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.

Contents:

For more information please refer to:

- British Society of Gastroenterology (BSG) guideline for the management of IBD (external link)
- 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 (external link)

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:

ORAL mesalazine doses:		*RECTAL mesalazine doses:*
Preferred options: Octasa 4.8g daily OR Salofalk granules 3g daily *(good if difficulty with swallowing tablets/pill burden and for distal disease)*	+	**Proctitis only** - 1g suppository daily OR **More extensive disease** - 1g suppository daily + 1 or 2g enema daily – *please refer to 'rectal formulation' section below*
Oral mesalazine should be prescribed by brand due to differing release properties. *If patients previously are stabilised on Pentasa brand this can be continued and increased to specific flare dosing:* • *Pentasa 4g daily* *Asacol has been discontinued. Patients previously on Asacol should be switched to Octasa at the same dose.*		*There is no need to prescribe rectal mesalazine by brand.*

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

UC MAINTENANCE Management

- During maintenance therapy, to remain in remission, at least 2g daily of mesalazine treatment is recommended (1.5g daily if taking Salofalk).
    - Gradual reduction from 'flare' to 'maintenance' doses is recommended.
    - Please consider which mesalazine was used for flare/previously and de-escalate dose accordingly:

ORAL mesalazine doses: *Preferred options:* Octasa 2.4g daily 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 are stabilised on Pentasa brand this can be continued at Pentasa 2g daily* *Asacol has been discontinued. Patients previously on Asacol should be switched to Octasa at the same dose.*

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

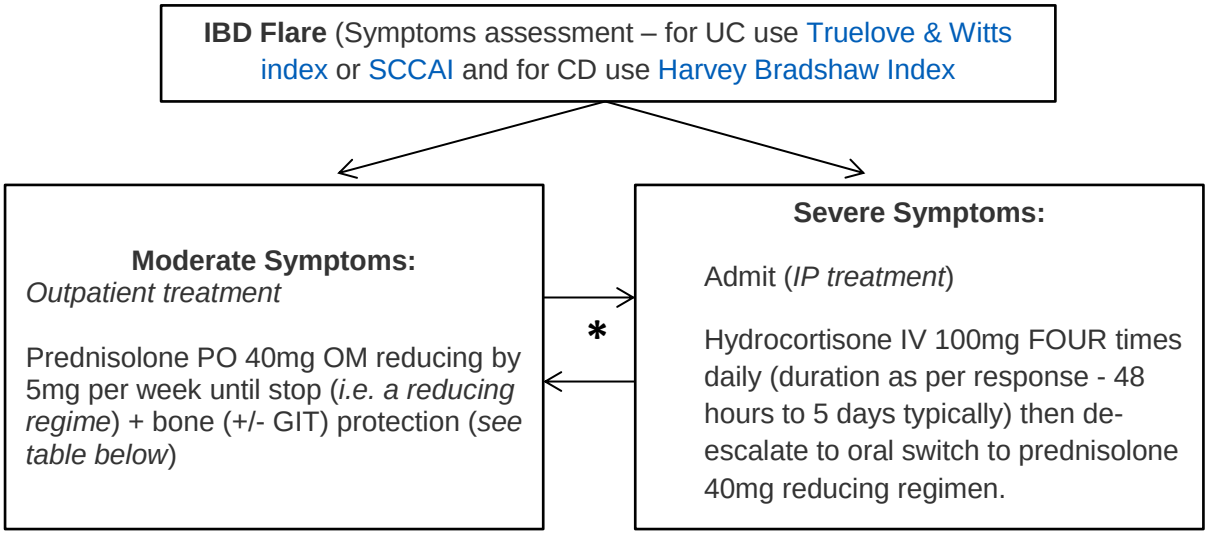
☎ 01273 664427 (an answerphone service)

✉ uhsussex.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:



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

Protective Medications to Co-prescribe Alongside Hydrocortisone & Prednisolone:

Medication	Indication	Dose	Monitoring Requirements
Adcal D3^	Bone protection whilst on steroids	One tablet BD while on prednisolone	Calcium
Lansoprazole	Peptic ulcer protection whilst on steroids only if have other ulcer development risk factors or dyspepsia	At least 15mg OD while on prednisolone. If already on PPI continue on regular dose.	Sodium
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-trimoxazole	*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.

Please do a full osteoporosis risk review to determine if co-administration of bisphosphonates with steroids is recommended.

Budesonide:

If concerned regarding immunosuppression or other side effects of prednisolone, budesonide can be used. Please note:

- Budesonide may not be as effective as prednisolone in anti-inflammatory activity.
- The correct brand needs to be prescribed depending on diagnosis (see table below).
- Weaning of dose is not usually required – refer to specialist IBD team for advice if patient is getting rebound symptoms.

Diagnosis	Brand	Dose	Duration
Crohn's Disease	**Budenofalk** gastro-resistant capsules NB: Entocort CR capsules is also acceptable if Budenofalk out of stock	9mg (3x3mg) once daily	8 weeks
Ulcerative Colitis	**Cortiment** prolonged release tablets	9mg (1x9mg) once daily	8 weeks

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 (azathioprine and mercaptopurine), methotrexate and the biologics (infliximab, adalimumab, golimumab, ustekinumab, vedolizumab, tofacitinib, filgotinib and upadacitinib).
- Work-up is required and to be done at ward level.
    - For thiopurines and methotrexate:
        - TPMT
        - Full blood count
        - Virology screen including HIV, HBVsAg, HBVcAb, HCV, EBV, CMV, VZIG
        - Faecal calprotectin stool sample
    - For biologics (new and switch):
        - Full blood count
        - Virology screen including HIV, 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 (tofacitnib, filgotinib and upadacitinib i.e., JAK Inhibitors)
    - Virology screen, T-spot and Chest X-ray can be up to 3 months old, unless evidence of exposure risk has 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:

uhsussex.ibdnursingservice@nhs.net

or

uhsussex.gastro.pharmacy.brighton@nhs.net

Post-operative ileocolonic resection in Crohn's patients

Note this provides antibiotic cover and prevents disease recurrence[1, 2]

On recommendation of consultant surgeon only

Metronidazole 400mg TDS for 3 months

If metronidazole allergy, please refer to consultant surgeon

- Patient must be counselled on risk of peripheral neuropathy due to long term use of metronidazole[3]
- Patient must be provided with the metronidazole patient information leaflet [link to leaflet once complete]
- Advise patient to contact IBD helpline if develops symptoms (contact details on PIL)
- Ensure following information is included in discharge letter (this should come up in the notes for metronidazole on EPMA and can be copied and pasted as a 'note to appear on the discharge letter')

"3 months course (post-surgery). If patient experiences any numbness, pins and needles or confusion stop treatment and contact the IBD team"

1. Lamb CA, Kennedy NA, Raine T, et al. British Society of Gastroenterology consensus guidelines on the management of inflammatory bowel disease in adults. BMJ Gut 2019;68:s1-s106.
2. NICE. Crohn's disease management 2019. Available at: Recommendations | Crohn's disease: management | Guidance | NICE; Accessed on 29th Nov 2022.
3. Chin HY & Hughes S. Metronidazole: high doe and long duration risks peripheral neuropathy. Clinical Pharmacist, 2018; 10 (8): DOI: 10.1211/PJ.2018.20205255.

Guidance Information

Lead Author(s): **Fiona Rees, Archna Parmar, Anja St Clair Jones, Emma Hills, Dr M Smith Megan Hockly, Mr Alfredo Tonsi (BSUH IBD Team)**

Approved: MGC **March 2023, Updated March 2023**
Microguide support, comments or contributions - contact uhsussex.microguide@nhs.net