Inflammatory Bowel Disease (Ulcerative colitis, UC and Crohn's disease, CD)

Any patient admitted for their inflammatory bowel disease (IBD) should be managed by the gastroenterology/IBD team. This guideline is to be used as first steps of management until specialist review is available.

Guidance for common acute situations whilst awaiting their input is included below.

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For more information please refer to:

- British Society of Gastroenterology (BSG) guideline for the management of IBD
- BSUH UC self-management patient information leaflet (please note this is for outpatient management of mild-moderate flares, not for acute severe UC)
- NICE guidance for Crohn's Disease (external link)
- NICE guidance for Ulcerative Colitis (external link)
- Area Prescribing Joint Formulary – Gastroenterology
Oral aminosalicylates – UC only

Mesalazines are first line treatment for mild to moderate ulcerative colitis (UC), but should not be used in Crohn’s Disease (CD) unless advised by gastroenterology/IBD team.

A ‘flare’ is categorised as moderate to severe IBD. For classification please use the Truelove & Witts’ severity index (scoring tool) – available here

UC FLARE Management

- ‘Flaring doses’ should be continued for 4 to 6 weeks after symptom improvement seen.
- During a UC flare a full treatment PO dose should be prescribed alongside PR products:

<table>
<thead>
<tr>
<th>ORAL mesalazine doses:</th>
<th>RECTAL mesalazine doses:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred options: Octasa 4.8g daily</td>
<td>Proctitis only - 1g suppository daily</td>
</tr>
<tr>
<td>OR Salofalk granules 3g daily (good if difficulty with swallowing tablets/pill burden and for distal disease)</td>
<td>OR More extensive disease - 1g suppository daily + 1 or 2g enema daily – please refer to ‘rectal formulation’ section below</td>
</tr>
</tbody>
</table>

Oral mesalazine should be prescribed by brand due to differing release properties.

If patients previously stabilised on Asacol or Pentasa brand this can be continued and increased to specific flare dosing:
- Asacol 4.8g daily
- Pentasa 4g daily

There is no need to prescribe rectal mesalazine by brand.

<table>
<thead>
<tr>
<th>Rectal Formulation</th>
<th>Site of Action</th>
<th>Disease Extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suppository</td>
<td>Rectum</td>
<td>Proctitis</td>
</tr>
<tr>
<td>Foam</td>
<td>Sigmoid Colon (i.e. not good for rectal disease)</td>
<td>Procto-sigmoidosis</td>
</tr>
<tr>
<td>Liquid Enema</td>
<td>Left colon but with poor rectal coverage Retention of the enema may be problematic – switching to foam enemas may help</td>
<td>Left-sided (distal) colitis</td>
</tr>
</tbody>
</table>

UC MAINTENANCE Management

- During maintenance therapy, to remain in remission, at least 2g daily of mesalazine treatment is recommended.
  - Gradual reduction from ‘flare’ to ‘maintenance’ doses is recommended.
  - Please consider which mesalazine was used for flare/Previously and de-escalate dose accordingly:

<table>
<thead>
<tr>
<th>ORAL mesalazine doses:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Preferred options: Octasa 2.4g daily</td>
<td></td>
</tr>
</tbody>
</table>
OR

Salofalk granules 1.5g daily
(good if difficulty with swallowing
tablets/pill burden and for distal disease)

Oral mesalazine should be prescribed by
brand due to differing release properties.

If patients previously stabilised on Asacol
or Pentasa this can be continued:
- Asacol 2.4g daily
- Pentasa 2g daily

A patient information leaflet on self-management of mild to moderate UC flares is available and
should be provided to all UC patients.  Click here for leaflet

All patients should be given advice on how to access the IBD helpline; contact details are
☎ 01273 664427 (an answerphone service)
✉️ bsuh.ibdnursingservice@nhs.net
Steroids in IBD

- Steroids should only be used in a severe flare of IBD or where the mild-moderate treatment has already been tried and has not resolved symptoms within 2-3 weeks.
  - Please use a full treatment course (see below) - 5 day courses or 'half dose' courses are not effective and increase overall exposure and risk.
- Please ensure infective cause is ruled out alongside initiating steroids
  - Complete a stool screen including *C. difficile*.
- Please refer all patients requiring steroids to treat their symptoms to their IBD specialist
  This is particularly important if they are unable to wean steroids or if this is the second course in a year.

Steroid dosing:

**IBD Flare** (Symptoms assessment – for UC use Truelove & Witts index or SCCAI and for CD use Harvey Bradshaw Index)

### Moderate Symptoms: Outpatient treatment

Prednisolone PO 40mg OM reducing by 5mg per week until stop (*i.e. a reducing regime*) + bone (+/- GIT) protection (see table below)

### Severe Symptoms:

Admit (*IP treatment*)

Hydrocortisone IV 100mg FOUR times daily (duration as per response - 48 hours to 5 days typically) then de-escalate to oral switch to prednisolone 40mg reducing regimen.

* Escalate and de-escalate steroids, depending on symptoms and response.

**Protective Medications to Co-prescribe Alongside Hydrocortisone & Prednisolone:**

<table>
<thead>
<tr>
<th>Medication</th>
<th>Indication</th>
<th>Dose</th>
<th>Monitoring Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adcal D3^</td>
<td>Bone protection whilst on steroids</td>
<td>One tablet BD while on prednisolone</td>
<td>Calcium</td>
</tr>
<tr>
<td>Lansoprazole</td>
<td>Peptic ulcer protection whilst on steroids only if have other ulcer development risk factors or dyspepsia</td>
<td>At least 15mg OD while on prednisolone. If already on PPI continue on regular dose.</td>
<td>Sodium</td>
</tr>
</tbody>
</table>

**If on triple immunosuppression e.g. steroid plus biologic and thiopurine/methotrexate (don’t forget may be on an immunosuppressant for non-gastro condition) add**

| Co-termination | Pneumocystis jirovecii prophylaxis | 480mg BD on Monday, Wednesday & Friday while on steroid | Renal function, full blood count |

^Osteoporosis risk: for full guidance refer to NICE or BSG guidelines.

Co-administration of bisphosphonates (generic alendronic acid) with steroids is recommended for patients aged over 65 years or with known osteoporosis/osteopenia. Unless advised on other grounds, the bisphosphonate should only be given while the patient is on steroids.
Rectal corticosteroids in IBD

- If patients do not tolerate or do not fully respond to rectal mesalazine then rectal steroids can be used as second line or in conjunction with rectal mesalazine.
- The following products are available at BSUH:
  - Prednisolone 5 mg suppositories – 5 mg up to BD for 2 weeks and then review.
  - Budesonide (Budenofalk®) 2 mg foam enema - 2 mg OD for 2 weeks and then review.
  - Prednisolone 20 mg/100mL liquid enema – 20 mg ON for 2 weeks and then review.
- Products to avoid:
  - Please avoid using prednisolone foam enemas due to their high cost.
  - Hydrocortisone enemas have a higher systemic absorption than prednisolone enemas therefore are not preferred.

Immunomodulator therapies in IBD

- These are only to be started by IBD specialists and need IBD MDT approval.
- This includes the thiopurines (azathiopurine and mercaptopurine), methotrexate and the biologics (infliximab, adalimumab, golimumab, ustekinumab, vedolizumab, tofacitinib).
- Work-up is required and to be done at ward level.
  - For thiopurines and methotrexate:
    - TPMT
    - Full blood count
    - Virology screen including HIV, HAV, HBVsAg, HBVcAb, HCV, EBV, CMV, VZIG
    - Faecal calprotectin stool sample
  - For biologics:
    - Full blood count
    - Virology screen including HIV, HAV, HBVsAg, HBVcAb, HCV, EBV, CMV, VZIG
    - Faecal calprotectin stool sample
    - T-spot (available Monday to Thursday only. To rule out TB)
    - Chest X-ray (to rule out TB)
    - Lipid profile (tofacitinib only)
  - Virology screen, T-spot and Chest X-ray can be up to 6 months old, unless evidence of exposure risk occurred.
- If on triple immunosuppression, will need Pneumocystis jirovecii prophylaxis; Co-trimoxazole 480mg BD on Monday, Wednesday & Friday until reduced to double immunosuppression.

The IBD team will advise on prescribing, supply, administration and monitoring for any immunomodulator therapy and need to be informed of any patient with anticipated need for biologics. Please speak with the IBD team directly (office in DDC OP department) or email:

bsuh.ibdnursingservice@nhs.net
or
bsuh.gastro.pharmacists@nhs.net
Guidance Information

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