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**Influence of environmental factors on the onset and course of inflammatory bowel disease**

Dutta AK *et al*. Environmental factors and IBD

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**Abstract**

Numerous environmental factors have been linked with inflammatory bowel disease. These include smoking, diet, hygiene, drugs, geographical and psychosocial factors. These factors may either increase the risk of or protect from developing this condition and can also affect the course of illness in a positive or negative manner. A number of studies have explored the influence of environmental factors on whole of inflammatory bowel disease as well as on ulcerative colitis and Crohn’s disease separately. As there are differences in the pathogenesis of ulcerative colitis and Crohn’s disease, the effect of environmental factors on their onset and course is not always similar. Some factors have shown consistent association while reports on others have been conflicting. In this article we have discussed the current evidence on the role of these factors on inflammatory bowel disease, both as causative/protective agents and as a modifier of disease course.

**Key words:** Environmental factors; Crohn’s disease; Ulcerative colitis; Etiology; Outcome

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**Core tip****:** Environmental factors have an important influence on the onset and course of inflammatory bowel disease. Multiple factors have been implicated with some showing consistent effect while the roles of others have been variable. The current evidence on their role in inflammatory bowel disease has been discussed. A better understanding of these factors may help plan preventive strategies in future.

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**INTRODUCTION**

The latter half of twentieth century witnessed a steep increase in prevalence of inflammatory bowel disease (IBD) in developed nations of North America and Europe. During the last three decades populations previously considered as low risk such as in Asia and eastern Europe are witnessing a substantial increase of this disease[1]. This may be explained by change of environmental factors in these regions. The environmental factors that have been proposed to play a role in the emergence of IBD are smoking, diet, drugs, major life stressors, hygiene and lifestyle[1,2]. In this paper we review the role of environmental risk factors on the onset and course of ulcerative colitis (UC) and Crohn’s disease (CD), the two main types of IBD.

**ENVIRONMENTAL FACTORS IN THE PATHOGENESIS OF IBD**

IBD is a complex disorder where interplay between host genetics, gut microbiota and environmental factors are regarded as drivers of chronic inflammation in the gut[3]. Genetic factors play an important role with more than 150 IBD susceptibility gene loci identified to date. However, about two-thirds of the patients with IBD have no identifiable genetic defect which suggests that gut microbiota and environmental factors play an important role[4]. Studies on people migrating from countries with low prevalence of IBD to regions with high prevalence have shown increased risk of IBD among migrants further supporting the role for environmental factors[5-8]. These factors include smoking, diet, drugs, psychosocial factors, climate, pollution and hygiene[9]. Composition of gut microbiota , currently considered a key factor in the pathogenesis of IBD is affected by environmental factors like breast feeding, antibiotics, smoking, obesity and diet[10,11]. For example, breast fed and formula fed infants show difference in quantity of *Bifidobacteria* in the gut[12]. Smoking cessation changes the gut flora by increasing the proportion of *Firmicutes,* reducing *Proteobacteria* and increasing microbial diversity making the flora different from gut microbiota in IBD where there is abundance of *Proteobacteria* and *Actinobacteria* , reduced *Firmicutes* along with reduced microbial diversity[10,13]. These data suggest that alteration of microbial composition of intestine by environmental factors is one mechanism by which environmental factors increase susceptibility to IBD.

Environmental factors may also directly act on the intestinal mucosa and alter immune function and gene expression. This can be due to change in intestinal permeability, alteration of host gene expression by epigenetic modification or other mechanisms[14-16]. The end result is an abnormal host immune function and chronic inflammation in the gut. An interesting example of how environmental factors affect gut immune function is provided by studies on transcription factor aryl hydrocarbon receptor (AhR)[17]. This transcription factor which is altered by dietary and environmental factors affects innate immunity in gut and immune cells (T cells and natural killer cells). Intestinal T cells and natural killer cells isolated from Crohn's disease patients have shown low levels of expression of AhR and these receptors respond to AhR ligands by upregulating interleukin-22 and downregulating inflammatory cytokines[17]. It is therefore plausible that environmental factors that downregulate AhR alter immune function and predispose to CD[17]. Smoking has also been shown to affect gene expression and immune function in gut[18]. The complex interaction between host genes and environmental factors works both ways[19]**.** While the above examples demonstrate the effect of environment on host gene expression, host genes can also influence the composition of microbiota which forms the local gut environment. *NOD2* gene mutation predisposes to development of IBD. A possible mechanism may be alteration in gut microbiota in *NOD2* gene mutation as shown in animal studies[20].Mutation in autophagy-related 16-like 1 gene (*ATG16L1*) have also been found to increase the risk of IBD and it is possible that defective autophagy may alter the gut microbiome[19]. Further insights into gene environment interaction will lead to a better understanding of the pathogenesis of IBD.

The ‘hygiene hypothesis’ has been commonly cited as the reason for difference in prevalence of IBD in different regions[21]. Better hygiene in developed regions leads to reduced microbial exposure in childhood which may affect development of gut immune system and immune tolerance. Helminth infestation in animal models has been shown to upregulate Th2 cytokines and attenuate Th1 pathway in the intestinal mucosa leading to suppression of inflammation and enhancement of the mucosal barrier[22,23]. Reduced exposure to helminths in developed societies, has been suggested to be a risk factor for CD. Other factors like stress, linked to exacerbation of IBD, may affect immune function by altering gut permeability and NSAIDs by non-selective inhibition of cyclo-oxygenase[24,25].

Dietary factors may affect gut immune function directly in addition to their effect on microbiota[26]. There has been a recent increase in interest in the role of vitamin D in CD[27]. Our group and others have shown that vitamin D levels are reduced in patients with CD and levels correlate negatively with disease activity[28]. Data obtained mainly from animal studies have shown that vitamin D has immune regulating properties[29]. This includes maintenance of CD8+ T cells in quiescent stage, shifting the cytokine profile to anti-inflammatory type and inhibition of epithelial cell apoptosis mediated by vitamin D receptor[29]. Chen *et al*[30] have shown that TNF-α downregulates vitamin D receptor which in turn may promote inflammation. High fibre diet protects against IBD by promoting formation of short chain fatty acids (SCFA) like butyrate which are a source of energy for colonocytes and by regulating T cell function[31]. Nurses health study showed that soluble dietary fiber (fruits and vegetables) was associated with a reduced risk for CD[31]. Protective effect of fruits and vegetables may be through their antioxidant properties and clearing of reactive oxygen species[32]. Red meat has been associated with increased risk of IBD. Linoleic acid (long-chain omega-6 fatty acid) found in red meat and food oils is metabolized to arachidonic acid metabolites which are involved in the production of inflammatory mediators such as leukotrienes and prostaglandins[33]. Higher consumption of fish oils made up of omega-3 fatty acids ( higher omega-3 to omega-6 fatty acid ratio) has been shown to be protective in children with CD[32]. There is some evidence that phytochemicals like curcumin found in turmeric, have antioxidant and free radical scavenging property which may limit inflammation and help maintain remission in IBD[34,35]. These data suggests that environmental factors play a role in pathogenesis of IBD by altering gut microbiota and affecting gut immunity by numerous mechanisms.

**INTERPRETING THE AVAILABLE EVIDENCE**

There are a large number of publications exploring the link between environmental factors and IBD. Except for smoking and appendectomy, the roles of other risk factors have been inconsistent and it is important to understand the type of study design when interpreting the results of these studies. Many of these are case-controls studies which are relatively easy to perform and require few resources. However an important limitation is the recall bias which affects the accuracy of ascertaining risk factors. Several prospective cohort studies have been done and data obtained from them are more robust. An important cohort study of note in this regard is the Nurses Health Study (NHS) I and II from USA[31]. NHS I was initiated in 1976 and had 121700 subjects and NHS II was initiated in 1989 and had 116000 subjects. Periodic assessment of factors like smoking, OCP, alcohol and diet were carried out prospectively and occurrence of disease was noted. While this was mainly initiated for the outcomes of cardiovascular illness and cancer, a number of studies have been published on the role of these factors and IBD. The main limitation is that the subjects were women and most of them were white and generalisability across race, gender and various socioeconomic strata is difficult. Some of the studies have made use of population based registry to minimise referral bias and reflect population characteristics[36]. Finally a number of meta-analysis have been published on various risk factors and IBD and these represent higher quality of evidence. One must be cautious in interpreting the results of meta-analysis as inclusion of low quality studies and heterogeneity among studies may affect the outcome.

**ENVIRONMENTAL FACTORS AND ONSET OF IBD**

A large number of environmental factors have been proposed to have a causative or protective effect on the onset of both CD and UC. Available evidence from many of these studies has been summarised in Tables 1, 2 and 3. These tables have been grouped according to the study design to keep the quality of evidence in perspective. Table 1 includes meta-analysis, Table 2 cohort studies and Table 3 summarises data from case control studies.

***Smoking***

There is adequate evidence linking smoking with IBD. It has opposing effects on CD and UC. The meta-analysis by Mahid *et al*[37] showed that current smoking increases the risk of CD but has a protective effect on onset of UC. Interestingly former smokers had an increased risk of developing UC. Data from NHS cohort showed that both current and former smoking was associated with increased risk of CD[38]. Unlike the result from meta-analysis, the study showed current smoking was not protective against UC but former smoking was a risk factor. Population based case-control studies from New Zealand, Hungary and Sweden have also shown increased risk of CD and decreased risk of UC with smoking[39-41]. The strong data linking smoking to IBD suggests that prenatal and childhood exposure to passive smoking may predispose to CD. However a meta-analysis which included 13 studies did not show any significant impact of prenatal and childhood exposure to smoking on the occurrence of CD or protection against UC[42]. Based on these data, there is a strong case to recommend smoking cessation to reduce risk of CD.

***Diet, vitamin D and breast feeding***

Western diet high in refined sugar and low in fibre has been proposed as a risk factor for IBD[26]. Increasing consumption of western diet is considered a reason for rising incidence of IBD in Asia. The Nurses Health Study (NHS) data on 170776 subjects showed that intake of a median of 24. 3 g of fibre per day reduced the risk of CD by about 40%[31]. Further analysis showed that this benefit was highest for soluble fibre in fruits while insoluble fibre from legumes, whole grains and cereals did not affect the risk. Interestingly the amount and type of fibre had no significant impact on risk of UC[31]. A case control study from Canada exploring dietary pattern and risk of CD among subjects upto 20 years of age found a diet containing vegetable, fish, olive oil, fruit, grain and nut was negatively associated with CD[43]. Another case control study from Denmark showed increased risk of both CD and UC in patients on a diet containing low fibre and high sugar[44]. A study from our center showed regular fish consumption reduces the risk of CD[45]. Tjonneland *et al*[46] performed a nested case control study from the participants of EPIC (European Prospective Investigation into Cancer and Nutrition ) study to assess link between dietary linoleic acid (source of arachidonic acid whose metabolites encourage inflammation) and UC. Dietary linoleic acid was found to be associated with increased risk of developing UC and the effect was greater with higher intake[46].

There has been increasing reports of vitamin D deficiency among patients with IBD especially CD[27]. While this may be a consequence of the disease, vitamin D may also play a role in modulating gut immune function and have an effect on onset of IBD[47]. The prospective study on 72719 subjects in the NHS cohort showed a protective role for a higher predicted vitamin D level against development of CD[48]. A case control study by our group in India which included 34 patients with CD and 34 controls found significantly low level of serum 25(OH) vitamin D in patients compared with controls (16. 3 ± 10. 8 ng/mL *vs* 22. 8 ± 11. 9 ng/mL, *P <* 0. 05)[28]. Disease severity had a negative correlation with vitamin D levels. Lower duration of sunlight exposure with consequent vitamin D deficiency in northern latitudes might be a factor contributing to north-south gradient of IBD but this needs to be confirmed. In contrast to the above positive studies, a case control study from USA failed to show significant difference in the vitamin D levels between IBD subjects and controls[49].

The data on breast feeding and onset of IBD is conflicting. The meta-analysis by Barclay *et al*[50] showed that breast feeding reduced the overall risk of early onset IBD but had no impact on the onset of CD or UC separately. The recently published case control study from Asia Pacific region which had subjects from different Asian countries and Australia showed that breast feeding for more than a year reduced the risk of both CD and UC[51]. The case control studies from Slovakia in 2013 and Denmark in 2011 also suggested that breast feeding may be protective[44,52]. In contrast data from 146681 subjects in the NHS cohort did not show any association between breast feeding with onset of CD or UC[53]. Interestingly, a study from France showed that breast feeding may increase the risk of CD.

The evidence for benefits of high fibre and low fat diet, longer period of breast feeding and correcting vitamin D deficiency in preventing IBD is not conclusive. However, as some studies show that they may be beneficial and as they also have other health benefits, it may be reasonable to encourage these interventions.

***Drugs***

Among the drugs, oral contraceptive pills (OCP), non-steroidal anti-inflammatory drugs (NSAID) and antibiotics have often been linked to onset and course of IBD. The meta-analysis by Cornish *et al*[54], which included 14 studies having a total of 75815 subjects showed increased risk of CD with the use of OCP and risk increased with longer duration of use. There was also an increased risk of developing UC but the effect was less than in CD. A large prospective cohort study involving 232452 women (NHS 1 and 2) also showed that oral contraceptive use was associated with CD. The association of OCP with UC was restricted to women with a history of smoking[55]. Though current evidence suggests that there is a moderate association between exposure to OCPs and the development of CD, no conclusions can be made regarding the use of OCP and risk of developing IBD.

A study which explored the risk of IBD with NSAID and aspirin intake among 76795 subjects from NHS I cohort found an increased risk of developing CD and UC among those who used NSAID for at least 15 d every month. There was however no association between aspirin use and IBD[56]. Antibiotics, by affecting gut microbiota, may modulate gut immune response and might be a risk factor for IBD. A nested case control study from Canada (2234 patients and 22346 controls) which assessed the risk of IBD with antibiotic use (2-5 years pre diagnosis ) found a positive association between antibiotic use and risk of both CD and UC[57]. In a case control study involving 587 patients with Crohn’s disease , antibiotic use 2–5 years pre-diagnosis was found more often in patients than controls[58]. Virta *et al*[36], from Finland used the national register to explore the link between antibiotics and risk of UC and CD. They found an increased risk of pediatric CD but no added risk for pediatric UC with the use of antibiotics. Study also showed stronger association of CD in boys and with the use of Cepahalosporins[36]. Interestingly a study from Asia Pacific showed decreased risk of CD and UC with antibiotic usage[51]. Data on the association of IBD with specific antibiotics are limited to pediatric literature. Penicillins, cephalosporins, and tetracyclines have been linked with the development of CD, but the exact mechanism is not well understood[59,60]. Though studies support a link between antibiotic exposure and the onset of CD, causality has not been firmly established. However, prudent use of antibiotics is good clinical practice. Interpreting the association of drugs with IBD is challenging because of the wide variety of antibiotics, NSAIDs and OCPs available as well as difficulty in determining the magnitude, type of exposure and duration of use of the drugs.

***Hygiene***

A number of studies have explored surrogate factors associated with ‘hygiene hypotheis’ and risk of IBD. These include urban residence, family size, toilet facilities, helminth infestation, drinking water facilities, etc[21]. Most were case control studies, results from some of which are summarised in Table 3. While the results are quite variable, some studies showed urban residence, high social status, high social class and safe drinking water to be associated with increased the risk of IBD[39,45,61,62]. A meta-analysis which included 40 studies also showed a positive association between urban residence and both CD and UC[63]. Pugazhendhi *et al*[45] from our center showed positive association between safe drinking water and CD but not with urban residence. Various studies have found childhood respiratory and gastrointestinal infection, childhood helminth infestation, pet exposure and shared housing reduce the risk[61,62]. In contrast, the Asia Pacific study which showed reduced association of UC with presence of hot water tap and flush in toilet in childhood and the recent study from Northern India which showed reduced risk of UC with better toilet facilities and private bed refute the hygiene hypothesis[51,64]. The evidence for hygiene hypothesis is conflicting. The reasons may be the inclusion of a wide variety of factors under this category, lack of large prospective cohort studies, presence of confounders or a true lack of association.

***Other factors***

Several other factors like appendectomy, infections, air pollution, seasonal variation, physical activity, vaccination, and psychological factors have been implicated in the etiology of IBD. A large Swedish study showed reduced risk of UC in patients whose appendix was removed for inflammatory pathology before the age of 20 years[65]. Other studies have also shown that appendectomy was associated with decreased risk of UC[66,67]. Unlike in UC, some studies including a meta-analysis showed that appendectomy increases the risk of CD up to 5 years after surgery and thereafter the risk falls to that seen in general population[68,69]. As clinical symptoms of CD may be similar to acute appendicitis, some of the association seen during the initial time period after appendectomy may be related to erroneous diagnosis . *Helicobacter pylori* infection was shown to have a protective association with IBD in a meta-analysis of 23 studies[70]. It is unclear whether this is a reflection of overcrowding and low socioeconomic status associated with *H pylori* infection or an effect of this bacterium on gut immunity[71]. On the other hand, a population based cohort study from Denmark showed past infection with *Salmonella* and *Campylobacter* to be associated with increased risk of both UC and CD[72]. In the past *Mycobacterium avium* subspecies paratuberculosis was considered an etiological agent for CD but recent data does not support this[73,74]. Large cohort studies have also shown reduced incidence of IBD in subjects with more siblings and those who lived in a farm with livestock in childhood[75,76]. In a study from UK , air pollution did not affect the overall onset of IBD; subset analysis however showed there was increased risk of early onset CD with exposure to nitrogen dioxide and early onset UC after exposure to sulphur dioxide[77]. The north south gradient of IBD observed in some regions may be related to differences in climate. In a Norwegian cohort, Aamodt *et al*[78] studied the influence of temperature, altitude and precipitation to assess the impact of latitude on incidence of UC . Temperature had a negative association with UC while the other factors had no significant effect. Others have shown association of IBD with childhood vaccines and physical activity[44,52,79]. Thompson and colleagues were the first to suggest that measles vaccination was associated with a 3-fold increased risk of CD and UC compared to unvaccinated controls[80]. Subsequent studies have not confirmed these findings[81,82]. Available data gives no firm evidence to suggest that routine vaccinations have an effect on development of CD. Psychological factors have also been linked with onset and course of IBD[83,84]. Data from 152461 subjects in the NHS cohort showed increased risk of CD with recent and baseline depression but no significant impact on UC[84]. Though a number of factors have been suggested to influence the onset of IBD the data is inconsistent and conflicting.

**ENVIRONMENTAL FACTORS AND COURSE OF IBD**

The usual reasons for disease exacerbation in IBD are natural history of the disease, non-compliance with drugs and gastrointestinal infections; environmental factors may also influence the course of disease. Table 4 summarises data from some of the studies evaluating environmental factors and course of IBD.

Smoking seems to have a definite, detrimental effect on the course of CD. Several studies have shown increased risk of flares, more active disease, increased hospitalisation rates, increased risk of surgery and post operative recurrence in patients with CD who are smokers compared with non-smokers[85-87]. It also affects disease behaviour and is associated with higher risk of penetrating disease and extra-intestinal manifestations[88,89]. There is a strong case for quitting smoking in CD as shown in an interventional study from France where patients who quit smoking had reduced rate of disease exacerbations compared to smokers[90]. Based on these findings, smoking cessation should be strongly encouraged in CD. A recent meta-analysis of 20 studies in UC showed lower colectomy rates in active smokers[91]. Another population based cohort study which included 771 patients with UC from seven European countries and Israel found lower relapse rates in current smokers[92]. The reason for differential effect of smoking on CD and UC is unclear.

Psychological factors have been proposed to have a greater role in influencing the course of IBD as compared to their etiological role. A large population based cohort study from Canada showed increased risk of flare up in IBD patients with high perceived stress at one year follow up[93]. A couple of other cohort studies, one of which included patients with CD and the other with UC, also showed association of stress with increased disease exacerbation[94,95]. A prospective observational study from Belgium showed that major depressive disorder was a risk factor for failure to achieve remission with infliximab and for earlier relapse in patients with active Crohn's disease[96]. In addition to flare ups, psychiatric comorbidity may also affect risk of surgery. A multi-institutional cohort study showed that psychiatric comorbidity increased risk of surgery in patients with CD but no association was observed with UC[97]. In contrast, a systematic review which included 12 studies showed a lack of convincing evidence that therapy of depression and anxiety alters disease course in IBD[98]**.** Though the evidence for psychological factors influencing the course of IBD is not robust, it may be prudent to treat these patients to improve their quality of life.

Drugs may also influence the course of IBD. Data on NSAID as a trigger for disease relapse in IBD is conflicting. Case reports and small series suggest that nonselective NSAIDS trigger disease relapse[99]. In an uncontrolled study, Takeuchi *et al*[25], found increased risk of flares in IBD patients taking non-selective NSAID but not with selective COX1 or COX 2 inhibitors. A randomised controlled trial of celecoxib and placebo in UC did not show significant difference in relapse rates between the two groups[100]. The Canadian population based cohort study and a recent study from USA also showed no impact of NSAID on disease flare up[93,101]. Though the evidence is weak, the American College of Gastroenterology practice guidelines currently recognize NSAID use, including use of COX-2 inhibitors, as a potential exacerbating factor for relapse of CD[102]. The role of antibiotics and OCP in modulating disease activity in IBD is unclear[93,101,103]. A systematic review of 10 RCTs involving 1160 patients showed that antibiotics were more effective than placebo in inducing remission in active CD[104]. Shortcomings of the study were moderate heterogeneity between studies and multiple antibiotics used either alone or in combination. As multiple antibiotics were used in different studies, the data is difficult to interpret, and additional studies are required to address the role of antibiotics in influencing the course of IBD. A systematic review that included 10 studies suggested that there is no risk of disease exacerbation in women with IBD who use oral contraceptives[105].

Dietary factors have been suggested as triggers for disease flares. Data on this subject is limited and confusing as patient surveys show heterogeneity regarding trigger foods[106,107]. Fish oil which has omega-3 fatty acid with anti-inflammatory properties may be beneficial in maintaining remission in IBD. They may be of some utility in managing UC but have not proven to be a substitute for conventional drugs[108]. A prospective study on 191 patients with UC, who were followed up for one year, to determine the effects of dietary factors on relapse showed higher meat and alcohol consumption to be associated with increased risk of relapse[109]. The sulphur content in the food was proposed to be the likely trigger.

Other factors like air pollution, exposure to ultraviolet light and physical activity have also been linked to the course of IBD. A systematic review of seven studies found physical activity to be associated with increased quality of life and decreased disease activity among patients with IBD[110]. Cucino *et al*[111], found manual work and farming to be associated with decreased mortality in IBD. Low exposure to ultraviolet light has been associated with increased risk of hospitalisation and surgery among IBD patients[112]. Exposure to pollutants in air was also shown to increase hospitalisation rates[113]. Although the environmental factors have not been as extensively evaluated with respect to their role on the course of IBD compared to their etiological role, there is modest evidence that some of these factors may influence the course of illness.

**CONCLUSION**

Data suggests that environmental factors play a significant role in the etiology of IBD and probably on the course of disease. While the evidence for some factors is strong, many factors require further supportive data. Interventional studies assessing the effects of modifying these risk factors on natural history and patient outcomes are an important unmet need.

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**Table 1 Environmental factors and onset of inflammatory bowel disease – meta-analyses**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Author**  | **Study setting** | **Effect on CD** | **Effect on UC** | **Effect on IBD overall** |
| Soon *et al*[63], 2012 | Urban living and risk of CD and UC | IR (Incident rate ratio, 1. 42; 95%CI: 1.26-1.6) | IR (Incident rate ratio, 1. 17; 95%CI: 1.03-1.32) |  |
| Luther *et al*[64], 2010 | *H. pylori* infection and risk of IBD,(23 studies) |  |  | DR (RR, 0.64; 95%CI: 0.54-0.75) |
| Barclay *et al*[50],2009 | Breast feeding and early onset IBD(7 studies ) | NA | NA | DR (OR, 0.69; 95%CI: 0.51-0. 94) |
| Jones *et al*[42], 2008 | Prenatal or childhood passive smoking and risk of IBD(13 studies ) | NA | NA |  |
| Cornish *et al*[54], 2008 | OCP and risk of IBD (14 studies) | IR (RR, 1.46 ; 95%CI: 1.26-1. 70) | IR (RR, 1.28 ; 95%CI: 1.06-1. 54) |  |
| Mahid *et al*[37], 2007 | Smoking and risk of IBD (13 studies related to UC and 9 related to CD) | IR with current smoking (OR, 1.76; 95%CI: 1.40-2.22) | DR with current smoking (OR, 0. 58; 95%CI: 0. 45-0. 75)IR with former smoking (OR, 1. 79; 95%CI: 1. 37-2. 34) |  |

IR: Increased risk; DR: Decreased risk; NA: No association; CD: Crohn’s disease; UC: Ulcerative colitis; RR: Relative risk; IBD: Inflammatory bowel disease; OCP: Oral contraceptive pill.

**Table 2 Environmental factors and onset of inflammatory bowel disease – cohort studies**

|  |  |  |  |
| --- | --- | --- | --- |
| **Author**  | **Study subjects** | **Effect on CD** | **Effect on UC** |
| Timm *et al*[76], 2014, Europe | Population based cohort10864 subjects from ECRHS1 cohortOutcome - place of upbringing and risk of IBD | DR with being born and living on livestock farm for first 5 years of life |
| Khalili *et al*[53],2013, USA | 146681 subjects from NHS I and II3373726 person-years of follow upOutcome – risk of IBD in adulthood | NA – Breastfeeding, low or high birth weight, preterm birth | NA – Breastfeeding, low or high birth weight, preterm birth |
| Ananthakrishnan *et al*[25], 2013, USA | 170776 subjects from NHS I and II3317425 person-years of follow upOutcome – diet and risk of IBD in adulthood | DR – Long term intake of higher dietary fibre especially from fruit | NA with dietary fibre |
| Ananthakrishnan *et al*[84], 2013, USA | 152461 subjects from NHS I and II1787070person-years of follow upOutcome - Depressive symptoms and risk of IBD | IR with recent and baseline depressive symptoms | NA with recent and baseline depressive symptoms |
| Levi *et al*[75], 2013, Israel | Cohort of 953684 Jewish adolescentsOutcome - sociodemographic factors and risk of IBD | IR with high socioeconomic status, western origin, male sexDR with four or more children in childhood |
| Higuchi *et al*[38], 2012, USA | 229111 subjects from NHS I and IIOutcome – Smoking and risk of IBD | IR – Current smoker, former smoker | NA – Current smokerIR – Former smoker |
| Ananthakrishnan *et al*[50], 2012, USA | 76795 subjects from NHS I1295317 person-years of follow upOutcome – NSAID and aspirin exposure and risk of IBD | IR – frequent use of NSAIDNA - Aspirin | IR – frequent use of NSAIDNA - Aspirin |
| Ananthakrishnan *et al*[48], 2012, USA | 72719 subjects from NHS1492811 person-years of follow upOutcome - Vitamin D and risk of IBD | DR – Higher predicted level of plasma Vitamin D | NA - Vitamin D level in plasma |

1European Community Respiratory Health Survey. IR: Increased risk; DR: Decreased risk; NA: No association; CD: Crohn’s disease; UC: Ulcerative colitis; RR: Relative risk; IBD: Inflammatory bowel disease; NSAID: Nonsteroidal anti-inflammatory drug; NHS: Nurses health study.

**Table 3 Environmental factors and onset of inflammatory bowel disease – case control studies**

|  |  |  |  |
| --- | --- | --- | --- |
| **Author**  | **Study setting** | **Effect on CD** | **Effect on UC** |
| Ng *et al*[51], 2014, Asia Pacific | CD – 186UC – 256Controls – 940Outcome – environmental risk factors and IBD | DR with breast feeding for > 12 mo, antibiotic use, having dogs, daily tea intake, daily physical activity | DR with breast feeding for > 12 mo, antibiotic use, daily tea and coffee intake, presence of hot water tap, flush toilet in childhoodIR with smoking |
| Sood *et al*[64], 2014, India | UC- 518Controls – 188Outcome – environmental risk factors and UC |  | IR with owning a pet and stressful eventsDR with better toilet facilities and having private bed |
| Chu *et al*[62], 2013, South Africa | CD – 88UC – 63Control – 219Outcome – childhood risk factors and IBD | DR – Helminth infection, shared housing, raw beef consumptionIR – Urban dwelling, parental tertiary education | DR – Helminth infection, mixed race, smoking, shared housing, raw beef consumptionIR –parental tertiary education |
| Jakobsen *et al*[114], 2013, Denmark | CD – 59UC – 56Controls – 477Outcome – environmental risk factors and pediatric IBD | IR with bedroom sharing, prior hospitalisation with gastrointestinal infection, family historyDR with whole meal bread consumption | IR with prior hospitalisation with gastrointestinal infection, family historyDR with daily vegetable consumption |
| Hlavaty *et al*[52], 2013, Slovakia | CD – 190UC – 148Controls – 355Outcome – environmental risk factors and IBD | IR with short duration of breast feeding, infrequent childhood sports activity, smoking, infrequent contact with animals in childhood | IR with short duration of breast feeding, infrequent childhood sports activity, smaller family size in childhood |
| Pugazhendhi *et al*[45], 2012, India | CD – 200Controls – 200Outcome – environmental risk factors and CD | IR with safe drinking waterDR with regular fish consumption and presence of cattle in house |  |
| Castiglione *et al*[115], 2012, Italy | CD – 468UC – 527Controls – 562Outcome – environmental risk factors and CD | NA with any factors except IR with smoking and appendectomy | NA with any factors except DR with smoking and appendectomy |
| Hansen *et al*[44], 2011, Denmark | CD – 123UC – 144Controls – 267Outcome – environmental risk factors and IBD | DR with breast feeding, tonsillectomy,IR with pertussis and polio vaccine, measles infection, smoking, low fibres and high sugar | DR with breast feeding, tonsillectomy, appendectomy, smokingIR with pertussis and polio vaccine, measles infection, low fibres and high sugar |
| Lopez Serrano *et al*[61], 2010, Spain | 124 CD and 235 controls146 UC and 278 controlsOutcome – onset of IBD | IR – Living in urban area, high educational level, social statusDR – Childhood respiratory infection and gastroenteritis | IR - Living in urban area, high educational level, social statusDR – Childhood respiratory infection and gastroenteritis, appendectomy, current smoking |
| Gearry *et al*[39], 2010, New Zealand | Population based case control studyCD – 638, UC – 653, Controls – 600Outcome – risk factors and IBD | IR with smoking, high social class at birth, Caucasian ethnicityDR with breastfeeding and childhood vegetable garden | IR with high social class at birth, Caucasian ethnicity, migrantDR with smoking, breast feeding and childhood vegetable garden |
| Joseph *et al*[28], 2009, India | CD – 34Controls – 34Outcome – vitamin D and CD | IR – lower levels of Vitamin D |  |
| Amre *et al*[32],2007, Canada | CD – 130Controls – 202Outcome – diet and pediatric CD | DR – higher consumption of vegetable, fruit, fibre, fish, long chain omega three fatty acid |  |
| Baron *et al*[116], 2005, France | CD – 222UC – 60Matched controlsOutcome – pediatric onset IBD | IR - Family history, Breast feeding, BCG vaccination, history of eczemaDR – Regular drinking of tap water | IR – Family history, disease during pregnancy, bedroom sharingDR- Appendectomy |

IR: Increased risk; DR: Decreased risk; NA: No association; CD: Crohn’s disease; UC: Ulcerative colitis; RR: Relative risk; IBD: Inflammatory bowel disease.

**Table 4 Environmental factors and course of inflammatory bowel disease**

|  |  |  |  |
| --- | --- | --- | --- |
| **Author**  | **Study setting** | **Effect on CD** | **Effect on UC** |
| Ott *et al*[89], 2014, Germany | Cohort studyCD – 161UC – 96Outcome – Smoking and EIM | IR of EIM | NA |
| Feagins *et al*[101], 2014, USA | Case control studyActive IBD – 166IBD in remission – 68Outcome – triggers for flare of IBD | NA with NSAID, antibiotics, stress, smoking, infection and travel in past 3 mo |
| Ananthakrishnan *et al*[97], 2013, USA | Multi institutional cohort study, CD – 5405, UC – 5429Outcome – psychiatric comorbidity and surgery and hospitalisation in CD and UC | IR of surgery with psychiatric comorbidity | NA of surgery with psychiatric comorbidity |
| Bernstein *et al*[93], 2010, Canada | Population based cohortIBD – 704Outcome – risk factors for flareFollow up – 1 year | IR of flare – High perceived stressNA with flare – NSAID, antibiotics, non-enteric infection |
| Packer *et al*[110], 2010 | Systematic review, 7 studiesOutcome - Physical activity and course of IBD | Physcial activity significantly increased quality of life and decreased disease activity |
| Bitton *et al*[95], 2008, Canada | Cohort study ,101 patients with CD in remissionOutcome – biopsychosocial factors and relapseFollow up – 1 year | IR with stress/avoidance coping, higher CRP, fistulising disease behaviour, disease confined to the colon |  |
| Takeuchi *et al*[25], 2006, UK | Case seriesIBD – 209Outcome – risk of flare with NSAID | IR of flare with non-selective NSAID |
| Sandborn *et al*[100], 2006, USA | RCT – Celecoxib *vs* placebo for 2 weeksUC – 222Outcome – exacerbation during 2 weeks |  | No significant difference between celecoxib (3%) and placebo group (4%) |
| Persoons *et al*[96], 2005, Belgium  | Cohort studyCD – 100Outcome - major depressive disorder and response to Infliximab | Major depressive disorder associated with reduce response to infliximab |  |
| Cosnes *et al*[103], 1999, France | Cohort studyCD – 331Outcome – OCP and flare up of CDFollow up -12 to 18 mo | NA between OCP use and disease flare up |  |
| Cosnes *et al*[87], 1999, France | Cohort studyCD – 622Outcome – risk factors for flare of CDFollow up -12 to 18 mo | IR of flare – Current smokersNA with flare – Obesity, dyslipidemia and alcohol consumption |  |
| Boyko *et al*[117], 1998, USA | UC – 209, compared smokers with non-smokersOutcome: Smoking and course of UC |  | DR of hospitalisationNA with colectomy rates |

IR: Increased risk; DR: Decreased risk; NA: No association; CD: Crohn’s disease; EIM: Extraintestinal manifestation; IBD: Inflammatory bowel disease; NSAID: Nonsteroidal anti-inflammatory drug; RCT: Randomised controlled trial, CRP: C reactive protein, OCP: Oral contraceptive pill.