



crohn's colitis

Name of Clinical Care Pathway

Therapy Decision Tree—Ulcerative Colitis

Objective

Provide direction regarding choice of therapy for patients with ulcerative colitis

Patient Population

Adult patients (≥ 18 years) with a known diagnosis of ulcerative colitis

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Highlight Box

New therapies are constantly being developed and should be considered.

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

Ulcerative colitis (UC) is a chronic inflammatory condition of the large intestine limited to the mucosal layer of the colon extending proximally from the rectum, to varying extent. UC is diagnosed based on a combination of clinical presentation, endoscopic findings, and histological features indicating chronic inflammation. It is important to define the extent and severity of inflammation to guide the selection of appropriate treatment and predict prognosis.

Montreal classification of UC based on disease extent is classified as follows:



Ulcerative proctitis



Left-sided colitis



Extensive colitis/Pancolitis

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Partial Mayo scoring system for ulcerative colitis disease activity

Parameter	Clinical evaluation (single choice)	Score
Stools frequency (per day)	Normal number of stools	0
	1-2 more than normal	1
	3-4 more than normal	2
	≥5 more than normal	3
Rectal bleeding (indicate the most severe bleeding of the day)	No blood seen	0
	Streaks of blood with stool less than half the time	1
	Obvious blood with stool most of the time	2
	Blood alone passed	3
Physician's global assessment	Normal	0
	Mild	1
	Moderate	2
	Severe disease	3

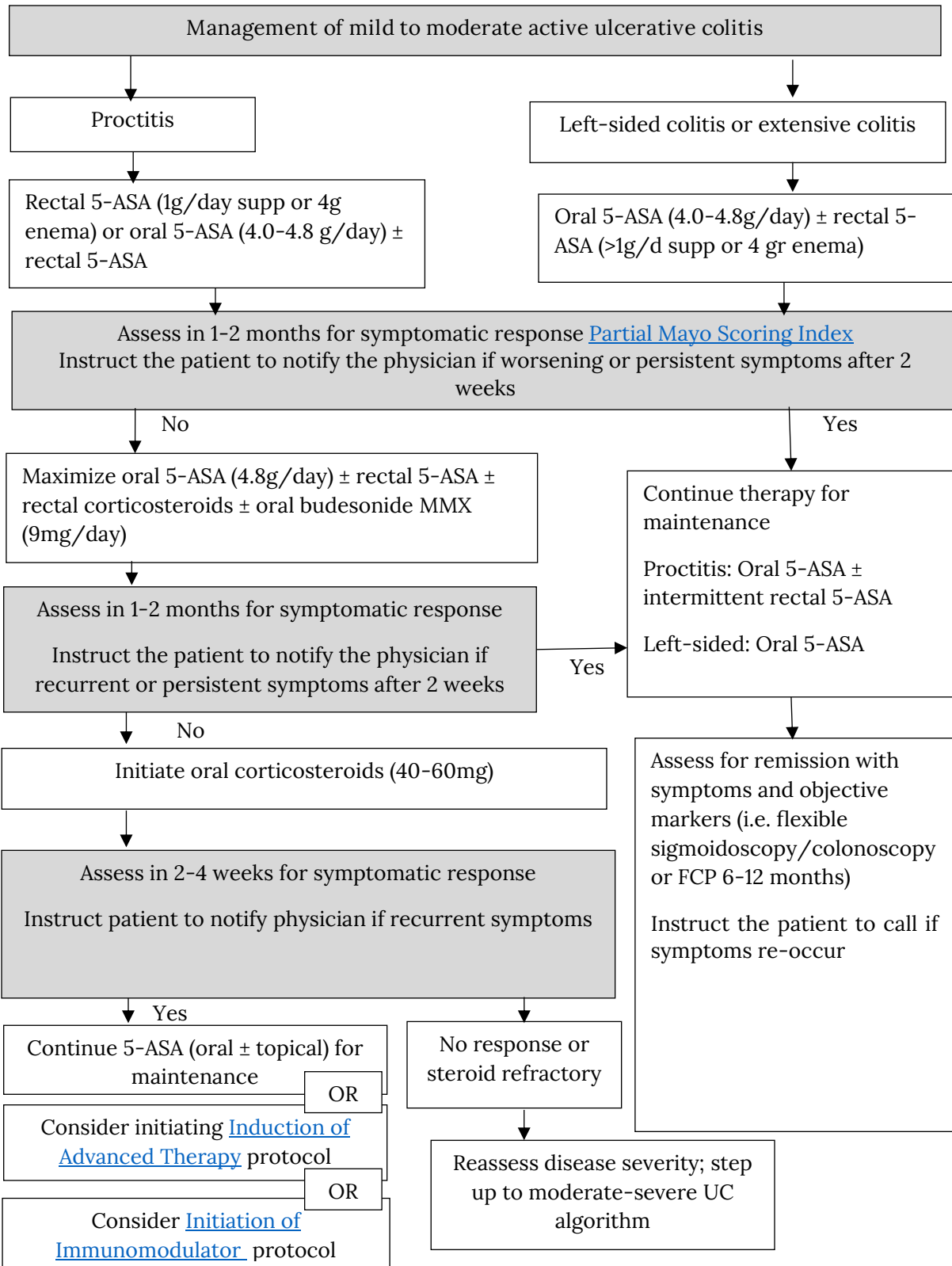
Score	Interpretation
0-1	Remission
2-4	Mild activity
5-6	Moderate activity
≥7	Severe activity

Definitions, suggested diagnostic work-up and goal of therapy:

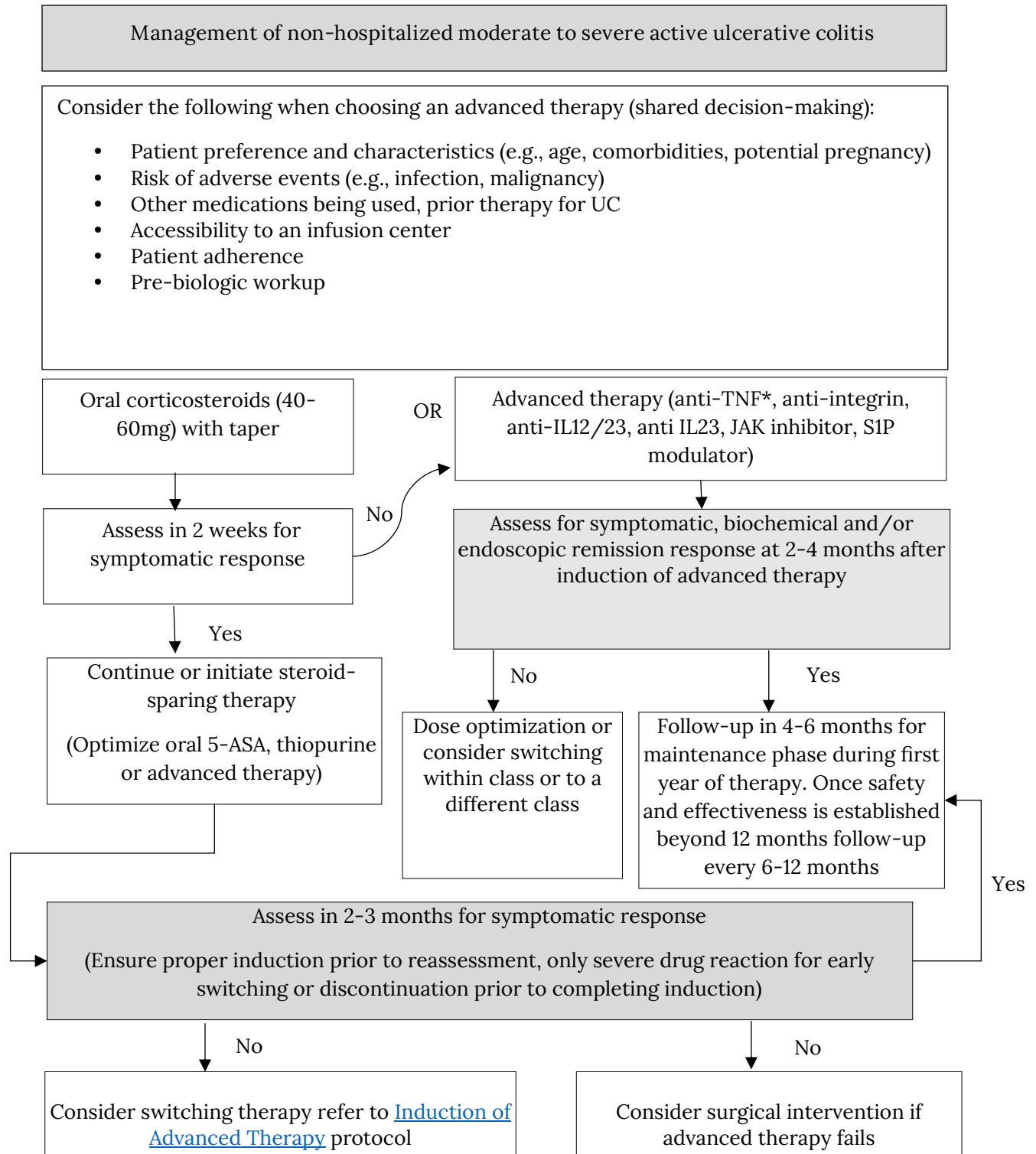
- Corticosteroid refractory UC: If there is no clinical response to oral prednisone (40 to 60 mg or equivalent) within 30 days.
- Corticosteroid dependent UC: If corticosteroids cannot be tapered within 3 months of starting without disease recurrence or if relapse occurs within three months of stopping corticosteroids.
- Laboratory investigation includes Complete blood count, liver biochemical tests, albumin, iron studies and C-reactive protein.
- Stool studies include *Clostridium difficile*, routine stool cultures, and fecal calprotectin (FCP).
- If the patient recently travelled to a parasitic infection endemic region, consider ova and parasites.
- Endoscopy (flexible sigmoidoscopy or colonoscopy) if needed for change in therapy.
- Goal of therapy: To achieve clinical and endoscopic remission.

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The following algorithms are best practice clinical pathways for therapy decisions for patients with UC:



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* Anti-TNF ± thiopurine is recommended to reduce antibody formation

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Management of hospitalized acute severe ulcerative colitis

Initiate:

- Supportive care*
- Intravenous (IV) corticosteroids (methylprednisolone 40-60 mg/day) ± topical corticosteroids
- Pre-biologic workup

On-admission conduct:

- Assays of stool samples for *C. difficile*, FCP and bacterial pathogens
- Abdominal X-ray
- Flexible sigmoidoscopy
- Chest X-ray and Tuberculosis testing
- Hep B serology
- Testing for CMV (flexible sigmoidoscopy)

Assess for clinical response at 3-4 days after initiation of IV steroids

Yes

Transition from IV to oral corticosteroids with taper add thiopurines or 5-ASA

Assess for clinical response

Yes

Arrange for outpatient IFX infusion to complete induction doses of IFX, and then continue with maintenance IFX ****

Yes

Discharge patient from hospital ensuring:

- Normalization of vital signs
- <6 stools per day with little or no blood with each bowel movement
- Resolution of severe abdominal pain
- Tolerance of oral diet
- Discuss follow up plans
- Consider out-patient therapy plan regarding initiation of maintenance therapy

No

Escalate medical therapy

Infliximab (IFX)**

No

Administer second IFX infusion (10 mg/kg)

Assess for clinical response

No

Surgery

OR

Surgery

Cyclosporine IV***

No

Discontinue cyclosporine

Yes

Transition from IV to oral cyclosporine; consider maintenance therapy OR Transition from IV to oral corticosteroids with taper

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* Monitoring vital signs, stool output, intravenous fluid, electrolyte replacement, venous thromboembolism prophylaxis and nutritional support **The threshold for escalating therapy in time and/or dose should be low, especially in sick patients with low albumin. *** Not commonly used in Canada ****IFX should be administered as combination therapy for at least 6 months on discharge

Other Resources

Inflammatory Bowel Disease: [Drug Comparison chart](#) (log-in required)

UpToDate® – Patient education: Ulcerative colitis (Beyond the Basics) (free access)

https://www.uptodate.com/contents/ulcerative-colitis-beyond-the-basics?topicRef=2004&source=see_link

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