. Your IBD care team can help connect you with a mental health provider that specializes in treating patients with chronic diseases like IBD. Depression is a treatable condition that can be resolved with medications and counseling. Many people find it helpful to connect with other IBD patients. ECHO IBD will provide patients with the option to speak to a Health Coach that has been affected by IBD, along with social events to meet other patients with IBD. Additionally, The Crohn’s and Colitis Foundation of America (CCFA) hosts IBD support groups throughout the country, including many groups in the state of Florida. The CCFA also has the Power of Two program where IBD patients can be paired up with a mentor that is living with IBD. Visit the CCFA’s website if you would like to find out more information about either of these programs.

The Six Sides of Breathing

- Breath In
- Breath Out
- Hold
Sexual Health and IBD

Sexual health is an important part of your overall health and quality of life. Crohn’s disease and ulcerative colitis can affect your sexual health. When the disease is active, you may feel very tired and have little desire for sex. Major abdominal or pelvic surgery (for example, removal of the colon) increases the risk for erectile dysfunction (impotence), which means not being able to have or keep an erection. Surgery can also affect body image and how a person feels about their desirability. Some people with Crohn’s disease develop a fistula. If it is an anal fistula, intercourse can be painful. Please talk to your doctor if you are concerned about any of these issues.

A sexually-transmitted disease (STD) can make it harder to treat IBD. For example, if you get genital herpes while you are taking an immunosuppressive medicine, you may have to stop taking the medicine until the herpes is treated. Women with IBD who are taking an immunosuppressive medicine may have a higher risk for infection with the human papillomavirus (HPV). Many people are exposed to HPV, and in some women it causes cervical cancer. In addition to a yearly PAP test (PAP smear) and getting the HPV vaccine (see Vaccines in the section Maintaining My Health), always use condoms to protect yourself from STDs.

Overall, when treated, patients with IBD have happy and healthy sexual activity. Treatment of your condition leads to increased energy level and interest in intimacy.
Reproductive Health and IBD

Women who have IBD are able to get pregnant and carry a baby to term. Having IBD does not reduce the chances you will get pregnant. The effect of IBD on pregnancy depends on how severe the disease was before and during pregnancy. If the disease is in remission at the time the baby is conceived it will likely stay in remission during pregnancy. If your IBD is well-controlled, you can expect to have a normal pregnancy.

Women with more severe IBD have a greater risk of early delivery and of having a baby with low birth weight. This stresses the need for continued excellent control of IBD during pregnancy by getting regular care from your health team and by taking your medications faithfully. Major abdominal or pelvic surgery increases the risk of not being able to get pregnant and may affect a woman’s ability to carry a pregnancy to term. The most common problem is caused by the growth of scar tissue that blocks the fallopian tubes. If this occurs, in vitro fertilization may be an option.

If you are pregnant or trying to get pregnant, it is essential to discuss the safety of your medications with your doctor. The U.S. Food and Drug Administration decides the safety level of drugs taken during pregnancy. Category A includes medicines like Tylenol®, which have been shown to be of very low risk to the baby during pregnancy. Category B medicines are the next safest medicines to take. These are generally considered very low risk to the baby during pregnancy. Category C means there are no studies to show if the medicine is safe or not safe to take during pregnancy. However, the benefits of taking the medicine often outweigh the risks of not taking the medicine. Category D means that there is some proof that the drug causes problems during pregnancy. However, the benefit of taking the medicine may still outweigh the risk of not taking the medicine. Category X means the drug should ABSOLUTELY NOT be taken during pregnancy and should be stopped for several months before getting pregnant. It is also important to check with your doctor if you can breastfeed on your current medications. In some cases, it may be better for you and your baby to continue your medications and bottle-feed your baby. For more information on the safety of medications during pregnancy and breastfeeding, visit MotherToBaby.org.

In men, major abdominal or pelvic surgery increases the risk for erectile dysfunction. Sulfasalazine, a medicine used to treat IBD, causes a decrease in sperm count and fertility in 10% of men who take it. If you are taking sulfasalazine and your partner is having a hard time becoming pregnant, talk to your doctor about switching your medication. While most medications do not affect male reproductive health, it is important for all men with IBD to consult with their doctors when they are considering a potential pregnancy.
Accommodations at Work and School

While it may be stressful for you to ask about accommodations at work or school, many things can be done to make your life a little bit easier. For example at work, your desk or office could be moved closer to the restroom. If you are a college student or work for a large company, there will most likely be an office that is solely for people with disabilities that need special accommodations. It is important to find out if your work or school has a disability office because they can help you with dorm selection, your work/class schedule, exam accommodations and many other concerns you may have. Living with IBD can make your life more challenging than others, so it is important to ask for accommodations to improve your quality of life.

IBD and COVID-19

Current data shows that having IBD should not put you at a higher risk for developing a severe illness from COVID-19. However, you may be considered high-risk if you are on steroids, biologics or immunosuppressive medications for your IBD. The Crohn’s and Colitis Foundation recommends that all IBD patients should get vaccinated against COVID-19. Since the COVID-19 vaccine is not a live vaccine, IBD patients are allowed to get it. In regards to COVID-19 booster vaccines, the CDC recommends that patients on steroids, biologics and immunosuppressive medications should receive a third dose of the mRNA vaccines. The Foundation also recommends that IBD patients engage in social distancing, wear masks and avoid big crowds. For more information on COVID-19 and IBD, please visit crohnscolitisfoundation.org/coronavirus.
Resources

University of Florida’s Inflammatory Bowel Disease Website

gastroenterology.medicine.ufl.edu/ibd/

The UF Inflammatory Bowel Disease website has many useful resources:

- Useful information about the diagnosis and the disease
- Facts about IBD for friends and families
- Facts for students with IBD
- A glossary of some of the medical terms we use when talking about IBD
- Details about clinical research studies
- Facts about IBD research at the University of Florida, including the research websites of our faculty members
- How to make an appointment (for patients)
- How to refer a patient for an appointment (for physicians)

University of Florida Student Support Group

The UF Crohn’s and Colitis Student Initiative is an IBD support group for college-aged students. They meet monthly in Marston Library or via Zoom during this unique COVID-19 time period. Contact Karen Yung, IBD Patient Navigator for more information at karen.yung@medicine.ufl.edu.

ECHO IBD Health Liaisons

ECHO IBD Health Liaisons are a team of health coaches who form individualized long-term relationships with patients to guide them through IBD care and management. They act as peers, mentors, and teachers — checking in with you regularly, answering any questions you may have, and creating an IBD support community.

If you are interested in learning more about ECHO IBD Health Liaisons or would like to start working with one, please email DOM-IBD-ECHO@ad.ufl.edu.
Crohn’s & Colitis Foundation of American (CCFA)

The Crohn’s & Colitis Foundation of America (CCFA) is the largest grassroots organization devoted to curing Crohn’s disease and ulcerative colitis, and improving the quality of life of children and adults affected by these diseases.

The CCFA is a nonprofit, volunteer-driven organization with more than 50,000 members and 40 chapters in the United States that:

- Provides information and support groups for patients with Crohn’s disease and ulcerative colitis.
- The Information Resource Center provides information, support, and guidance on Crohn’s and colitis. Call between 9 a.m. and 5 p.m. eastern time on weekdays 1-888-MY GUT PAIN (1-888-694-8872). Interpreters are available for more than 20 languages. Information about the Local Chapter is at www.ccfa.org/chapters.
- Maintains Disease Information web pages at www.ccfa.org/info/resources/ with information about tests, medications, and treatment options in IBD.
- Puts together educational workshops and symposia, and a scientific journal, Inflammatory Bowel Diseases, to help medical professionals to keep pace with the newest research discoveries in IBD.
- Funds leading-edge studies at major medical institutions (often at the University of Florida), and nurtures investigators with grants at the early stages of their careers.
- Conducts a national research meeting each year, Advances in IBD, to promote the exchange of new research findings in Crohn’s disease and ulcerative colitis. Find out more at www.ccfa.org.

Local Resources

Find support and connect with others in the IBD community—wherever you are.

The Crohn’s & Colitis Foundation has a variety of local resources and events across the country. From chapters and support groups to educational programs and special events, there’s a way for everyone to get involved.

Our Chapters

Our nationwide network of chapters brings the work of the Foundation to a community level. Attend special events, get support and make a difference by participating in a chapter near you.

Find a Chapter

Support Groups

Support groups provide a space for patients and caregivers to share stories, find answers and connect to those who understand the unique challenges of living with IBD. Our chapter network hosts more than 200 local support groups throughout the United States.

Find a Support Group or visit our Online Community

Local Events

At our events, IBD patients, caregivers and supporters come together to empower one another and have fun—all while driving critical research, education and advocacy efforts. Use our search tool to look for education programs, galas, fundraising events
Improving quality of life for IBD patients.

Acknowledgements
This handbook was created by Avery Weisman, Manavii Kumar, and the Project ECHO IBD Team. Various resources were used to create this guide including:

- University of Michigan IBD Patient Guide
- University of Florida IBD Patient Guide
- University of Florida IBD Pediatric Patient Guide
- University of Florida ECHO Diabetes Program
- Crohn’s and Colitis Foundation Resources