crohn's colitis

Name of Clinical Care Pathway

Maintenance of Advanced Therapy

Objective

Appropriate management of patients on advanced therapies during maintenance

Patient Population

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

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.

Dr. Nancy Fu MD, MHSc, FRCPC (University of British Columbia)
Dr. Yvette Leung MD, MSc, FRCPC (University of British Columbia)

Abbreviations

CD	Crohn's Disease
CRP	C-reactive Protein
CT	Computed Tomography
FCP	Fecal Calprotectin
HBI	Harvey-Bradshaw Index
IBD	Inflammatory Bowel Disease
IUS	Intestinal Ultrasound
MRE	Magnetic Resonance Enterography
MRI	Magnetic Resonance Imaging
pMayo	Partial Mayo Score
PROs	Patient-Reported Outcomes
UC	Ulcerative Colitis

crohn's colitis

Highlights from this CCP

Patients maintained on advanced IBD therapy should have regular monitoring.

Introduction

Routine monitoring may include clinical visits, laboratory tests, endoscopy and imaging studies. The results can assist the healthcare team in detecting and minimizing IBD flare.

IBD provider:

1. **Clinical evaluation (PROs)**

   Clinical visits should be scheduled between 6 to 12 months during quiescent disease.

   Obtain and document clinical disease activities

   - Crohn's disease, including the Harvey Bradshaw Index
   - Ulcerative colitis, including Partial Mayo (pMayo) stool frequency, or rectal bleeding

   If the patient is flaring, refer to the Suspected IBD Outpatient Flare protocol.

   Review available records collected during biologic administration or relevant nursing/allied health documentations.

2. **Biochemical evaluation**

   Regular monitoring every 3 to 6 months for adults. This should include blood tests with CRP (and albumin) and fecal calprotectin.

   Consider therapy optimization if FCP >250 (refer to Loss of response/Partial response protocol), but consider the FCP trend

3. **Endoscopic evaluation**

   Consider colonoscopy or flexible sigmoidoscopy in left-sided ulcerative colitis in 8-12 months after therapy optimization or at the provider's discretion, recognizing that not all agents have therapy optimization. Additionally, depending on disease duration, mucosal healing may not be an achievable goal; therefore, the decision should be at the discretion of the healthcare provider.

4. **Imaging evaluation**

   Consider early cross-sectional evaluation at around 3–6 months after treatment optimization or at the provider's discretion. Options include intestinal ultrasound (IUS) or MRI/CT enterography, depending on availability. For patients with Crohn's, proactive monitoring with IUS* or MRE* can be considered every 12 months.

   Plan follow-up appointments for 6-12 months and send out lab requisitions. Plan endoscopy or cross-sectional imaging if indicated.

Support staff:

1. Arrange follow-up clinic visit 6-12 months (adults), after the initial 3-4 months follow-up.
2. Along with the appointment notification, send the patient the following lab requisitions:
   - Follow-up bloodwork to be done every 3 - 6 months.
   - Fecal Calprotectin(FCP) kit for the patient to complete every 3 to 6 months or prior to the next appointment. In the pediatric population, FCP should be completed every 6 months for the first year, then annually. FCP can be added to the follow-up requisition if available at the local lab.
3. Ensure that the patient has been scheduled for a colonoscopy at 8-12 months or at the provider's discretion, as per IBD Patients on advanced therapy – Induction of Advanced Therapy protocol
4. Ensure cross-sectional imaging (usually IUS*) at 12 weeks and/or at 12 months after therapy optimization, or at provider discretion.

**Availability of IUS and access to MRE may vary across healthcare settings in Canada.*