

Developing a fistula can be distressing, even if you've lived with Crohn's Disease or Ulcerative Colitis for some time. You may find it difficult to talk about, even to people you normally confide in.

But you're not alone. We're here to support you and this information will:

- Help you to understand more about fistulas.
- Find out about treatment options.
- Share tips for living well with a fistula.

Key facts about fistulas	2
What is a fistula?.....	2
Different types of fistula	3
More about anal or perianal fistulas.	4
Causes of a fistula	6
Symptoms of a fistula	7
Diagnosis	8
Treatment	9
If treatments don't work.	16
Managing your fistula.....	16
Top tips.....	17
When to seek urgent medical help	19
Where to go for more help and support	20
Help and support from Crohn's & Colitis UK.....	20
About Crohn's & Colitis UK	22

Key facts about fistulas

1. A fistula is a narrow tunnel or passageway that links one organ to another.
2. Around 1 in 3 people with Crohn's will likely develop a fistula at some time, it's less common in Colitis.
3. Anal fistula is the most common type of fistula. Symptoms include a tender swelling or lump in the area round the anus, often followed by pain and irritation which gets worse when you sit down, move around, poo or cough.
4. Medicines and surgery, often in combination, can be helpful in managing a fistula.

'Although being diagnosed with a fistula is quite difficult and scary at the beginning, once you get used to it, it does get easier to deal with. You just get on with your life as normal and do most of the things you did before.'

Claire, age 38

Living with Ulcerative Colitis.

What is a fistula?

A fistula is when a tunnel develops that connects an organ to another part of your body. These tunnels can connect one internal organ to another, or to the outside surface of the body. A fistula can develop in any part of the body, but many involve the gut.

Around 1 in 3, (33%) people with Crohn's develop a fistula at some time, and around 1 in 35 (3%) people with Ulcerative Colitis. Some people develop a fistula before Crohn's or Colitis is diagnosed.

Different types of fistula

The most common fistulas associated with Crohn's.

- **Anal or perianal.** These connect the anal canal or rectum to the surface of the skin near the anus where poo leaves the body. These are the most common type of fistula and often occur following an abscess around the anus. An abscess is a painful collection of pus usually caused by infection.
- **Bowel to bladder fistulas**
- **Bowel to vagina fistulas**
- **Bowel to skin** These occur in areas other than the anus, most commonly on the tummy area. This is often after surgery, along the line of the incision (cut). But they may occur in Crohn's even when you haven't had an operation. If contents of the gut leak out, this can injure the skin. The same enzymes in your gut that digest food will make contact with your skin and cause it to become very red and sore. It can be painful and prone to infection.
- **Bowel to bowel.** These link different parts of the gut together, bypassing a section in between.

Fistulas associated with Ulcerative Colitis.

- **Ileo-anal pouch fistula.** A small number of people who have had surgery with pouch formation can also develop a fistula linking the pouch to the bowel, bladder, vagina or the outside skin. These are often treated with medicines but may occasionally need an operation. For more information Ileo-anal pouch surgery see [Surgery for Ulcerative Colitis](#)

Health professionals may also use some of these words to describe where a fistula is.

Word	Meaning	Fistula type
Peri	around	Perianal - around the anus
Entero	bowel or gut	Enteroenteric – linking sections of the gut
Cutaneous	skin	Enterocutaneous - opens onto the skin
Vesical	bladder	Enterovesical - links to the bladder
Colo	colon – part of the bowel	Enterocolonic – links colon to another part of the gut

More about anal or perianal fistulas.

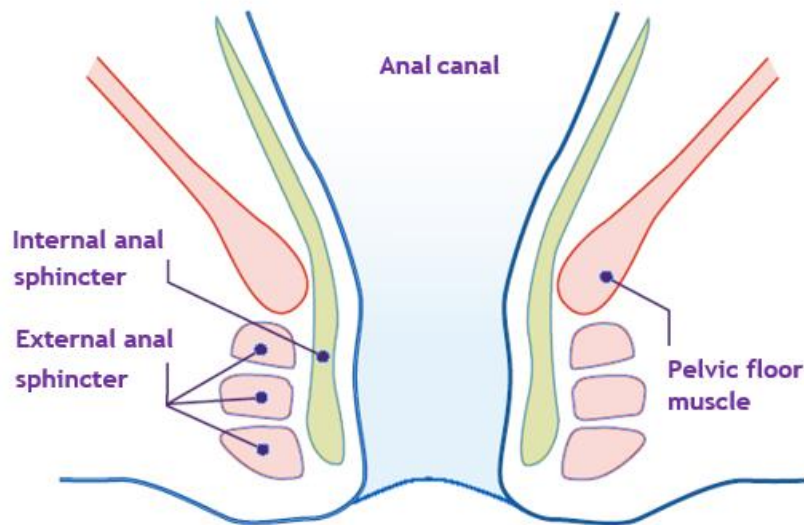
To understand the different types of anal fistulas and treatment options, it's helpful to know about the structure of the muscles around the anus. Two doughnut shaped muscles, known as the anal sphincters surround the anal canal where poo travels. These allow you to control when you open your bowels to poo.

There are two sets of muscles:

- **Internal anal sphincter.** This is an involuntary smooth muscle which means you can't mentally control it. It keeps liquid and gas from escaping unexpectedly.
- **External anal sphincter.** This wraps round the internal sphincter. It's the muscle you relax to pass wind or squeeze when you feel the urge to poo but you're not near a toilet.

Damage to these muscles can mean you have less control over wind, liquid, and sometimes even solid poo.

Anal sphincter muscles

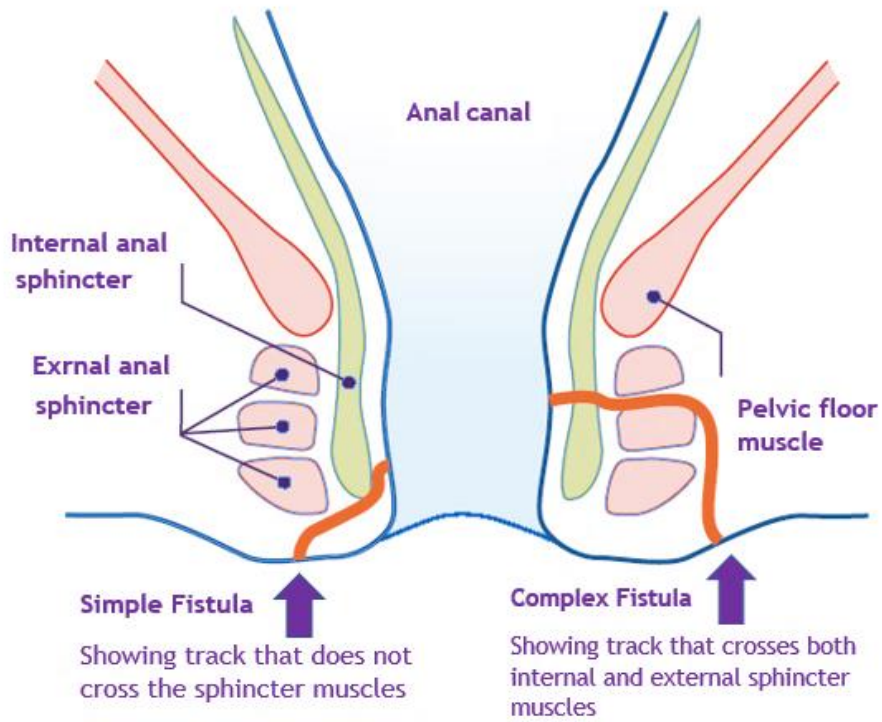


This illustration shows the position of the muscles around the anal canal where poo travels. The pelvic floor muscles also help you to release pee, poo and wind and to delay this until you reach a toilet.

The name tells you where they are and if they involve the external or internal sphincters.

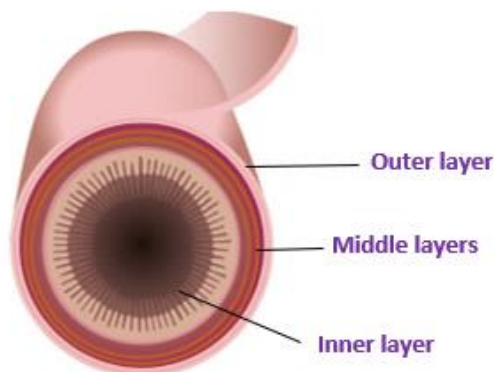
- **Simple fistulas** usually occur below the sphincter muscles and only have one passageway.
- **Complex fistulas** involve the sphincter muscle and may have several linked tunnels. They can also come with abscesses or may connect with the bladder and vagina.

Simple and complex fistula



Causes of a fistula

It's not yet fully understood what causes fistulas, but certain genes and gut bacteria may play a role in their development. If you have Crohn's, the cells involved in healing may not work as they should.



Bowel Layers

Fistulas are more common if you have Crohn's. This is because gut inflammation can spread through all the layers in the bowel wall.

This can cause small leaks and abscesses to form. As the abscess develops it may hollow out a chamber or hole. This can become a channel linking the bowel to:

- another loop of bowel.
- another organ.
- the outside skin.

If the abscess bursts, the pus may drain away, but the channel may remain as a fistula. Fistulas can occur anywhere in the bowel. The longer you have Crohn's, the more likely you are to develop a fistula.

In Ulcerative Colitis the inflammation doesn't spread through the full thickness of the bowel wall, so fistulas are less likely to form.

Symptoms of a fistula

The symptoms you experience depend on where your fistula is.

Anal fistula. The first sign can be a tender swelling or lump in the area round the anus. This is often followed by pain and irritation which gets worse when you sit down, move around, poo or cough. Pus, poo, or blood can drain from the fistula opening.

Bladder fistula. Symptoms include passing air, pus, or poo when you pee. Some people find pee may leak from the anus. You may also have an urge to pee very often and experience urinary tract infections (UTIs).

Vaginal fistula. Symptoms include pain ranging from mild to severe, depending on how big the fistula is and where it is located. It may make having sex extremely painful, or even impossible at times. Some women find they pass wind, poo or pus through the vagina.

Bowel to skin fistula. Symptoms include leakage of bowel contents through the skin. This can lead to dehydration, diarrhoea, malnutrition and upset the body's chemical balance.

Bowel to bowel fistula. Symptoms depend on how much of the bowel is affected and location of the two ends of the fistula. Where only a short section of bowel is bypassed by

the fistula, people may not have any symptoms. When a large part is involved, people can experience **diarrhoea**, problems absorbing nutrients and **dehydration**.

Diagnosis

How fistulas are diagnosed depends on the type of fistula you have. Your IBD team will aim to find out:

- where the fistula opens
- the route that the fistula takes
- the number of different channels involved
- whether the fistula passes through the sphincter muscles – see the section on **Anal Fistulas**
- if you have an infection.

Anal fistula

First, your doctor will carry out a physical examination of the skin around the anus, as fistulas can be seen as tiny holes or raised red spots. The doctor may press on the skin around the fistula to see if there is leakage of pus or poo. For some fistulas, you may have a general anaesthetic so that the area can be examined while you sleep. This is because the examination is painful and it's helpful to have the anal sphincters and pelvic floor muscles fully relaxed. This is known as examination under anaesthetic or EUA. Sometimes a special probe is used to trace out the route of the fistula. As well as finding out whether the fistula crosses the sphincter muscles (see [More about anal fistulas](#)), the procedure allows any abscesses to be drained or setons to be put in place (see [Surgery](#)).

To see where the fistula is in relation to the sphincter muscles, you may have the following tests:

- Pelvic MRI, uses magnetic fields and radio waves.
- Endoanal ultrasound (using high frequency ultrasound).
- Fistulography, where fistulas are injected with X-ray contrast materials, less commonly performed now.

Often, a combination of all these techniques is used to fully assess a fistula.

Vaginal fistula

In addition to MRI, ultrasound and fistulography, a blue dye test can be used. This is where the doctor inserts a tampon into the vagina and blue dye into the rectum. If the tampon stains blue, this shows that there is a connection.

Bowel to bladder fistula

Using a long thin telescope with a camera (cystoscope), doctors can look inside the bladder and the tube carrying pee from the bladder (urethra). They may carry out the 'poppy seed test'. Here, the person eats poppy seeds which remain undigested in the bowel with yoghurt. If the seeds appear in the pee this shows that there is a bowel to bladder connection.

Treatment

Fistulas may be managed with medicines, an operation, or a combination of both. Your treatment will depend on the type of fistula you have and the treatment you're already having for Crohn's or Colitis.

Your IBD team should explain the treatment choices available to you and the pros and cons for each. Ask as many questions as you need to. [Our Guide to Appointments](#) can help you to make decisions about your care and treatment together with your IBD team.

Continuing your usual treatment for Crohn's or Colitis often helps, as active disease tends to make fistulas worse. But your doctor may recommend avoiding steroids as these can increase the chance of developing an infection or abscess and the need for surgery.

More is known about treatment of anal fistulas than other types of fistulas.

Anal fistulas

Treatment aims to get a balance between healing the fistula and keeping control over your bowels.

Medicines

- **Antibiotics.** Antibiotics, such as metronidazole and ciprofloxacin, may help reduce discharge and make your fistula feel more comfortable. It can take around six to

eight weeks for a course of antibiotics to work. In some instances, treatment is continued for some months. But antibiotics rarely lead to complete and lasting healing.

- **Biologic medicines.** Anti-TNFs such as **infliximab** and **adalimumab** have been shown to bring about and maintain healing in perianal fistulas. These are usually started when any abscesses have been treated with antibiotics. If anti-TNFs don't work, **ustekinumab** or **vedolizumab** are possible options.
- **Other medicines** sometimes used to treat anal fistulas include ciclosporin, tacrolimus, **azathioprine**, **methotrexate** and thalidomide.

Surgery

Up to 1 in 3 people with Crohn's who have an anal fistula will need an operation at some time. The goal of surgery is to heal the fistula while avoiding damage to the anal sphincter muscles. These muscles surround the anus and control the release of poo.

The type of surgery you're offered will depend on:

- where your fistula is
- how much of the anal sphincter muscle is involved.

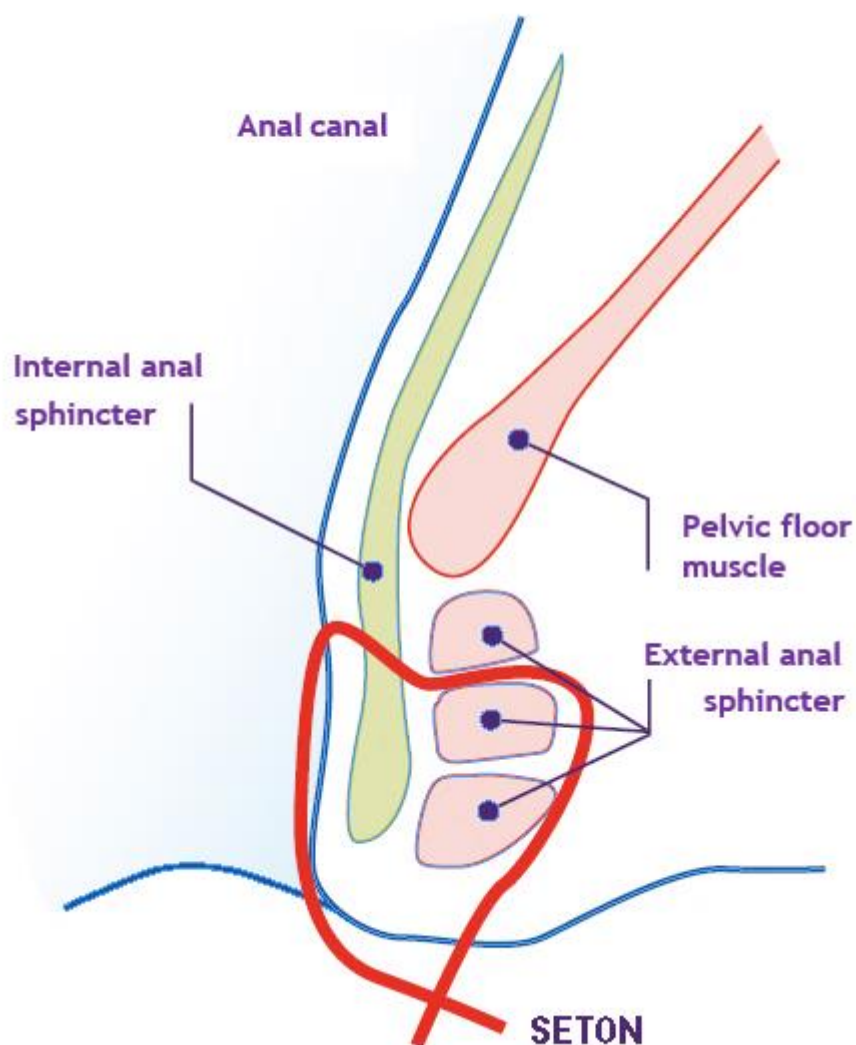
If you have any abscesses, these will be drained before surgery.

Setons Loose setons are soft surgical threads. The surgeon passes these through the opening in the skin, along the track of the fistula and out through the anus. It's then tied to form a loop. The ends hang out of your anus, allowing the pus or infected tissue to drain away. The seton is usually left in for several weeks and removed if the fistula is healing. Studies show that adding loose setons to infliximab treatment leads to better results for people with anal fistulas. Some people say that a loose seton feels like having a rubber band hanging out of your bottom, but after a few days they no longer notice it's there. In some cases, setons are used as a long-term treatment if fistula healing is unlikely.

“It is quite embarrassing to tell someone that I have a little rubber band coming out of my bum (a seton). But I only tell people I trust and feel comfortable with, and they have been really supportive. “

Finlay, age 23

Living with Crohn's.



Before you're offered one of the operations below your IBD team will talk to you about the risks and benefits. Long-term results are not always good especially if you have complex and ongoing disease.

Fistulotomy. This is the most common type of operation for anal fistulas and the most effective for many. In this operation the length of the fistula is cut open, much like cutting open a cardboard tube along its length and flattening it out. This promotes healing from the base of the fistula to the surface. Healing may take from a week to several months.

This procedure is only suitable for simple fistulas that either don't cross the sphincter muscle at all or only pass through a small amount.

'I had day surgery for an anal fistula. I was anxious before the operation as I had never had a general anaesthetic before, and the surgeon couldn't say whether he would be able to lay it open or if I would need a seton stitch. In the end it went very smoothly and he was able to lay it open. Having the operation has made such a difference. I started to feel the benefits quickly afterwards and the relief was immense.'

Lucy, age 45

Living with Crohn's.

Advancement flap. After the fistula track has been cleaned, leaving sphincter muscles intact, the inside lining of the rectum is lifted and pulled down inside the anal canal to cover the internal opening of the fistula.

This operation is used for complex fistulas where the sphincter muscles are involved and where cutting the fistula track open would carry a high risk of losing bowel control.

LIFT (Ligation of intersphincteric fistula tract). This operation aims to avoid cutting the sphincter muscle. The surgeon gains access to the space between the internal and external anal sphincter muscles through a small cut at the entrance to the anal canal. Once the surgeon has found the fistula tunnel crossing this space, it is cut in two. Both ends are then stitched closed to stop poo getting into the fistula.

Video-assisted anal fistula treatment VAAFT. Using a telescope, the technique allows the doctor to see the fistula track from inside. After cleaning, the fistula can be sealed using an electric current to close the track. Stitches and fibrin glue can also be used. This technique may help surgeons find extra passages running off the main fistula, which need treatment for the fistula to heal.

Advancement flaps, LIFT and VAAFT will only be used in selected people and only after counselling as long-term results are poor, particularly for people with complex disease and ongoing disease activity.

Risks of anal fistula surgery

Like any treatment, surgery for anal fistulas has some risks. The main ones are:

- Infection – this may require a course of antibiotics and if the infection is severe it may be treated in hospital.
- Recurrence of the fistula – the fistula can sometimes come back despite surgery.
- Loss of bowel control – this is a potential risk with most types of anal fistula treatment, although severe incontinence is rare. Your surgeon will make every effort to prevent this.

Research funded by Crohn's & Colitis UK found that asking your healthcare professional about the following topics can help you make an informed decision about surgery for an anal fistula:

- how to care for your wound.
- the effect the surgery will have on the perianal area.
- the severity of the procedure

[Find out more about this research](#)

The level of risk will depend on where your fistula is and the type of operation you have. Talk to your surgeon about the possible risks of the operation and the benefits that it can offer you.

Other treatments

Other treatments for anal fistulas include trying to close the fistula with fibrin glue, a bioprosthetic plug (using materials such as Gore-Tex®), or collagen paste, or sealing the fistula tract with a laser probe.

- **Stem cells.** Stem cells have been shown to be effective in treating complex perianal fistula in people with mildly active Crohn's Disease. This is potentially a treatment option when drug treatments haven't been effective, or someone doesn't want to undergo surgery. As yet this treatment hasn't been approved in the UK because of cost.

Bladder and vaginal fistulas

If you have a fistula which involves the bladder or vagina, a specialist from the Urology or Gynaecology departments, as well as your IBD team may assess this. Ask your consultant to arrange this.

Bowel to bladder fistulas

Treatment can include:

- resting the bowel. You may be given a liquid food mixture into the bloodstream through a needle in the vein known as parenteral nutrition.
- Antibiotics.
- Steroids.
- medicines such as azathioprine.

Surgery aims to remove the affected bowel, join up the healthy bowel and close the hole in bladder wall. This may be carried out in stages. A recent study showed that many people undergoing surgery for bowel to bladder fistulas maintained remission for over eight years.

Vaginal fistulas.

Medicines aim to treat the underlying active Crohn's or Colitis with antibiotics, immunosuppressants and infliximab.

Operations for vaginal fistulas include:

- draining any abscesses with a loose seton.

- folding a flap of healthy tissue over the fistula opening – known as a vaginal advancement flap.
- using the fat pad inside the outer vaginal lip to close the fistula.⁷⁶ This is known as a modified ‘Martius Graft’.

A surgeon who has specialised in this type of complex and difficult operation will usually perform these.

Bowel to bowel and bowel to skin fistulas.

The aim of surgery is to remove the affected bowel, join up the healthy bowel, and close the fistula opening on the abdominal wall. People with bowel to skin fistulas may need to stay in hospital for long periods.

Some bowel to bowel and bowel to skin fistulas may not need any treatment as they may heal by themselves.

For bowel to bowel and bowel to skin fistulas, biologics, such as infliximab, may help to heal the fistula or improve symptoms.

If surgery is needed with bowel to bowel fistulas, the diseased bowel is removed, and the fistula opening in the healthy bowel is stitched. For bowel to skin fistulas, the fistula may close on its own. But if the fistula stays open for longer than two months this isn’t likely and surgery may be considered.

Some people with these types of fistulas may not absorb adequate nutrients from their food or may lose nutrients through the opening in the skin. This can be treated through a special liquid only diet with all the necessary nutrients or by an infusion of nutrients directly into a vein. Find out more in **Food**.

For **bowel to skin fistulas**, your body fluid levels and electrolytes (levels of sodium, potassium, magnesium, and chloride in the blood) are regularly monitored and corrected to replace any losses. If the fistula opens onto your skin, a drainage bag can be positioned over the area where the fistula opens to collect any discharge. Your skin will need to be protected from the irritant effects of the gut contents as these can injure the skin.

Surgery for bowel to skin fistulas can be difficult. It may be affected by factors such as the position of the fistula and how active your Crohn’s or Colitis is. The aim of surgery is to remove the affected bowel, join up the healthy bowel, and close the fistula opening on

the abdominal wall. People with bowel to skin fistulas may need to stay in hospital for long periods.

If treatments don't work.

It's sometimes hard for fistulas to heal completely if you have active Crohn's, and sometimes fistulas that have closed may come back. Around 1 in 3 people have a fistula relapse – where the fistula comes back.

Unfortunately, none of these ways of closing fistulas is guaranteed to be successful. Multiple or repeat operations may be needed.

Some people continue to have problems with fistulas even when Crohn's is in remission. Sometimes a fistula that isn't painful may remain, but this may still leak and need ongoing care.

Where treatment has not worked for anal fistulas, a small number of people may have an operation to remove the rectum to allow the fistula to heal. The gut is brought to the surface of the abdomen as a stoma so that waste can be collected outside the body in a bag. Find out more in [Surgery for Crohn's Disease](#).

Managing your fistula

If you've had an operation for your fistula, the hospital staff will show you how to do your dressings. When you get home a district nurse may visit to do the dressing for you. Depending on the type of fistula, you may soon find that you can manage this yourself.

You'll have regular reviews to check that the fistula is healing properly. Your IBD team, especially your IBD nurse, will be able to help with practical advice. Your GP and the practice nurse may also be a good source of information about day-to-day care of your fistula.

Talk to your team about the best ways to:

- keep your fistula clean.
- avoid infection.
- protect the surrounding skin – you may be advised to use a barrier cream.

Ask your nurse or doctor about the different types of dressing available. You can get many of these on prescription. If you have a permanent fistula that needs on-going surgical dressings, you can be issued with a 'Medical Exemption Certificate' to get free NHS prescriptions. Talk to your IBD team or GP to find out whether you are eligible.

'I found using fragrance free toilet wipes and using a hairdryer on a very low heat to gently dry my bottom, helped me to prevent getting an infection in the anal fistula I had.'

Lucy, age 45

Living with Crohn's Disease.

Top tips

Caring for your fistula

- With a perianal fistula, only use warm water and soft cotton wool or a disposable cloth, rather than flannels or sponges when you wash the skin around your fistula. Pat it dry rather than rubbing vigorously or try using a hair dryer on a low setting to dry the area.
- Regular warm baths can help to relieve fistula pain and discomfort. But don't use soap or put salt or perfumed products in the water as this can irritate. Make sure to clean the bath every time you use it to avoid any risk of infection. Portable bidets or sitz baths can help to keep the area clean.
- Avoid using anything with a strong perfume, such as scented soap or shower gel, as these may irritate the area. Talc may also irritate the skin. Some people have found that even when a fistula has healed, it's better to continue to use soaps specially made for sensitive skin around the scar area.

Everyday Life

- Your doctor will probably prescribe a barrier cream to protect the skin around the fistula. Avoid using creams or lotions unless your doctor or nurse have recommended these.

- If you have an anal or vaginal fistula don't use tampons or pessaries without checking first with your IBD team. Following surgery for vaginal fistulas you should avoid having sex until your surgical team has checked healing.
- If you have any discharge from your fistula, it can help to wear a pad or panty liner. This may also make sitting more comfortable.
- Cushions or pillows may help to relieve pressure when you're sitting. There are several types of cushions available, such as ring cushions and those made from Tempur which are designed to relieve discomfort and pain. If you have an anal fistula which makes sitting particularly painful, try lying on your side on a sofa or bed.
- It may help to wear loose-fitting clothing and cotton underwear.
- If you've gone back to work and feel you need better access to toilets to help you manage your fistula, our [Employment](#) information can help. Our Talking Toolkit on the [It Takes Guts](#) website can support you to talk to your colleagues and employer.

Using the toilet

- After a recent operation, it can help to take oral painkillers about half an hour before you poo or have your dressing changed to reduce discomfort. But avoid ibuprofen, diclofenac, and aspirin if you can. These are non-steroidal anti-inflammatory drugs (NSAIDs) which may trigger a flare-up of Crohn's or Colitis. Paracetamol may be an option.
- If you find it difficult to pee after surgery, it can help to pee while you're in the bath or shower.
- Take steps to avoid the risk of becoming constipated. Constipation may mean you have to strain when you poo, which could cause complications or pain. Drink plenty of fluids to keep poo soft, as this makes it easier to pass. Ask your doctor if a poo softener such as lactulose or macrogol might help. A dietitian can work with you on a diet that would be best for you. Find out more in our information on [Diarrhoea and Constipation](#).

‘The sitz bath was the easiest, least painful and most effective way for cleaning myself after a toilet motion.’

William, age 61

Living with Crohn’s Disease.

Kit to help manage your fistula.

A kit to help you manage your fistula might contain:⁸⁵

- a small hand mirror.
- disposable wipes and swabs.
- barrier cream.
- clean dressings.
- micropore tape.
- Scissors.
- small pads such as incontinence pads.
- nappy sacks or small plastic bags for easy disposal of used dressings.
- clean underwear.
- hand sanitiser or anti-bacterial handwash.
- odour neutralising spray.

When to seek urgent medical help

If you have an abscess there’s a small risk of developing sepsis, also known as blood poisoning or septicaemia. **This is potentially life-threatening.** Sepsis is not common in people with a simple fistula but can occur in more complex cases or where there’s a large collection of pus such as an abscess that fails to drain. With sepsis, chemicals released into the bloodstream to fight infection can occasionally trigger inflammatory responses throughout the body that lead to organ failure. If not recognised and treated quickly, sepsis can be fatal. If sepsis is detected early and quickly treated people usually recover well.

Warning signs of sepsis include:

- high temperature or fever, chills and shivering, or a low body temperature.
- mottled or discoloured skin.
- if you haven’t peed all day.

- fast heartbeat or fast breathing.
- sudden changes in your mental state or slurred speech.

This is a medical emergency. Sepsis can be hard to spot but if you think you have symptoms call 999 or go to A&E.

Where to go for more help and support

Fistulas can be really difficult to deal with, impacting on your body image and self-esteem. Fistulas can also affect your feelings about sex and intimacy and may make it harder to take part in sport and swimming. It's understandable to feel frustrated and depressed, as well as embarrassed by these symptoms.

Don't be afraid to ask for help. Your IBD team should be able arrange for you to see a psychologist or counsellor. This can help you to feel more in control and able to cope better with living with a fistula. For more help see [Mental health and wellbeing](#)

It may help to remember that having a fistula is not uncommon and that they also occur in people who don't have Crohn's or Colitis. For most people, living with a fistula becomes much more manageable once they get used to the care their condition needs.

Help and support from Crohn's & Colitis UK

We're here for you whenever you need us. Our award-winning information on Crohn's Disease, Ulcerative Colitis, and other forms of Inflammatory Bowel Disease have the information you need to help you manage your condition.

We have information on a wide range of topics, from individual medicines to coping with symptoms and concerns about relationships and employment. We'll help you find answers, access support and take control.

All information is available on our website: crohnsandcolitis.org.uk/information

Our Helpline is a confidential service providing information and support to anyone affected by Crohn's or Colitis.

Our team can:

- help you understand more about Crohn's and Colitis, diagnosis and treatment options.
- provide information to help you live well with your condition.
- help you understand and access disability benefits.
- be there to listen if you need someone to talk to.
- help you to find support from others living with the condition.

Call us on **0300 222 5700** or email helpline@crohnsandcolitis.org.uk.

See our website for LiveChat: crohnsandcolitis.org.uk/livechat.

Crohn's & Colitis UK Forum

This closed-group community on Facebook is for everyone affected by Crohn's or Colitis.

You can share your experiences and receive support from others at:

facebook.com/groups/CCUKforum.

Help with toilet access when out

Members of Crohn's & Colitis UK get benefits including a Can't Wait Card and a RADAR key to unlock accessible toilets. This card shows that you have a medical condition, and will help when you need urgent access to the toilet when you are out. See crohnsandcolitis.org.uk/membership for more information, or call the Membership Team on **01727 734465**.

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Crohn's & Colitis UK information is research-based and produced with patients, medical advisers and other professionals. They are prepared as general information and are not

intended to replace advice from your own doctor or other professional. We do not endorse any products mentioned.

We hope that you've found this information helpful. You can email the Knowledge and Evidence Team at evidence@crohnsandcolitis.org.uk if:

- you have any comments or suggestions for improvements.
- you would like more information about the research on which the information is based.
- you would like details of any conflicts of interest.

You can also write to us at **Crohn's & Colitis UK, 1 Bishops Square, Hatfield, Herts, AL10 9NE** or contact us through the **Helpline: 0300 222 5700**.

About Crohn's & Colitis UK

We are Crohn's & Colitis UK, a national charity fighting for improved lives today – and a world free from Crohn's and Colitis tomorrow. To improve diagnosis and treatment, and to fund research into a cure; to raise awareness and to give people hope, comfort and confidence to live freer, fuller lives. We're here for everyone affected by Crohn's and Colitis.

This information is available for free thanks to the generosity of our supporters and members. Find out how you can join the fight against Crohn's and Colitis: call **01727 734465** or visit crohnsandcolitis.org.uk.