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 inflammatory bowel disease (IBD)

Patient Population

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

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PACE Inflammatory Bowel Disease Clinical Care Pathways

crohn's colitis

Highlight Box

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

These clinical decision support tools were developed by Canadian experts in IBD, based on their interpretation of current evidence and considerations specific to Canadian healthcare. International guidelines from Europe and the United States are available. However, these may reflect regional factors not directly applicable in Canada.

Introduction

Corticosteroids (steroids) 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 appropriate maintenance therapy are required.

Steroid refractory – Patients whose symptoms do not adequately respond to steroids.

Steroid dependent - Patients who initially respond to corticosteroids but lose response during taper or shortly after completion of corticosteroid taper; therefore, requiring additional corticosteroids to control symptoms.

IBD provider:

1. Screen for (and correct) general osteoporosis risk factors: Optimize disease control, nutrition, stop smoking, and encourage weight-bearing exercise. Consider bone mineral density where appropriate.
2. Mental health should also be considered prior to starting steroid therapy and should be discussed with the patient and significant others.
3. Corticosteroid treatment should be considered in conjunction with a maintenance agent, azathioprine, methotrexate, mesalamine (5-ASA)*, or advanced therapy (PACE QPI 23).

   *For ulcerative colitis

4. At the initiation of corticosteroid treatment, ensure that the patient is supplied with:
   - Patient information sheets for the corticosteroid he/she is prescribed: Prednisone-patient information, prednisone tapering patient instructions, Entocort (ileal release budesonide) patient information sheet, Cortiment (colonic release budesonide) patient information sheet and budesonide tapering patient instructions (PACE QPI 22).
   - IBD flare labs and fecal calprotectin are to be completed at baseline and in 3 months to allow for assessment of response.

- 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).

5. 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).

   - If there is a significant subjective improvement in IBD symptoms and HBI <5 or pMayo <1:
     - Continue with corticosteroid taper.
     - Send a message to support staff to make a follow-up appointment at 6 weeks.

   - If there is no adequate response, optimize therapy. Complete the pretherapy workup and refer to the Induction of Advanced Therapy protocol.

6. Issue one corticosteroid prescription taper of three months maximum only. No repeats.

Support staff:

1. Arrange clinic follow-up at 6 weeks.

References

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