NGN NCLEX · 2026 TEST PLAN · GASTROINTESTINAL

MED-SURG | GI | HIGH-YIELD

Crohn's Disease vs. Ulcerative Colitis

Two faces of Inflammatory Bowel Disease — a side-by-side clinical judgment guide for priority recognition, pharmacology, and NCLEX traps.

01 Definition & Overview

WHAT IT IS · WHY IT MATTERS

IBD · UMBRELLA TERM

Inflammatory Bowel Disease

A group of **chronic, idiopathic autoimmune** disorders causing inflammation of the GI tract. Characterized by **remissions and exacerbations** across the patient's lifetime.

CROHN'S DISEASE

Mouth → Anus. Anywhere.

Can inflame **any segment** of the GI tract, but favors the **terminal ileum**. Inflammation is **transmural** (all bowel wall layers) with patchy "**skip lesions**" and a cobblestone appearance.

ULCERATIVE COLITIS

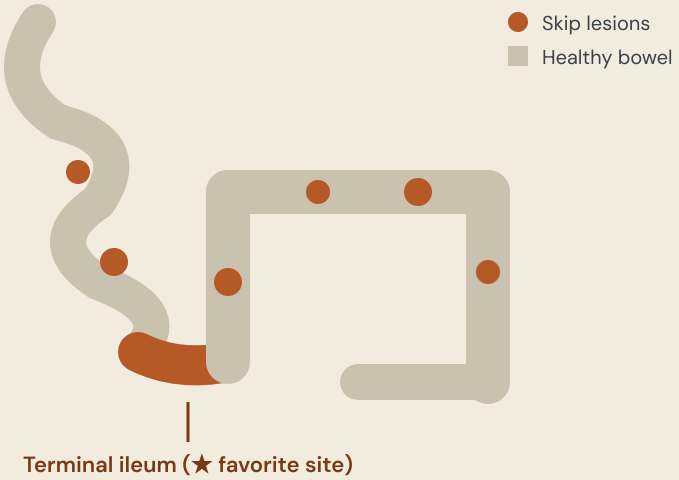
Colon & Rectum. Only.

Limited to the **large intestine and rectum**. Inflammation is **continuous**, starts in the rectum and spreads proximally, affecting only the **mucosa & submucosa**.

02 Anatomy & Pathophysiology

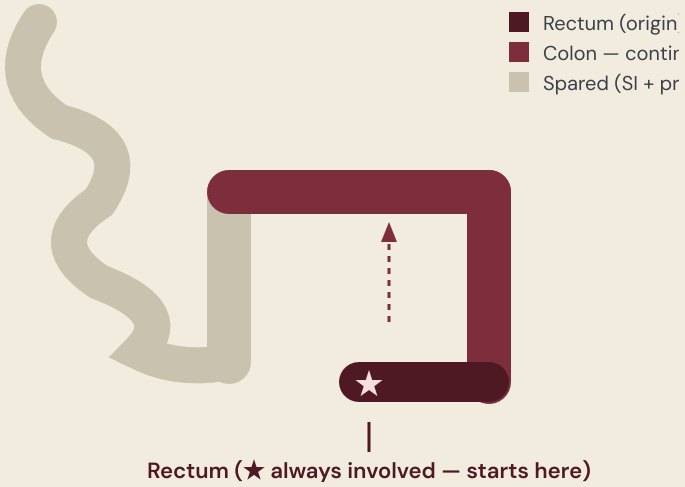
WHERE · HOW DEEP · WHAT PATTERN

Crohn's — Patchy & Transmural



- **Skip lesions** — inflamed areas between normal bowel
- **Transmural** inflammation → fistulas, strictures, abscesses
- **Cobblestone** mucosal appearance on colonoscopy
- Surgery is **NOT curative** — disease recurs

Ulcerative Colitis — Continuous & Superficial



- **Continuous** inflammation — no skip areas
- **Mucosa & submucosa only** — superficial, not full-thickness
- Starts in **rectum**, spreads proximally through colon
- Total colectomy **IS curative** — disease cannot recur without a colon

03 Side-by-Side Clinical Comparison

THE NCLEX'S FAVORITE DISTINCTION

Feature	Crohn's Disease	Ulcerative Colitis
LOCATION	Mouth → anus; favors **terminal ileum**	**Colon & rectum only**
PATTERN	**Skip lesions** (patchy)	**Continuous** (rectum upward)
DEPTH	**Transmural** (all layers)	**Mucosa & submucosa** only
PAIN LOCATION	**Right lower quadrant (RLQ)** — cramping	**Left lower quadrant (LLQ)** — crampy
DIARRHEA	5–6 loose stools/day · **non-bloody** · **steatorrhea** (fat)	10–20 stools/day · **BLOODY** · mucus · tenesmus (urgency)
WEIGHT LOSS	**Severe** — malabsorption of B12, fat, vit D	Mild to moderate
COMPLICATIONS	**Fistulas, strictures, abscesses, obstruction, perianal disease**	**Toxic megacolon**, perforation, hemorrhage, ↑ colon cancer risk
SCOPE FINDING	**Cobblestone** mucosa	Friable mucosa, **pseudopolyps**, ulcerations
SURGERY	**NOT curative** — recurs at anastomosis	**Total colectomy = CURE**
SMOKING	**WORSENS** Crohn's	Paradoxically may ease UC (but still quit!)

04 Red Flag Complications

PRIORITY RECOGNITION · LIFE-THREATENING

Toxic Megacolon — UC Emergency

Massive colonic dilation with systemic toxicity. **Risk of perforation = sepsis = death.**

- ⚠ **Fever > 101.5°F (38.6°C)**
- ⚠ **Tachycardia > 120 bpm**
- ⚠ **Abdominal distension** & tenderness
- ⚠ **Dehydration, hypotension**
- ⚠ Altered mental status
- ⚠ Decreased / absent bowel sounds
- ⚠ Hypokalemia, metabolic alkalosis
- ⚠ **NEVER** give antidiarrheals in acute UC — can trigger this!

PERFORATION

Bowel Perforation

Sudden, severe abdominal pain · rigid board-like abdomen · rebound tenderness · signs of shock. **Call HCP immediately.**

CROHN'S

Obstruction & Fistula

Strictures narrow the lumen → obstruction (no stool/flatus, vomiting). Fistulas connect bowel to skin, bladder, vagina — **drainage, UTIs, passage of stool/air through unusual sites**.

UC · LONG-TERM

Colorectal Cancer

UC increases colon cancer risk significantly after ~10 years. **Annual colonoscopy surveillance** is essential patient education.

05 Priority Nursing Interventions

ABC · SAFETY · CLINICAL JUDGMENT

ASSESS & MONITOR

Recognizing Deterioration

- → **Vital signs** — fever, tachycardia, hypotension = brewing sepsis
- → **Abdominal assessment** — bowel sounds, distension, rigidity, tenderness
- → **Stool** — count, character, presence of blood, occult blood
- → **Strict I&O** and daily weight (same time, same scale)
- → **Electrolytes** — especially K^+ (diarrhea depletes potassium fast)
- → Skin: assess perianal area for breakdown & fistula drainage

ACT & TREAT

Acute Flare Management

1. **NPO** — rest the bowel during acute exacerbation
2. IV fluids + electrolyte replacement (K^+, Mg^{++})
3. Administer prescribed meds: aminosalicylates, corticosteroids, biologics
4. Pain management (**avoid opioids** — risk of toxic megacolon + ileus)
5. TPN for severe malabsorption / prolonged NPO
6. Emotional support — chronic illness, body image, fatigue

06 Pharmacology Spotlight

5 DRUG CLASSES · STEP-UP THERAPY

Sulfasalazine · Mesalamine

5-ASA / AMINOSALICYLATES

ACTION

Anti-inflammatory on bowel mucosa — **first line for UC**

SIDE EFFECTS

Photosensitivity (sunscreen!), HA, rash, nausea, orange-yellow urine, folate deficiency

NURSING

Give with food + full glass of water; monitor CBC; allergy alert if sulfa allergy

Prednisone · Budesonide

CORTICOSTEROIDS

ACTION

Reduces acute inflammation during flares

SIDE EFFECTS

Hyperglycemia, immunosuppression, weight gain, moon face, osteoporosis, mood swings, ↑ BP

NURSING

NEVER stop abruptly — taper! Short-term use only; monitor BG, signs of infection

Azathioprine · 6-MP · Methotrexate

IMMUNOSUPPRESSANTS

ACTION

Suppress immune response; steroid-sparing maintenance therapy

SIDE EFFECTS

Bone marrow suppression, hepatotoxicity, ↑ infection risk, pancreatitis

NURSING

Monitor CBC, LFTs; avoid live vaccines; report fever/bruising; MTX + **no aspirin**

Infliximab (Remicade) · Adalimumab (Humira)

BIOLOGICS / ANTI-TNF

ACTION

Neutralize TNF-alpha → blocks inflammatory cascade

SIDE EFFECTS

Infusion reactions, reactivation of latent infections (**TB, hepatitis**), serious infection risk

NURSING

TB skin test & hepatitis screen BEFORE starting; monitor during infusion; teach infection prevention

Metronidazole (Flagyl) · Ciprofloxacin

ANTIBIOTICS

ACTION

Treat fistulas, abscesses, bacterial overgrowth — especially in Crohn's

SIDE EFFECTS

Metallic taste, peripheral neuropathy, **disulfiram-like reaction** with alcohol

NURSING

Avoid all alcohol during & for 48h after metronidazole; assess for neuropathy

Loperamide · Diphenoxylate

ANTIDIARRHEALS — *USE WITH CAUTION*

ACTION

Slow peristalsis for chronic diarrhea in **stable** disease

SIDE EFFECTS

Can precipitate toxic megacolon in acute UC flare!

NURSING

NEVER give during acute exacerbation of UC; only for mild, stable outpatient use per HCP

07 NCLEX Test Traps ⚠

WHERE STUDENTS LOSE EASY POINTS

TRAP #1 · DIET TIMING

"Which diet should the nurse implement during an acute IBD flare?"

~~High-fiber, high-residue~~ → **NPO or low-residue, high-protein, high-calorie**. Fiber is introduced ONLY during remission.

TRAP #2 · ANTIDIARRHEAL DANGER

"The client with acute UC flare has 15 bloody stools/day. Which PRN order should the nurse question?"

Answer: **Loperamide (Imodium)**. Slowing peristalsis during an acute flare can precipitate **toxic megacolon** and perforation.

TRAP #3 · BLOODY VS. FATTY

"The client reports non-bloody loose stools with oily appearance. Which disease is most likely?"

Answer: **Crohn's** (steatorrhea = malabsorption). **Bloody diarrhea** points to UC.

TRAP #4 · "SURGERY CURES IT"

"A client with Crohn's is scheduled for bowel resection. What teaching is appropriate?"

~~"Surgery will cure your disease"~~ → **Surgery relieves symptoms but Crohn's recurs.** Only UC is cured by total colectomy.

TRAP #5 · CORTICOSTEROID DISCONTINUATION

"The client feels better and stops prednisone. What is the priority concern?"

Adrenal crisis — corticosteroids must be **tapered, never abruptly stopped**. Teach reliably before discharge.

TRAP #6 · BIOLOGIC PRE-SCREENING

"Before initiating infliximab, which test is essential?"

Answer: **TB skin test (PPD) and hepatitis B screen**. Biologics can reactivate latent infections.

TRAP #7 · PAIN MED CHOICE

"Which pain medication should be avoided in the patient with acute IBD?"

Opioids — slow GI motility and increase risk of **toxic megacolon** & ileus. **NSAIDs also avoided** — worsen bowel inflammation.

08 Patient Education

EMPOWERING SELF-MANAGEMENT

LIFESTYLE & SELF-CARE

Daily Management

1. **Medication Compliance**
   Take meds as ordered — even when symptoms resolve. Stopping = relapse risk. Never stop steroids abruptly.
2. **Stress Management**
   Stress does not cause IBD but triggers flares. Teach relaxation, counseling, support groups.
3. **Smoking Cessation**
   Crohn's patients: smoking worsens disease and surgical recurrence. Refer to cessation programs.
4. **Colonoscopy Screening**

NUTRITION

Dietary Guidance

🚫 Avoid During Flares

- High-fiber (raw fruits, veggies, whole grain)
- Nuts, seeds, popcorn
- Dairy (if lactose intolerant)
- Caffeine, alcohol, carbonated drinks
- Spicy, fried, fatty foods
- Cold or very hot foods

✅ Encourage

- Small, frequent meals (5–6/day)
- High-protein, high-calorie foods
- Low-residue during flare
- Cooked/canned fruits & veggies (peeled)
- White bread, rice, refined grains
- Plenty of fluids (oral rehydration)

UC: annual colonoscopy after 8–10 years of disease due to elevated colon cancer risk.

5

Symptom Diary

Log stools, foods, pain, stress. Helps identify personal triggers and assess treatment.

- Vitamin B12, iron, folate supplements

Report to HCP: fever, severe pain, >6 stools/day, bloody stools, vomiting, weight loss, dehydration.

09 Clinical Judgment — NCJMM Framework

THINK LIKE A NURSE · NGN 2026

01
RECOGNIZE CUES

Bloody diarrhea (UC), RLQ pain + weight loss (Crohn's), fever, tachycardia, abdominal distension, low K^+, fatigue, skin breakdown at fistula sites.

02
ANALYZE CUES

Differentiate flare vs. remission. Identify complication: toxic megacolon? Perforation? Obstruction? Match cues to disease pattern — Crohn's transmural vs. UC mucosal.

03
PRIORITIZE HYPOTHESES

Airway/hemodynamic stability first → fluid/electrolyte balance → infection/sepsis risk → bowel rest → symptom management → psychosocial.

04
GENERATE SOLUTIONS

NPO + IV fluids, steroids/5-ASAs, monitor electrolytes, hold antidiarrheals in acute UC, surgical consult if toxic megacolon develops, nutritional support (TPN).

05
TAKE ACTION

Administer meds safely (taper steroids, pre-screen biologics), maintain IV access, daily weights, strict I&O, perianal skin care, document stool pattern.

06
EVALUATE OUTCOMES

Stool frequency ↓, no bleeding, VS WNL, weight stable/gaining, electrolytes WNL, no signs of complications, patient verbalizes understanding of meds & diet.

10 Memory Boosters & Mnemonics

PATTERN RECOGNITION FOR EXAM DAY

CROHN'S *"Cobblestones & Cramping"*

C	**Cobblestone** mucosa on scope
R	**RLQ** pain · Rectal sparing
O	**Obstruction** & fistulas (transmural)
H	**High** risk malabsorption (B12, fat, vit D)
N	**No blood** typically · **No cure** with surgery
'S	**Skip lesions** · **Smoking** worsens

ULCERS *"Urgency & Bloody Stool"*

U	**Ulcerations** continuous in colon
L	**LLQ** pain · **Large** blood in stool
C	**Colon only** (mucosa & submucosa)
E	**Extends** proximally from the rectum
R	**Rectum** always involved · **Risk** of toxic megacolon & cancer
S	**Surgery** (colectomy) is CURATIVE

PATTERN

"Crohn's Can Climb"

Crohn's **Can occur anywhere**, Climbs through **all layers** (transmural). UC stays **low & shallow** — colon only, mucosa only.

PATTERN

"Skip or Sweep"

Crohn's **SKIPS** around (patchy). UC **SWEEPS** continuously from rectum up.

PATTERN

"Right vs. Left"

RLQ pain = Crohn's (terminal ileum is on the **Right**). **L**LQ pain = UC (sigmoid/rectum on the **Left**).