CRONH'S & COLITIS UK

Fistulas

If you have Crohn's or Colitis, you may develop a fistula. A fistula is a tunnel that connects one organ to another part of your body. Fistulas can cause unpleasant symptoms. But there are different treatments and ways to manage them.

This information is for people affected by Crohn's or Ulcerative Colitis. Fistulas are not associated with Microscopic Colitis.

This information will help you to:

- Understand what a fistula is and what causes them
- Understand what the symptoms are and how a fistula is diagnosed
- Find out about different treatment options for fistulas
- Find ways to live well with a fistula

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Key facts about fistulas

- A fistula is a narrow tunnel that links one organ to another.
- Around 1 in 3 people with Crohn's will develop a fistula at some point. They are less common in Ulcerative Colitis. Fistulas are not associated with Microscopic Colitis
- Anal or perianal fistulas are the most common type of fistula. Symptoms include a sore swelling around the bottom. The pain may get worse when you sit down, move around, poo or cough.
- A combination of medicines and surgery can be used to treat a fistula.
- Contact your GP or IBD team if you think you have a fistula.
- Seek urgent help from your GP or call 111 if you have a temperature, pain and pus drainage, trouble controlling your bowels, vomiting or on-going tummy pain.

"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

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What is a fistula?

A fistula is when a tunnel develops that connects one organ to another part of your body. These tunnels can connect one internal organ to another or to the skin. A fistula can develop in any part of the body, but many involve the gut. A fistula is different to a fissure. A fissure is a small tear in the skin, often around the bottom.

Around 1 in 3 people with Crohn's develop a fistula at some point in their life. This risk is lower in Ulcerative Colitis. Some people develop a fistula before they are diagnosed with Crohn's or Ulcerative Colitis.

Perianal or anal fistulas are more common in men than women. It's not clear if people from some ethnic groups are more likely to develop fistulas than others. For example, some studies have found that anal or perianal fistulas might be more common in Afro-Caribbean, South Asian or Korean people. Others have found that Chinese people may have lower rates of fistula development. More research is needed to know if and why some ethnic groups are more likely to develop fistulas.

Children can also develop fistulas. You might be more likely to develop an anal or perianal fistula if your Crohn's or Colitis started when you were a child. Our supporting your child information has more advice for parents of children with Crohn's or Colitis.

Causes of a fistula

Experts do not fully understand what causes fistulas. Certain genes and gut bacteria may play a role. If you have Crohn's, the cells involved in healing may not work as they should. It is not your fault if a fistula develops.

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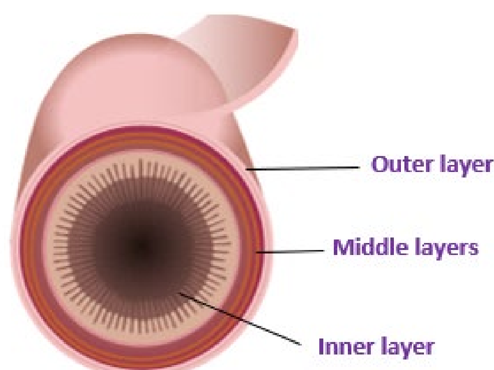

Bowel Layers

Fistulas are more common if you have Crohn's. This is because inflammation can spread through all the layers in the bowel wall. This inflammation can cause small leaks and abscesses to form. An abscess is a buildup of pus. 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

The longer you have Crohn's, the more likely you are to develop a fistula. Fistulas can happen anywhere in the gut, but commonly occur above strictures. Strictures are narrowed areas of the gut. Increased pressure and inflammation above strictures may cause fistulas to develop.

In Ulcerative Colitis inflammation does not affect all layers of the bowel wall. This means fistulas are less likely to form. Fistulas are not associated with Microscopic Colitis.

Different types of fistulas

Fistulas associated with Crohn's

- **Anal or perianal fistulas.** These fistulas connect the very end of the bowel to the skin near the bottom where poo leaves the body. These are the most common type of fistula. They often happen following an abscess around the bottom. An abscess is a painful collection of pus usually caused by infection. If you have an abscess there's a small risk of developing sepsis. Sepsis is life threatening and needs

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urgent medical attention. See when to ask for urgent medical help for more details.
- **Bowel to bladder fistulas.**
- **Bowel to vagina fistulas.**
- **Bowel to skin fistulas.** These fistulas happen most often on the tummy area. They often form after surgery, along the line of the cut. In Crohn's these fistulas may happen even when you have not had an operation. If digestive juices leak out of the bowel and onto the skin, it can become very red and sore. This can increase the risk of skin infection.
- **Bowel to bowel fistulas.** These fistulas link different parts of the bowel together, skipping the section between.

Fistulas associated with Ulcerative Colitis:

- **Ileo-anal pouch fistula.** Some people who have had surgery with pouch formation can develop a fistula. This fistula links the pouch to the bowel, bladder, vagina or outside skin. Treatments include medicine or surgery. For more information on Ileo-anal pouch surgery see Surgery for Ulcerative Colitis

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

Word	Meaning	Fistula type
Peri	around	Perianal - around the bottom (anus)
Entero	bowel or gut	Enteroenteric – linking sections of the gut
Vesical	bladder	Enterovesical – links to the bladder
Cutaneous	skin	Enterocutaneous – opens onto the skin
Colo	colon – part of the large bowel	Enterocolonic – links the colon to another part of the gut
Recto	rectum – part of the large bowel	Rectovaginal – links the rectum to the vagina
Inter	between	Intersphincteric – between two sphincters

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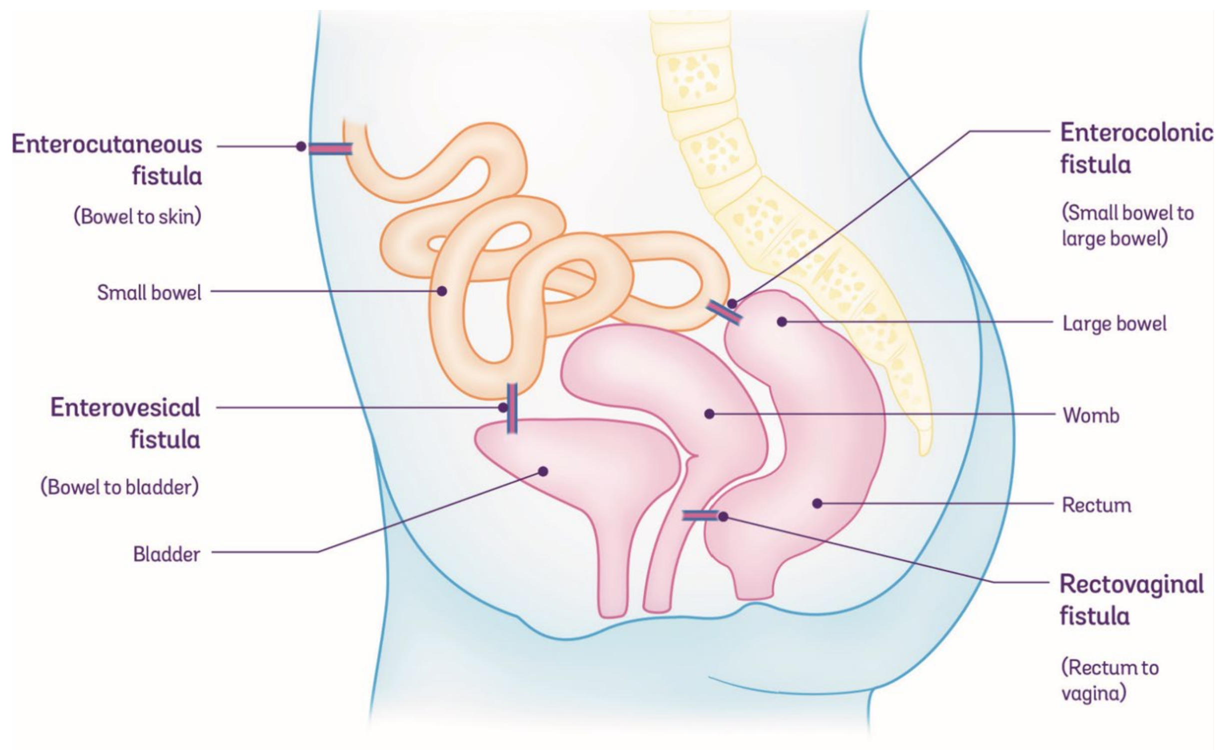

More about anal or perianal fistulas

There are different types of anal fistulas. Understanding the muscles around the bottom (anus) may help you understand the different types. Doughnut shaped muscles, called the anal sphincters, surround the anal canal. The anal canal is the final bit of bowel where poo travels before leaving the body. The anal sphincters allow you to control when you open your bowels to poo.

There are two anal sphincters:

- **Internal anal sphincter.** This is an involuntary smooth muscle which means you cannot mentally control it.
- **External anal sphincter.** This wraps round the internal sphincter. It's the muscle you relax to fart, or squeeze when you feel the urge to poo but do not want to.

Damage to these muscles can mean you have less control over farting and pooing.

The anal sphincters

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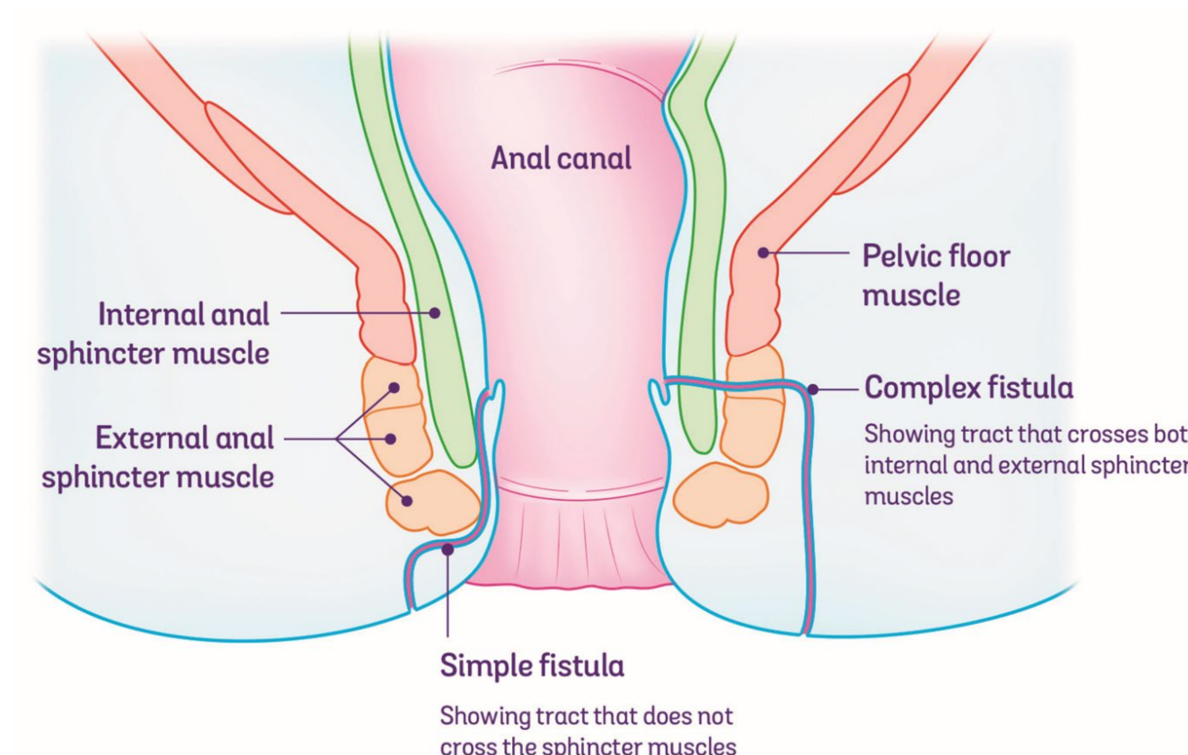

This diagram shows the position of the muscles around the anal canal where poo travels. As well as the anal sphincters, there are the pelvic floor muscles. These also help you to release pee, poo and fart, or to delay releasing until you reach a toilet.

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

- Simple fistulas usually happen below the sphincter muscles. They 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.

Symptoms of a fistula

The symptoms you have will depend on where your fistula is.

Anal fistula. The first sign can be a tender lump in the area around the bottom (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.

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Bladder fistula. Symptoms include passing air, pus, or poo when you pee. Some people find pee may leak from the bottom. You may also have an urge to pee very often and get urinary tract infections (UTIs). You may need to take antibiotics to treat a UTI.

Vaginal fistula. Symptoms include pain which may be mild to severe, depending on how big the fistula is and where it is. It may make having vaginal sex painful, or even impossible at times. Some people with vaginas find they fart, pass poo, or pass pus through the vaginal opening.

Bowel to skin fistula. Symptoms include leakage of gut contents through the skin. This can lead to diarrhoea (loose or liquid poo) and dehydration (when your body loses more fluids than you take in). It may also cause malnutrition (a serious condition that happens when your diet doesn't contain the right amount of nutrients) and upset the body's chemical balance.

Bowel to bowel fistula. Symptoms depend on how much of the bowel is affected and the location of the two ends of the fistula. Where only a short section of gut is skipped by the fistula, people may not have any symptoms. When a large part is involved, people can experience diarrhoea, dehydration and malnutrition.

Diagnosis

The tests you will need depend 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
- If you have an infection

Anal fistula

If your doctor suspects an anal fistula they will carry out a physical examination of the skin around the bottom (anus). Fistulas sometimes look like tiny pits, which may be

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leaking pus or poo. After an initial physical examination, you will have a further physical examination. This second examination will be done under a general anaesthetic. This is because the examination can be painful and it is helpful to have the anal sphincters and pelvic floor muscles relaxed. This is called an examination under anaesthetic or EUA. An EUA helps find out whether the fistula crosses the sphincter muscles. It also allows drainage of any abscesses.

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

- **Pelvic MRI**. This scan uses magnetic fields and radio waves to look at the body.
- **Endoanal ultrasound.** A small probe is inserted up the bottom. Ultrasound waves help find the route of the fistula.
- **Fistulography**. The fistula is injected with an x-ray contrast material, followed by an x-ray. This test is not used very much anymore as it is not very accurate and uses x-ray radiation.

Often, a doctor will use a combination of these techniques to assess a fistula.

Bowel to bladder fistula

Doctors use a long thin telescope with a camera attached at the end to look at the bladder. They will also look at the urethra (the tube which carries pee from the bladder). This is called a cystoscopy. Camera tests to look at the gut (called endoscopy), MRI and CT are also common tests. A CT scan uses x-rays to take detailed pictures of the body.

Vaginal fistula

Sometimes, as well as MRI, ultrasound and fistulography, you might have a blue dye test. 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 skin and bowel to bowel fistulas

Ultrasound, CT, MRI and endoscopy help investigate these types of fistula.

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Treatment

Treatment for fistulas involve medicines, surgery, or a combination of both. Your treatment will depend on the type of fistula you have.

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 has examples of questions you can ask. If you are already taking steroids, your doctor may tell you to stop. This is because steroids can increase the chance of an infection or abscess and the need for surgery.

Anal fistulas

We know more about the treatment of anal fistulas than other types of fistulas.

Medicines

- **Antibiotics.** Antibiotics, such as metronidazole and ciprofloxacin, may help ease discharge. This can make your fistula feel more comfortable. It can take around six to eight weeks for a course of antibiotics to work. Sometimes, treatment lasts for some months. But antibiotics rarely lead to complete and lasting healing.
- **Biologic medicines.** Anti-TNFs such as infliximab and adalimumab can help start and maintain healing. These medicines are started after any abscesses or infections have been treated. Healthcare professionals prefer to use infliximab as it has the biggest evidence base. In clinical trials, more than half the people who took infliximab experienced fistula healing in the short-term. For adalimumab this was around 1 in 3 people. But, even if these medicines start the healing process, they won't always work forever. If anti-TNFs do not work, ustekinumab or vedolizumab might be considered. But the evidence for these medicines is not strong.

Surgery

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Around 2 in 3 people with Crohn's who have an anal fistula will need an operation at some point. The aim of surgery is to heal the fistula while avoiding damage to the anal sphincter muscles.

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

- Where your fistula is
- How much of the anal sphincter muscle is affected

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

Seton insertion

Setons are soft surgical threads. Surgeons will pass setons through the opening in the skin, along the track of the fistula, and out the bottom. The seton is then tied to form a loop. The ends hang out of your bottom, allowing the pus and infection to drain away. The seton is usually left in for several weeks and removed if the fistula is healing. Some people say a seton feels like having a rubber band hanging out of your bottom. After a few days they no longer notice it's there. Inserting a seton before giving infliximab leads to better results. In some cases, setons are a long-term treatment if your fistula is unlikely to heal.

"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.

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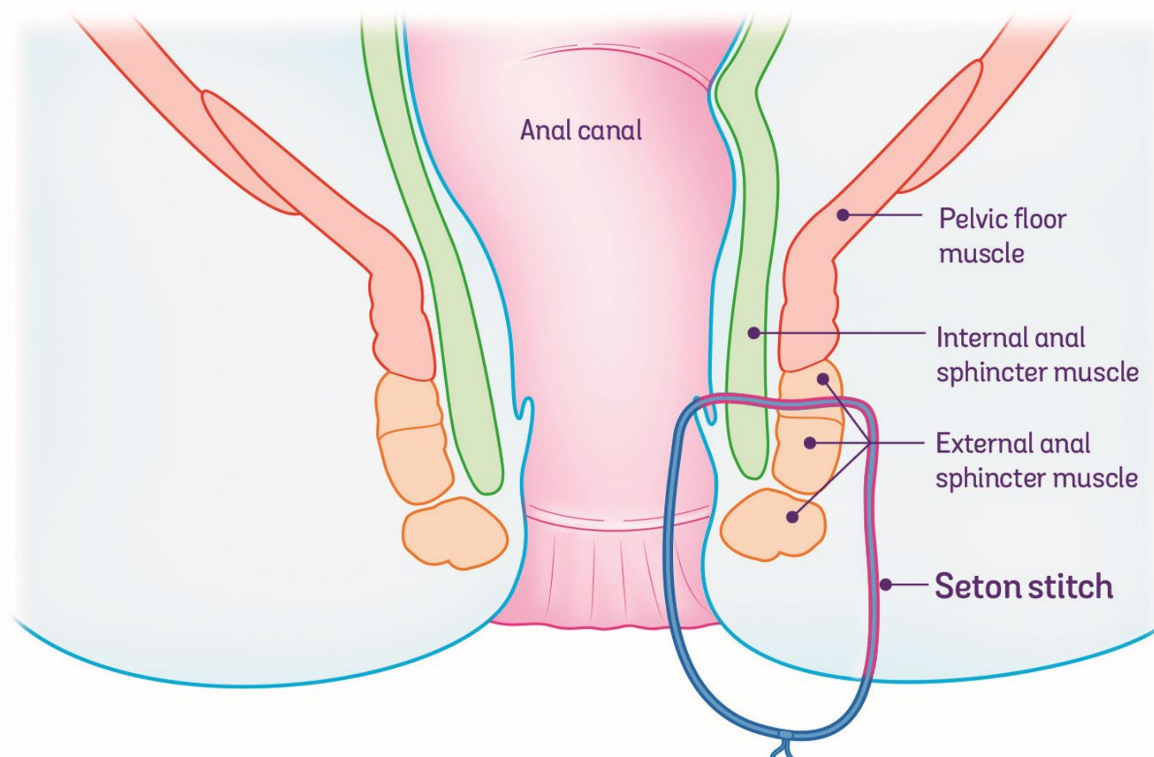

Setons are the most common surgical procedure for a fistula. There are other surgical options, but these won't be offered to everyone. These options include fistulotomy, advancement flap, LIFT and VAAFT. Long-term results following these surgeries are not always good. Results can often be worse for complex and ongoing fistulas.

Fistulotomy

In this operation, the length of the fistula is cut open. Imagine 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 anywhere from a week to several months.

Fistulotomy is only for fistulas that cross the sphincters a small amount, or not at all.

> **"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**

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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

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Advancement flap

The inside of the fistula is removed and the tract cleaned. The hole where the fistula joined the bowel is then covered with a flap. This flap is formed from the lining of the rectum, which is end of the bowel.

This operation is used for complex fistulas. This operation is also used when fistulotomy 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 accesses the space between the internal and external anal sphincter muscles. This is done through a small cut at the entrance to the bottom. Once the surgeon has found the fistula tunnel it is cut in two. Both ends are then stitched closed to stop poo getting into the fistula.

VAAFT (Video-Assisted Anal Fistula Treatment)

Using a telescope camera, the surgeon can see the fistula track from the inside. After cleaning, the fistula track is closed using an electric current. Stitches and fibrin glue can also be used. This technique also helps surgeons find extra passages running off the main fistula. These extra passageways also need treatment for the fistula to heal.

Risks of anal fistula surgery

Like any surgical procedure, surgery for anal fistulas has some risks. The main risks are:

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- Infection
- The fistula comes back (recurrence)
- Loss of bowel control (incontinence). This is a potential risk with most types of anal fistula treatment. Severe incontinence is rare. Your surgeon will make every effort to prevent this.

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. You will have an appointment with a surgeon prior to any operation.

Other treatments

Other treatments include closing the fistula with a special medical glue or paste. A plug made from materials like Gore-Tex® can also be used to cover the hole. Sometimes medical laser probes are used to seal the tract shut.

Stem cells

Stem cells might be effective in treating complex perianal fistulas in mild Crohn's. Stem cells could be useful if medicines have not worked, or someone does not want to have surgery. But this treatment is not approved for use in the NHS. This is because there is not enough evidence that this treatment is effective, and it is expensive.

Stoma formation

If other treatments have not worked, you may be offered an operation to remove the rectum. This allows the fistula to heal. The bowel is brought to the surface of the tummy as a stoma. Poo is then collected outside the body in a bag. Find out more in Surgery for Crohn's Disease.

Bowel to bladder fistulas

Less is known about the best treatment for bowel to bladder fistulas. Treatment can include a combination of:

- Medicines such as steroids, infliximab or azathioprine

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- Antibiotics. Symptoms like needing to pee suddenly or very often, burning, or passing blood can be signs of a urine infection. You may need to take antibiotics to treat a urine infection.
- Surgery
- Resting the bowel. You may get a liquid food mixture into the bloodstream through a needle in the vein. Having liquid food straight into the blood stream stops food from coming into contact with any inflamed bowel.

Generally, medicines are used first to try and control inflammation. If medicines do not work, your IBD team may talk to you about the option of surgery. 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. As well as your IBD team, a specialist from the urology department may also be involved in your care.

Vaginal fistulas

Like bowel to bladder fistulas, less is known about vaginal fistulas. Treatment involves a combination of medicine and surgery. Immunosuppressants, infliximab and antibiotics may help treat the underlying inflammation.

Operations for vaginal fistulas include:

- Draining any abscesses with a seton
- Folding a flap of healthy tissue over the fistula opening (vaginal advancement flap)
- Using the fat pad inside the outer vaginal lip to close the fistula (modified Martius graft)

These operations can be difficult, so specialist surgeons will usually perform them. You are likely to have a team of different surgeons. These could include people specialised in urology, gynaecology and colorectal surgery.

Bowel to skin fistulas

For some bowel to skin fistulas, the fistula may close on its own. But if the fistula stays open for longer than two months this is not likely. If only a small amount of gut contents leaks out of the fistula then medicines like infliximab can be used. If lots of gut contents

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are leaking out it is more likely surgery is needed. Surgery for bowel to skin fistulas can be difficult. It is affected by factors such as the position of the fistula and how active your Crohn's or Colitis is. Your surgeon will remove the affected bowel, join up the healthy bowel, and then closes the fistula opening on the tummy. People with bowel to skin fistulas may need to stay in hospital for long periods of time.

For bowel to skin fistulas, your body's fluid and salt levels are monitored and replaced if needed. Tell your IBD team or GP if the amount your fistula leaks changes from what is normal for you. They might need to assess your fluid and salt levels. A drainage bag can be positioned over the area where the fistula opens to collect any leakage. Your skin will need to be protected from the irritant effects of the gut contents, as these can injure the skin.

Some people with bowel to skin fistulas do not absorb enough nutrients from their food. They may also lose nutrients through the opening in the skin. This can be treated by a special liquid only diet. Find out more in Food.

Bowel to bowel fistulas

Bowel to bowel fistulas do not often need any treatment and they may heal by themselves. But surgery may be needed if there is an abscess or narrowing of the bowel. Here, the unhealthy bowel is removed and the fistula opening in the healthy bowel is stitched. Like bowel to skin fistulas, people with bowel-to-bowel fistulas may be low in nutrients. This can be treated by a special liquid only diet. Find out more in Food.

If treatments do not work

It's sometimes hard for fistulas to heal completely. Unfortunately, no treatment is guaranteed to be successful. Sometimes fistulas that have closed come back. This is called fistula relapse. Around 1 in 3 people with an anal or perianal fistula have a fistula relapse.

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Managing your fistula

If you've had an operation for your fistula, you will have a dressing over your wound. In some cases, this dressing is removed soon after your surgery. In other cases, you might need to change the dressings daily. This will depend on the procedure. Ask your nurse how to best care for your wound before you leave the hospital. Sometimes to stop the skin from healing too quickly, you might have to move your finger over the wound. This is done directly onto the skin. If you feel unable to do this a district or GP practice nurse can help. District nurses work in the community and can visit you in your home. Your IBD team, hospital team or GP can refer you to a district nurse.

Your IBD team, especially your IBD nurse, can 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

Ask your nurse or doctor about the different types of dressing available. You can get many of these on prescription. If you need long-term dressings, you might be able to get a 'Medical Exemption Certificate'. This makes NHS prescriptions free if you live in England. Prescriptions in Scotland, Wales and Northern Ireland are already free. Talk to your IBD team or GP to find out whether you are eligible.

"Having a perianal fistula initially felt quite isolating and I also felt limited in what I could do. However, medication and identifying what worked for me helped me drastically. For example, I've found that being well hydrated and using sensitive wipes rather

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than toilet tissue reduces the pain associated with it."

Eunice, age 19

Living with Crohn's Disease.

Top tips

Caring for your fistula

- Make sure to keep the area clean. Pat the skin dry rather than rubbing. You could also try using a hair dryer to dry the area. Make sure this is on a low setting before use.
- Regular warm baths can help to relieve fistula pain and discomfort. But do not use soap or put salt or perfumed products in the water as this can cause irritation.
- Portable bidets or sitz baths can also help to keep the area clean. Sitz baths are small plastic bowels that fit over the toilet that you can sit on.
- Avoid using anything with a strong perfume, such as scented soap or shower gel. These may irritate the area.
- If you have a scar from a healed fistula you may find it better to use soaps made for sensitive skin around the area.

Everyday Life

- Your doctor may prescribe a barrier cream to protect the skin around the fistula.
- If you have had surgery for a vaginal fistula do not use tampons without talking to your IBD team. Following surgery avoid having sex until your surgical team has checked for healing.
- If you have any discharge from your fistula, it can help to wear an incontinence pad, sanitary 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. Ring cushions may help to relieve discomfort and pain. If you have an anal fistula that 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.
- Exercising with a fistula might be uncomfortable. Gentle walking can help you stay active. You might find our information on Being active with Crohn's or Colitis useful.

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- If you've gone back to work and need better access to toilets our Employment and education information can help.
- You may find it useful to talk to your employer about your situation. This could include letting them know you may need longer toilet breaks to clean yourself after pooing. Our Talking Toolkit can help support you in talking to your colleagues and employer.

Using the toilet

- After a recent operation, it can help to take painkillers before you poo to ease discomfort. Try and take painkillers 20 minutes before going to the toilet. Avoid ibuprofen, diclofenac, and aspirin if you can. These are non-steroidal anti-inflammatory drugs (NSAIDs). NSAIDs may trigger a flare-up of Crohn's or Ulcerative Colitis. Paracetamol is likely to be the safest option. Always stick to the recommended dose on the packet.
- 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 becoming constipated. Constipation may mean you have to strain when you poo. This can 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 like 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.**

Kits to help manage your fistula

You might want to create a kit to help manage your fistula when you're out and about. This might contain:

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- A small hand mirror
- Disposable wipes and swabs
- Barrier cream (as recommended by your doctor or nurse)
- Clean dressings
- Micropore tape
- Scissors
- Incontinence or sanitary 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 ask for urgent medical help

If you have an abscess there's a small risk of developing sepsis. Sepsis is also known as blood poisoning or septicaemia. **This can be life-threatening.** Sepsis is not common in people with a simple fistula. But it can happen where there's an abscess that fails to drain. Sepsis happens when the body goes into overdrive in response to an infection. If not recognised and treated, sepsis can be fatal. If sepsis is detected and treated early 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. This can appear as blue, grey, pale or blotchy patches. On brown and black skin this may be easier to see on the palms of the hands or soles of the feet
- If you have not peed all day
- Fast heartbeat or fast breathing
- Sudden changes in your mental state or slurred speech
- A rash that doesn't fade when you roll a glass over it

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.

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Where to go for more help and support

Fistulas can be difficult to deal with and can have a negative effect on:

- Your body image and self- esteem
- Your feelings about sex and intimacy
- Your ability to take part in everyday activities, such as exercise

It may help to remember that lots of people have a fistula. Fistulas also happen in people who do not have Crohn's or Ulcerative Colitis. For some people, living with a fistula becomes easier once they get used to the care their fistula needs.

Some people find that having a fistula impacts body confidence, sex and relationships. Our Sex and Relationships resource has more information.

Do not be afraid to ask for help. Your IBD team should be able to arrange for you to see a psychologist or counsellor, or you can refer yourself. This can help you feel more in control and able to cope better with living with a fistula. For more help see Mental health and wellbeing

Other organisations

Continence Product Advisor – provide information and advice about continence products.

https://www.continenceproductadvisor.org/

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.

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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.

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

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

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.

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We hope that you've found this information helpful. You can email the Knowledge and Information 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**.

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