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Management of Mild Crohn's Disease in 2026

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Key Takeaways:

Mild Crohn's disease patients have limited anatomical disease involvement with no severe endoscopic lesions, and absence of stricturing, fistulizing or perianal features. They are usually older, ambulatory, eating well and have no prior surgery, abnormal biochemistry or signs of systemic toxicity.

Non-pharmacological management for mild Crohn's disease can include dietary interventions, NSAID and tobacco avoidance. Pharmacotherapy may include budesonide, sulfasalazine and immunomodulators. Mesalamines should not be used.

Mild Crohn's disease can be managed with close monitoring only. It should include regular clinical and biochemical evaluations with endoscopy, cross sectional studies and health maintenance assessments at recommended intervals.

Introduction

Crohn's disease (CD) is an idiopathic inflammatory condition that in most cases follows a progressive disease course. However, approximately 20% of patients with CD have

mild disease and are at low risk of progression.¹

In a retrospective cohort study among 473 patients with mild CD on presentation, up to 56% maintained a mild phenotype after 5 years of follow-up.² When managing mild CD, it is important to focus on accurate diagnosis, shared therapeutic goals, close monitoring, and health maintenance (Figure 1).

Diagnosis

Mild CD is characterized by limited anatomical disease involvement with no severe endoscopic lesions (Simple Endoscopic Score for Crohn's Disease [SES-CD] 3 to 6; Crohn's Disease Endoscopic Index of Severity [CDEIS] score of 3 to 9), and absence of stricturing, fistulizing or perianal features. Patients with mild CD are usually older (>30 years), ambulatory, able to tolerate oral intake, and have no prior surgery or systemic signs of toxicity such as fever, weight loss, or dehydration. Their biomarkers are generally normal or slightly elevated.³ In addition to endoscopy, small bowel and perianal imaging studies should be performed to ensure accurate



Figure 1. Management of mild Crohn's disease in 2026; created using ChatGPT (OpenAI, GPT-4o, Feb 2026 version) to generate a conceptual layout; finalized and verified by the author (Nancy Fu, MD, MHSc, FRCPC).

diagnosis. A comprehensive assessment is crucial for risk stratification, as some patients with otherwise mild CD may still be at increased risk of complications in the presence of younger age at diagnosis, ongoing tobacco use, early steroid dependence, upper gastrointestinal tract or small bowel involvement, or carry high-risk genetic and serological features.⁴

Goals and Therapies

The treat-to-target framework for management of CD, as described in STRIDE-II,⁵ is equally applicable for patients with mild CD. Providers can consider using a shared decision making process with patients to elicit preferred therapeutic approaches.⁶ Although the treatment armamentarium for CD has expanded, many advanced therapies are not justifiable for this low-risk population, considering their cost and potential adverse effects.

Controlled ileal-release budesonide delivers targeted therapy to the ileum and right colon with low systemic corticosteroid effects, making it a useful, localized induction agent for mild CD.^{7,8} It is significantly more effective than placebo at inducing remission after 8 weeks (47% vs. 22%; risk ratio [RR] 1.93, 95% confidence interval [CI] 1.37 to 2.73), although it is less effective than conventional steroids (52% vs. 61%; RR 0.85, 95% CI 0.75 to 0.97). A typical budesonide induction dose consists of 9 mg orally once daily for 2 months, followed by 6 mg daily for one month, then 3 mg daily for one month. A second steroid course can be considered in patients who relapse upon steroid withdrawal. However, failure to respond to treatment suggests a higher risk of disease progression and should prompt consideration of advanced therapies.

Sulfasalazine (3 to 6 g daily orally in divided doses) is useful for treating symptomatic colonic CD. In a systematic review, sulfasalazine demonstrated a non-significant trend toward greater remission rates over placebo (45% vs. 29%; RR 1.38, 95% CI 1.00 to 1.89).⁹ However, a network meta-analysis reported that sulfasalazine was not significantly superior to any therapy including placebo.¹⁰ Despite limiting supporting evidence, 5-aminosalicylates (5-ASAs) continue to be widely prescribed for management of CD. Comprehensive reviews have failed to show efficacy of 5-ASAs compared to placebo in

inducing remission, achieving mucosal healing, or maintaining remission.⁹⁻¹¹

Immunomodulators, azathioprine (AZA), 6-mercaptopurine (6-MP) and methotrexate (MTX) can be used as maintenance therapy for those with active disease after an initial response to steroid induction. AZA was superior to placebo for maintenance of remission over a 6-to-18-month period (73% vs. 62%; RR 1.19, 95% CI 1.05 to 1.34), although no significant differences were observed between AZA or 6-MP and 5-ASA or sulfasalazine. However, use of AZA/6-MP is less common as maintenance therapy because of their association with an increased risk of adverse events.¹² Intramuscular MTX was superior to placebo (65% vs. 39%; RR 1.67, 95% CI 1.05 to 2.67), whereas low-dose oral MTX showed no significant difference compared to placebo or 6-MP.¹³ Typical doses are AZA 2 to 2.5 mg/kg/day orally, 6-MP 1 mg/kg/day orally, and MTX up to 25 mg weekly by subcutaneous or intramuscular injection, or 15 to 25 mg/week orally. Given the need to balance effectiveness and adverse effects, some clinicians may instead consider biologic agents with more favourable safety profiles for maintenance therapy.

Some patients with mild CD may opt to forgo maintenance medical therapy. This approach is most suitable for motivated patients that engage in proactive disease monitoring. Treatments used for symptomatic relief often include anti-diarrheal agents and dietary modifications. Several dietary therapies have recently been explored for the management of CD.¹⁴ The Mediterranean diet remains the base of dietary recommendations, focusing on fresh fruits and vegetables, monounsaturated fats, complex carbohydrates, and lean proteins. Adherence to a Mediterranean diet for at least 6 months has been associated with improvements in biomarkers and quality of life among patients with CD.¹⁵ Exclusive enteral nutrition is well-established in the pediatric population as a steroid sparing induction method. The Crohn's disease exclusion diet may be an effective therapy for induction of clinical remission and endoscopic response in mild to moderate CD of relatively short duration.¹⁶

Disease Monitoring

Many patients with mild, asymptomatic CD can be managed with monitoring alone. However, providers should be mindful that

CD symptoms may not correlate with disease activity and asymptomatic patients remain at risk of silent disease progression.¹⁷ In a cohort of 60 patients with incidentally diagnosed asymptomatic CD, 88.3% did not receive any treatment after diagnosis, 9.4% experienced a disease flare, 7.5% had developed a change in disease phenotype, and 6% required surgery in subsequent follow-up (median 4.5 years).¹⁸

Patients with CD should undergo regular monitoring with clinical assessments and biochemical marker testing every 6 to 12 months after induction and during remission. Common clinical assessment tools include the Harvey-Bradshaw Index (HBI) and the Crohn's Disease Patient-Reported Outcome 2-item measure (CD-PRO2), which is a two-item subscore derived from the Crohn's Disease Activity Index (CDAI).¹⁹ Recommended laboratory tests include a complete blood count, metabolic and liver panels, albumin, ferritin, renal function, C-reactive protein, and fecal calprotectin. Periodic assessment of micronutrients (vitamins A, D, E, K, B12, and folate, as well as iron, zinc, and magnesium) can be considered depending on disease location. Ileocolonoscopy should be performed within 12 months after diagnosis to ensure mucosal healing, and subsequently as prompted by assessment of active disease and planned according to the dysplasia surveillance schedule. Cross-sectional imaging studies can also be considered every 1 to 3 years.²⁰ Intestinal ultrasound is emerging as a highly accurate, noninvasive bedside tool for the evaluation of CD activity²¹ and is increasingly being used as an alternative to endoscopy and imaging studies for assessing active disease.

Health Maintenance

A proactive health maintenance approach is an important component of care in this low-risk group. Regular use of nonsteroidal anti-inflammatory drugs (NSAIDs) has been found to increase the risk of CD exacerbation,²² while smoking has been associated with greater CD progression and higher rates of complications.²³ Accordingly, limiting NSAID use and promoting smoking cessation should be disease-modifiable care strategies. Other important aspects of preventive care include vaccinations, cancer screening, and assessment of mental health and nutritional status.²⁴

Patients with mild CD represent a unique group that can benefit from behaviour modifications, dietary interventions, and selected use of pharmacological therapies. Ongoing monitoring remains essential to detect disease progression and guide appropriate treatment optimization.

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N.F.: Advisory Boards: Janssen, AbbVie, Celltrion, Eli Lilly, Ferring

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