Supplementary Table 1 Summary of the statements

Statement 1: Ulcerative colitis (UC) is suspected when a patient especially in late adolescence or early adulthood, reports having bloody diarrhea for more than two weeks, rectal bleeding, rectal urgency, tenesmus, mucopurulent exudate, fecal incontinence, nocturnal defecation, and crampy abdominal pain. [100]
Statement 2: Examination of suspected patients with mild or moderate UC is usually unremarkable; digital rectal (DRE) examination can be done to confirm fresh blood in the rectum [100]
Statement 3: IBD is suspected when the patient has a family history of UC or Crohn's Disease (CD) [88.8]
Statement 4: Severe colitis is suspected when a patient presents with increased bowel frequency (six or more per day) abdominal pain/tenderness, anorexia, weight loss, tachycardia, reduced bowel sounds and fever. [100]
Statement 5: The diagnosis of IBD is established by clinical evaluation and a combination of endoscopic, histological, radiological, and/or biochemical investigations. [100]
Statement 6: Crohn's Disease (CD) is suspected when a patient, especially young, presents with abdominal pain, weight loss, constipation or chronic diarrhea. [88.8]
Statement 7: A patient with CD commonly presents with systemic symptoms of malaise, anorexia, or fever. [77.7]
Statement 8: Symptoms of CD are non-specific and mimics that of Irritable bowel syndrome (IBS), unexplained anemia and growth failure should be considered to avoid delayed diagnosis. [100]
Statement 9: The symptoms of acute terminal ileal CD may be mistaken for acute appendicitis. [88.8]
Statement 10: Physical examination of patients with CD may reveal tenderness or a palpable mass. Some may present with perianal disease (abscess, fistula, fissure) [88.8]
Statement 11: Infections or drug-induced colitis must always be excluded [88.8]
Statement 12: Genetic or serological testing is currently not recommended yet for routine diagnosis of IBD. [100]
Statement 13: If diagnosis of IBD is in doubt despite an interval of appropriate treatment, a repeated endoscopy is required. [88.8]

Statement 14: UC disease extent is defined by the maximal macroscopic extent at colonoscopy, and classified as proctitis, left-sided colitis, and extensive colitis. (according to the Montreal classification). [100]

Statement 15: According to severity, UC is either in remission characterized by the absence of symptoms and the absence of an endoscopic acute inflammatory changes, or an active disease characterized by the presence of symptoms and endoscopically active mucosal findings [77.7]

Statement 16: The severity of UC can be classified into mild, moderate, and severe, based on clinical symptoms and signs, blood tests and endoscopy. [100]

Statement 17: CD is classified according to disease location: terminal ileum, colon, ileocolonic and upper GI. (Montreal classification) [77.7]

Statement 18: CD is divided according to disease behaviour (stricturing, penetrating, non-stricturing/not-penetrating, with or without perianal involvement) (according to Montreal classification) [100]

Statement 19: Ileocolonoscopy with multiple biopsy specimens is the first-line procedure for diagnosing and determining the severity of IBD [100]

Statement 20: For a reliable diagnosis of CD or UC, a minimum of two biopsies from five sites around the colon (including the rectum) as well as from the ileum should be obtained. [100]

Statement 21: Stool specimens should be obtained to exclude common pathogens and specifically assayed for Clostridium difficile (C. difficile) toxin. [88.8]

Statement 22: Laboratory markers of chronic inflammation may correlate with the severity of IBD. [50]

Statement 23: C-reactive protein (CRP) broadly correlates with clinical severity. [77.7]

Statement 24: Elevated erythrocyte sedimentation rate (ESR), CRP, anaemia, number of bowel movements and hypoalbuminemia are signs of severe clinical activity which predict the need for colectomy in severe acute colitis. [88.8]

Statement 25: Microbial testing should be done in patients with colitis with every disease flare [100]

Statement 26: Serological testing currently available is not recommended for differentiating colonic CD from UC [77.7]

Statement 27: Diagnostic criteria for iron deficiency depend on the level of inflammation. In patients without clinical, endoscopic, or biochemical evidence of active disease, serum ferritin <30 μg/L is an appropriate criterion. In the presence of inflammation, serum ferritin up to 100 μg/L may still be consistent with iron deficiency. [88.8]

Statement 28: Cross-sectional imaging MRI and CT enterography and trans- abdominal ultrasonography (US) are used to complement endoscopy. [100]

Statement 29: Complementary radiological techniques using MRI, CT and US should be used to rule-out stenotic lesions and are necessary when the lesion is impassable with the endoscope. [88.8]

Statement 30: CD patient with symptoms of the upper GI tract should receive EGD to rule out proximal involvement [88.8]

Statement 31: Small bowel capsule endoscopy (SBCE) should only be used when the clinical suspicion for CD remains high despite negative evaluations with ileocolonoscopy and radiological examinations (MRI/CT). This could be useful to assess the disease extent. [66.6]

Statement 32: Small bowel capsule endoscopy (SBCE) is contraindicated in gastrointestinal obstruction, strictures and swallowing disorders. [100]

Statement 33: Device-assisted enteroscopy (DAE), is an invasive procedure that may only be performed by an expert, if the histological diagnosis of CD is needed or when endoscopic therapy is indicated, including dilatation of strictures, retrieval of impacted capsules, and treatment of bleeding. [88.8]

Statement 34: In acute severe UC, a plain abdominal radiograph should be performed to exclude colonic dilatation [37.5]

Statement 35: Flexible sigmoidoscopy should be used to confirm the diagnosis of severe colitis and help exclude infection, particularly Cytomegalovirus (CMV). [88.8]

Statement 36: Enema preparation before flexible sigmoidoscopy is considered safe in patients with severe UC. [77.7]

Statement 37: In case of colonic stenosis occurs in ulcerative colitis, multiple endoscopic biopsies should be taken else CT should be performed to exclude carcinoma. [77.7]

Statement 38: Endoscopic reassessment is appropriate whenever it seemed necessary to change management. [88.8]

Statement 39: Colonoscopy is also recommended for determine response to treatment and for surveillance of cancer development. [100]

Statement 40: In IBD, therapy and follow-up can be guided by CRP levels and faecal markers which are able to predict clinical relapse. [77.7]

Statement 41: The treatment strategy for ulcerative colitis [UC] is mainly based on the severity, distribution, and pattern of disease. Disease extent influences treatment modality, and choice of (oral, topical) therapy. [77.7]

Statement 42: Suppository is the preferred initial treatment for mild or moderately active proctitis. 5-ASA foam or enemas can be used as an alternative though less tolerated. [88.8]

Statement 43: Combined (oral and topical) therapy is more effective than topical alone for the treatment of proctitis. [77.7]

Statement 44: Refractory proctitis may require treatment with systemic steroids, immunosuppressants, and/or biologics. [100]

Statement 45: 5-ASA enema combined with oral 5-ASA is more effective than oral or topical 5-ASA or topical steroids alone in the treatment of mild to moderately active left-sided UC. [88.8]

Statement 46: Topical steroids alone are not more effective than topical 5-ASA. [50]

Statement 47: Once-daily dosing with 5-ASA is as effective as divided doses in mild to moderately active left- sided UC. [77.7]

Statement 48: Systemic corticosteroids are appropriate in patients with moderate to severe activity and in those with mild activity who do not respond to 5-ASA. [88.8]

Statement 49: Budesonide MMX can be considered in patients with mild to moderate disease who are intolerant or refractory to 5-ASA. [77.7]

Statement 50: Mild to moderately active extensive ulcerative colitis should initially be treated with an 5-ASA enema combined with oral 5-ASA [88.8]

Statement 51: Corticosteroids have potent anti-inflammatory property and are effective for induction of remission in UC but have no efficacy for maintenance of remission and their long-term use can lead to adverse events. [88.8]

Statement 52: In moderate disease refractory to oral steroids, anti-TNF, vedolizumab, ustekinumab and tofacitinib may be valid options. [88.8]

Statement 53: Acute severe UC is defined as having bloody diarrhoea ≥ 6/day. Any signs of systemic toxicity are an indication for hospital admission. [88.8]

Statement 54: Patients with severe UC should be assessed on the third day of IV steroid therapy; non-responders are shifted to infliximab or cyclosporine. Colectomy is recommended if there is no improvement following 4–7 days of salvage therapy. [77.7]

Statement 55: In severe active UC, in case of serious contraindication to steroids, infliximab or cyclosporine are an alternative to the recommended IV steroids. [88.8]

Statement 56: The choice between options for salvage/rescue, either infliximab or cyclosporine should be individualized. [88.8]

Statement 57: Prolonged use of corticosteroids should be avoided as being ineffective as maintenance therapy and may lead to increased risk of post- operative complications. [88.8]

Statement 58: Only a single attempt at rescue therapy with IFX or cyclosporine should be considered before referral for colectomy. [100]

Statement 59: Azathioprine can be used as a steroid-sparing agent in steroid-dependent UC. [100]

Statement 60: Anti-TNF agents, vedolizumab, tofacitinib and ustekinumab are effective for induction of remission in steroid-refractory or steroid-dependent moderate-to- severe UC. They are also effective in moderate colitis refractory to thiopurines. [88.8]

Statement 61: The goal of maintenance therapy in UC is to maintain steroid-free remission, defined clinically and endoscopically. [100]

Statement 62: Choice of maintenance treatment is determined by disease extent, disease course, response to previous maintenance treatment, severity and treatment of the most recent flare as well as the safety of maintenance treatment. [88.8]

Statement 63: For patients achieving remission with 5-ASA, the use of 5-ASA oral and / or topical should be used as maintenance therapy depending on disease extent. [88.8]

Statement 64: Once daily oral 5-ASA preparations are preferred over sulphasalazine for maintaining remission due to reducing toxicity. [88.8]

Statement 65: 5-ASA maintenance treatment should be continued long-term; this may reduce the risk of colon cancer. [77.7]

Statement 66: Thiopurines are effective in maintaining remission in patients with early or frequent relapse while taking 5-ASA or patients who are intolerant to it; patients who are steroid-dependent, and patients responding to cyclosporine. [88.8]

Statement 67: In patients responding to anti-TNF, maintaining remission by continuing anti-TNF therapy with or without thiopurines is appropriate. [100]

Statement 68: Vedolizumab is efficient in inducing and maintaining remission in patients who failed anti-TNF. [88.8]

Statement 69: Thiopurines are appropriate to maintain remission in thiopurine-naïve patients. [100]

Statement 70: The management plan for a patient with CD should take into account the activity, site, behavior of disease, and should always be discussed with the patient. [100]

Statement 71: Determining the activity of disease may be more difficult in CD than UC and should rely on objective evidence, e.g., inflammatory markers or colonoscopy. [77.7]

Statement 72: It is important to confirm disease activity as a cause of recurrent symptoms, although unnecessary to re-evaluate the distribution of disease unless this will alter management [77.7]

Statement 73: Oral Budesonide is the preferred treatment for the mildly active localized ileocecal CD. [88.8]

Statement 74: 5-ASA should not be used for induction of remission and achieving mucosal healing in patients with active Crohn's disease. [88.8]

Statement 75: Metronidazole should not be used as primary therapy for luminal inflammatory Crohn's disease. [100]

Statement 76: Antimycobacterial therapy has not been shown to be effective and should not be used as primary therapy. [100]

Statement 77: Biologic therapy should be considered in CD patients with high disease activity and features indicating a poor prognosis. [88.8]

Statement 78: Mild oesophageal or gastroduodenal CD may be treated with a proton pump inhibitor with close monitoring, while more severe or refractory disease requires additional systemic corticosteroids or a biologic-based strategy. [88.8]

Statement 79: Any patient who has an early relapse after a course of steroids should started immunomodulator or biologic therapy to reduce the risk of a further relapse and/or prolonged steroid therapy. [88.8]

Statement 80: Particular care should be taken to consider serious infections as a complication of immunosuppressive therapy, including biologics and steroids. [88.8]

Statement 81: The choice of biologic therapy depends on availability, route of delivery, patient preference and cost since they all have similar efficacy in luminal CD and similar adverse-event profiles. [88.8]

Statement 82: The severely active localized ileocecal CD should initially be treated with systemic corticosteroids. [100]

Statement 83: Conventional corticosteroids do not consistently achieve mucosal healing and should be used sparingly as a bridge to more tailored therapy. [88.8]

Statement 84: Intravenous corticosteroids and or biologic therapy can be used to treat severe Crohn's disease in the absence of any contraindications. [100]

Statement 85: For patients with moderately to severely active Crohn's disease, biologic therapy without an immunomodulator should be considered to be used for induction of symptomatic remission. [77.7]

Statement 86: Combination therapy of infliximab with immunomodulators (thiopurines) is more effective than treatment with either immunomodulators alone or infliximab alone in patients who are naive to those agents. [100]

Statement 87: Cyclosporine, mycophenolate mofetil, and tacrolimus should not be used for Crohn's disease. [50]

Statement 88: Immunosuppressive naïve patients who are dependent on corticosteroids should be treated with immunosuppressants and/or biologic therapy. [77.7]

Statement 89: Methotrexate (up to 25 mg once weekly IM or SC) may be effective and should be considered in patients with steroid- dependent Crohn's disease. [66.6]

Statement 90: Biologics should be used to treat Crohn's disease that is resistant/dependent to treatment with corticosteroids. [100]

Statement 91: In view of the adverse effects of cigarette smoking on the course of CD, smoking should be discouraged in all patients. [100]

Statement 92: In localized disease, a thiopurines or methotrexate should be considered for maintaining remission achieved by systemic steroids. [77.7]

Statement 93: Thiopurine methyltransferase (TPMT) testing should be performed before initial use of thiopurines [77.7]

Statement 94: Upon relapse, escalation of the maintenance treatment can be considered to prevent disease progression. Steroids should not be used to maintain remission. [100]

Statement 95: For CD patients with extensive disease, thiopurines and/or biologics are recommended for maintenance of remission. [77.7]

Statement 96: In CD patients with aggressive/severe disease course or poor prognostic factors, biologics approved for the disease should be considered. [88.8]

Statement 97: Biologics should be given for CD refractory to thiopurine or methotrexate [88.8]

Statement 98: If remission has been achieved with the combination of anti-TNF therapy and thiopurines in treatment naïve CD patients, maintenance with the same regimen is recommended. [88.8]

Statement 99: If remission has been achieved in CD patients with biologics monotherapy, maintenance with biologic monotherapy is appropriate. [88.8]

Statement 100: Infliximab monotherapy is effective at maintaining biologics induced remission, but because of the potential for immunogenicity and loss of response, the combination with thiopurines or methotrexate should be considered. [88.8]

Statement 101: Combination therapies are associated with increased risk of malignancies, and their use should always be balanced carefully against the substantial benefits associated with these treatments and discussed with the patient. [88.8]

Statement 102: Vedolizumab should be used for maintenance of remission of vedolizumab-induced remission of Crohn's disease. [100]

Statement 103: Ustekinumab should be used for the maintenance of remission of the ustekinumab-induced response of Crohn's disease. [100]

Statement 104: Loss of response to a biologic agent should be first managed by dose optimization guided by measurement of serum levels, if available, and anti-drug antibodies followed by switching to a different drug within class or a different mechanism of action. [77.7]

Statement 105: 5-ASA is not recommended for maintenance of medically induced remission in the CD. [77.7]

Statement 106: Antibiotics are not effective for induction of remission in CD [88.8]

Statement 107: Budesonide should not be used to maintain remission of Crohn's disease