

# crohn's colitis

## **Name of Clinical Care Pathway**

Initiation and tapering of corticosteroids (prednisone, budesonide, budesonide-mmx)

## **Objective**

To minimize the risk of repeated corticosteroid use for the treatment of IBD.

## **Patient Population**

Adult patients (>18 years) with a known diagnosis of IBD

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## Highlight Box

Corticosteroids should only be used for short-term induction therapy to treat acute IBD flares.

## Introduction

Corticosteroids are an effective induction short-term therapy for acute flares of IBD but are associated with significant morbidity and inadequate disease control when used for prolonged periods. Strategies to minimize adverse events and a long-term plan for alternative (and more appropriate) maintenance therapy are required.

\*Steroid refractory – patients whose symptoms never responded to corticosteroids and those who respond initially but develop recurrence despite continuing treatment.

\* Steroid dependent - patients who initially respond to steroids but lose response during taper or shortly after completion of steroid taper; therefore, requiring additional steroids to control symptoms.

### IBD Provider

1. Screen for (and correct) general osteoporosis risk factors – malnutrition, inflammation, smoking, and lack of weight-bearing exercise. Consider bone mineral density where appropriate. Mental health should also be considered prior to starting steroid therapy and should be discussed with the patient and significant others.
2. Corticosteroid treatment should be considered in conjunction with a maintenance agent: azathioprine (immunomodulator), mesalamine (5-ASA), or biologic. ([PACE QPI 23](#))
3. At the initiation of corticosteroid treatment, ensure that the patient is supplied with:
  - a. Patient information sheets for the corticosteroid he/she is prescribed ([Prednisone-patient information](#), [Prednisone Tapering-Patient instructions](#), [Entocort Patient Information Sheet](#), & [Cortiment Patient Information Sheet](#) and [Budesonide Tapering-Patient Instructions](#)) ([PACE QPI 22](#))
  - b. IBD Flare labs and fecal calprotectin to be completed at baseline and in 3 months to allow for assessment of response ([IBD Flare Lab Requisition](#))
  - c. Instructions to take 500 mg of elemental calcium (dietary sources) and vitamin D 2000 IU QD for the duration of corticosteroid therapy ([PACE QPI 27](#))

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4. Instruct the patient to call the GI clinic if not improving or if initially improving and then a loss of response.

Complete an assessment ([e.g. telephone visit](#)) and [Harvey Bradshaw Index](#) (HBI) or [Partial Mayo \(pMayo\)](#) to ensure response and identify steroid refractory\* patients ([PACE QPI 15](#)).

- a. If there is a significant subjective improvement in IBD symptoms and HBI <5 or pMayo <1:
    - o Continue with steroid taper
    - o Send a message to support staff to make a follow-up appointment at 4 months
  - b. If there is not an adequate response, then optimize therapy – see Therapy decision tree protocols and complete pre-biologic workup Biologic Induction Protocol.
5. Issue one corticosteroid prescription taper of three months maximum only. No repeats.

## Support Staff

1. Arrange clinic follow-up at 4 months.

## References

Dorrington AM, Selinger CP, Parkes GC, Smith M, Pollok RC, Raine T. The Historical Role and Contemporary Use of Corticosteroids in Inflammatory Bowel Disease. *Journal of Crohn's and Colitis*. 2020 Sep 16;14(9):1316-1329. <https://doi.org/10.1093/ecco-jcc/jjaa053>

Selinger CP, Parkes GC, Bassi A, et al. Assessment of steroid use as a key performance indicator in inflammatory bowel disease—analysis of data from 2385 UK patients. *Aliment Pharmacol Ther*. 2019;50(9):1009-1018. <https://doi.org/10.1111/apt.15497>

Seow CH, Coward S, Kroeker KI, et al. Declining Corticosteroid Use for Inflammatory Bowel Disease Across Alberta: A Population-Based Cohort Study. *Journal of the Canadian Association of Gastroenterology*. 2022;5(6):276-286. <https://doi.org/10.1093/jcag/gwac021>

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