crohn's colitis

Name of Clinical Care Pathway

Suspected IBD Outpatient Flare

Objective

Optimal management of inflammatory bowel disease (IBD) flare

Patient Population

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

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PACE Inflammatory Bowel Disease Clinical Care Pathways

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Highlight Box

The completed assessment will be used to triage patient symptoms to determine the degree of urgency. Good clinical judgement, assessment skills and knowledge of IBD will be utilized in consultation with the physician or nurse practitioner to determine further treatment or assessment required.

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

An IBD flare is the reappearance of disease symptoms. This CCP is intended to support clinicians in outpatient settings with their decision-making process when faced with concerns for a flare. Please see the steps mentioned below:

1. Complete the Harvey Bradshaw Index (HBI) or partial Mayo (pMayo) with the patient; if the patient has IBDU (IBD unclassified), an HBI will be used.
2. Communicate the completed assessment to the responsible physician/nurse practitioner (NP) within the following timelines (see Table 1).

Table 1: Timelines for patient assessment

Timeline	Patient assessment guidelines	Mode of communication
Urgent/emergent	The patient requires immediate intervention/investigation or may not be able to wait only until the next day in the following cases: • Abdominal pain that is not relieved with any intervention • Persistent nausea/vomiting • Profuse rectal bleeding • New fistula with an elevated temperature • Elevated temperature, not improved by intervention • Elevated temperature while on advanced therapy • Sudden/unexplained change in health status • Extensive bloating and pain or unable to pass stool for 48 hours (obstruction) • Perianal pressure, pain and swelling	Page and speak with the physician / NP directly. Recommend ER visit with plan for admission, as appropriate.

Timeline	Patient assessment guidelines	Mode of communication
Semi-urgent	Patient can wait for 2-3 days for intervention/investigation in the following cases: • Fistula draining – old site • Fecal incontinence/urgency • Up at night with diarrhea • More frequent diarrhea • Bloating • Fatigue • Change in daily activity	Send an email or EMR message to the physician / NP.

3. Under the direction of the physician/NP, or standard operating procedure process laboratory/diagnostic imaging investigations[+] based on the assessment:
    - IBD flare lab Requisition (CBC, FER, NA, K, CL, ALB, ALP, ALT, CRP, AST, creatinine, BUN).
    - Stool C. difficile culture and sensitivity (if diarrhea present) (PACE QPI 1)*.
    - Ova and parasite tests should be considered if the patient has recently travelled, camped, been exposed to well water, raw meat or fish*.
    - Stool fecal calprotectin (if available).
    - X-ray of abdomen with 3 views if the patient is experiencing bloating, abdominal pain, nausea, vomiting**.
    - If the introduction of advanced therapy is considered, see Induction of Advanced Therapy protocol for pre-biologic work-up.

[+]In some regions, requests may be coordinated through PSP.
*Order GI pathogen multiplex PCR panel instead of isolated C. difficile and O&P testing, where available.

**Caution: Although X-rays have a moderate sensitivity for the detection of high-grade small bowel obstruction, they are less useful in differentiating small from large bowel obstruction and differentiating partial obstruction from ileus. Follow-up abdominal CT is generally required.

4. Deliver requisitions to the patient by one of the following methods:
    - Fax requisition to the patient's closest laboratory/radiology centre.
    - Send the requisition to the patient via email, standard mail, or fax.
    - Give the requisitions to the patient if the patient is present in the clinic.

5. Once testing is complete, the patient should contact the clinic to review next steps. Results should be reviewed with the patient to decide on any further investigations, follow up plans, or changes to treatment.

6. If symptoms worsen, the patient should contact the clinic or visit urgent care or the emergency room (ER).

Physician guided:

1. Consider the following imaging:
   - Intestinal ultrasound
   - CT enterography/ MR enterography/ U/S: When the patient presents with abdominal pain in the right upper quadrant, there is a history of abscess/stricture. Surgery referral if needing EUA, seton placement, drainage of abscess, resection.
   - MRI pelvis: If new fistula or pain.
   - Endoscopy, depending on history, to document disease extent and severity.
   - Urgent surgery referral for assessment.

2. If the patient has left-sided disease, add budesonide (Cortiment).

3. Consider corticosteroids tapering course and refer to: Initiation and Tapering of Corticosteroids protocol.
   If the patient:
   - Has moderate to severe active disease, and infection has been ruled out.
   - Previously had good response to Corticosteroids (40 mg-60 mg per day for >14 days) with no or minor side effects (PACE QPI 3).
   - Had not required two or more courses of systemic steroids in the last year (PACE QPI 7).

4. If the patient is on advanced therapy, consider antibody serum levels, dose escalation or rescue dose:
   - Consider therapeutic drug monitoring (TDM) during maintenance therapy for anti-TNFs even without clinical symptoms.
   - If patients are flaring with evidence of active inflammation while already on advanced therapy, consider a timely transition to an alternative agent.

5. If the patient has failed initial advanced therapies, consider escalation to newer agents such as anti-integrins, interleukin 12/23 antagonists, sphingosine 1-phosphate receptor modulators, or Janus kinase inhibitors based on patient profile and disease characteristics.

6. If the patient is on azathioprine (stable dose for 1 month or following a change in dose):
   - Consider 6-thioguanine nucleotides (6-TGN) and 6-methylmercaptopurine (6-MMP) therapeutic levels.

7. Antibiotic stewardship: Ensure careful use of antibiotics if treating suspected perianal disease/abscesses.

8. Decide the timeline for a follow-up clinic/virtual visit or telephone to initiate care.

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