

# 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 ( $\geq 18$  years) with a known diagnosis of ulcerative colitis

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*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, including recommendations based on government policies and reimbursement policies by payers. International guidelines from Europe and the United States are available. However, these may reflect regional factors not directly applicable in Canada.*

PACE Inflammatory Bowel Disease Clinical Care Pathways

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## Abbreviations

5-ASA	5-Aminosalicylic Acid
CCP	Clinical Care Pathway
CMV	Cytomegalovirus
CRP	C-reactive Protein
FCP	Fecal Calprotectin
Hep B	Hepatitis B
IBD	Inflammatory Bowel Disease
IFX	Infliximab
IV	Intravenous
JAKi	Janus Kinase Inhibitor
PO	Per Os (Oral Administration)
SC	Subcutaneous
TNF	Tumor Necrosis Factor
UC	Ulcerative Colitis

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Highlights from this CCP

New therapies are constantly being developed and should be considered.

## 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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**Table 1: Partial Mayo scoring system for ulcerative colitis disease activity**

Parameter	Clinical evaluation (single choice)	Score
Stools frequency (per day)	Baseline number of stools	0
	1-2 more than baseline	1
	3-4 more than baseline	2
	≥5 more than baseline	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

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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.

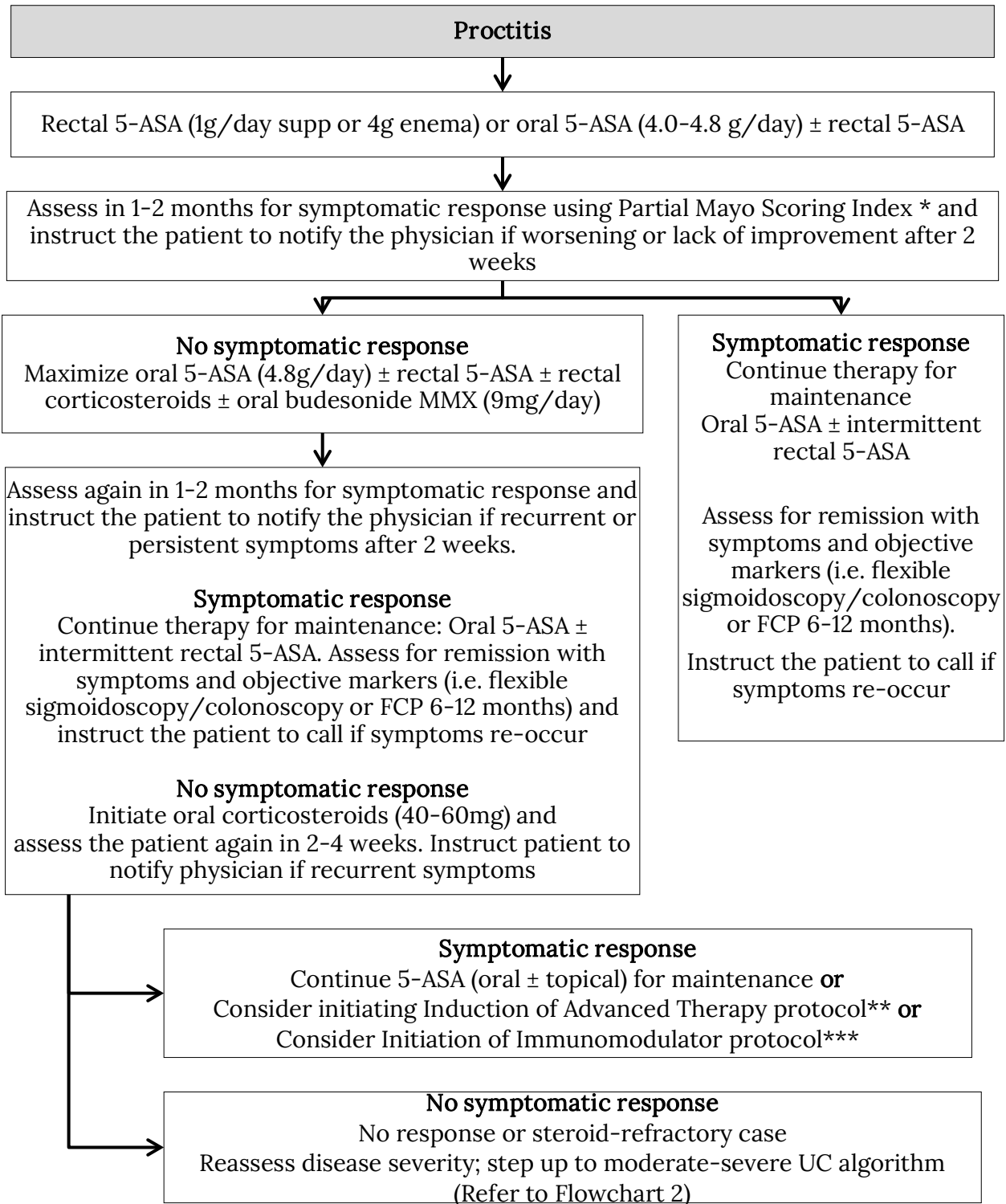
The following algorithms are best practice clinical pathways for therapy decisions for patients with UC:

- Management of mild to moderate active ulcerative colitis (Refer to Flowchart 1.1 and 1.2).
- Management of non-hospitalized moderate to severe active ulcerative colitis (Refer to Flowchart 2.1 and 2.2).
- Management of hospitalized bio-naive acute severe ulcerative colitis (Refer to Flowcharts 3.1 and 3.2).

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## Management of mild to moderate active ulcerative colitis

Flowchart 1.1: Management of mild to moderate active ulcerative colitis (Proctitis)

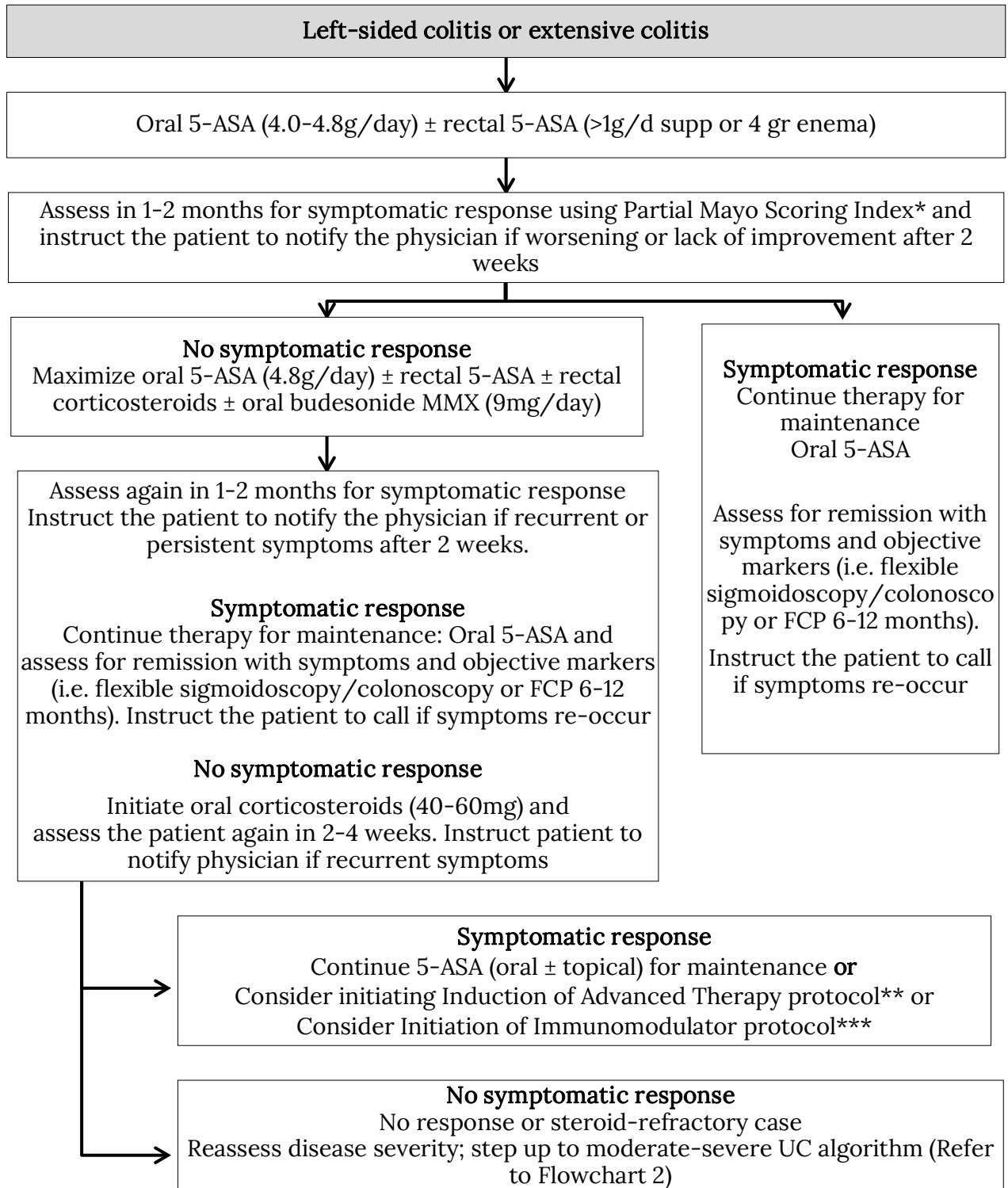


\*[Partial Mayo scoring Index](#) (Link) \*\*[Induction of Advanced Therapy CCP](#) (Link)

\*\*\*[Initiation of Immunomodulator protocol](#) (Link)

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Flowchart 1.2: Management of mild to moderate active ulcerative colitis (Left-sided colitis or extensive colitis)

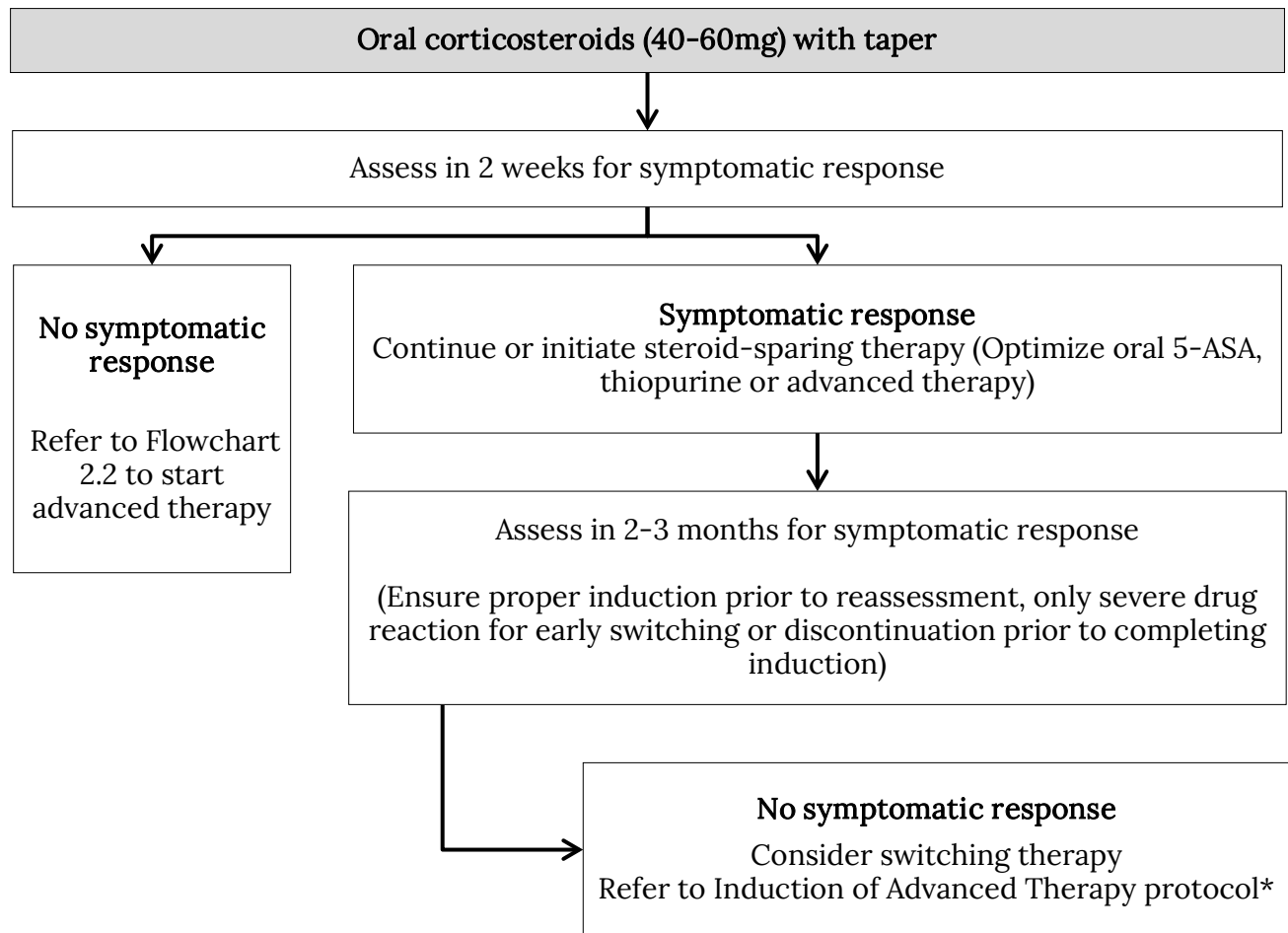


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\*\*\*[Initiation of Immunomodulator protocol](#) (Link)

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Management of non-hospitalized moderate to severe active ulcerative colitis  
Flowchart 2.1: Using oral corticosteroids



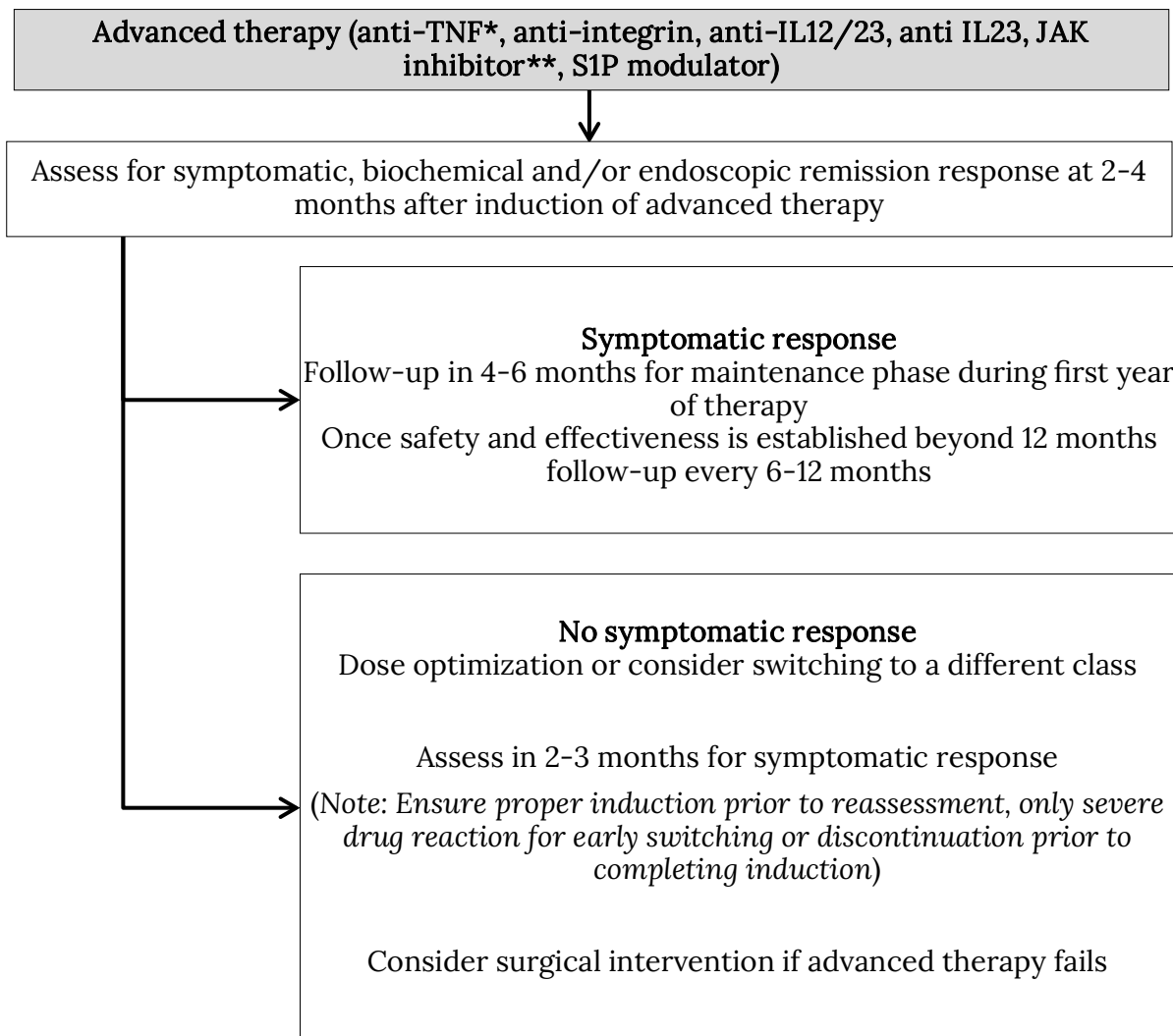
\*[Induction of Advanced Therapy CCP \(Link\)](#)

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## Flowchart 2.2: Using advanced therapy

### Consider the following when choosing an advanced therapy (shared decision-making):

- Patient preference and characteristics (e.g., age, comorbidities, potential pregnancy)
- Preferred route of administration (PO vs SC vs IV), accessibility to an infusion center
- Risk of adverse events (e.g., infection, malignancy)
- Other medications being used, prior therapy for UC
- Patient adherence
- Pre-biologic workup



\* Anti-TNF ± thiopurine is recommended to reduce antibody formation, especially for infliximab.

\*\*Note: The role of JAKi in hospitalized patients has not been established and requires expert consultation.

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## Management of hospitalized bio-naive acute severe ulcerative colitis

### On admission

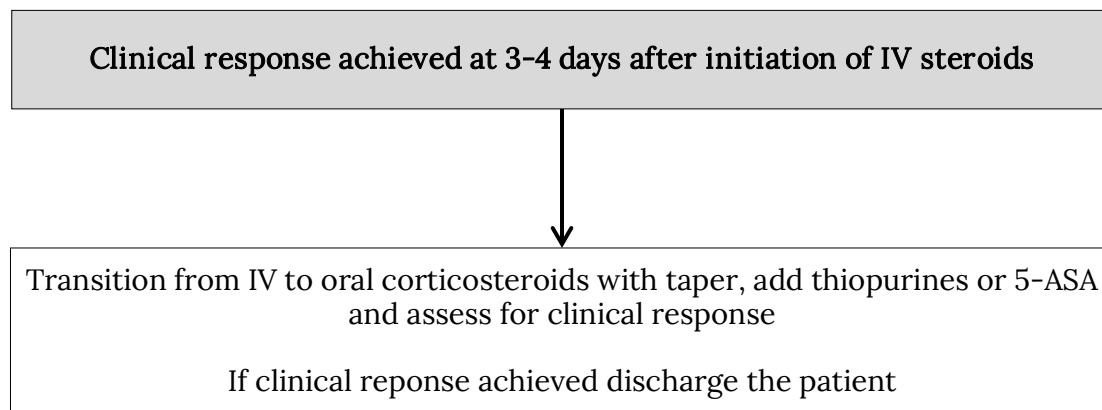
#### Conduct:

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

#### Initiate:

- Supportive care (Monitoring vital signs, stool output, intravenous fluid, electrolyte replacement, venous thromboembolism prophylaxis and nutritional support)
- Intravenous (IV) corticosteroids (Methylprednisolone 40-60 mg/day) ± topical corticosteroids and **assess for clinical response at 3-4 days after initiation of IV steroids.**
- Pre-biologic workup

### Flowchart 3.1: Clinical response observed after receiving IV corticosteroids

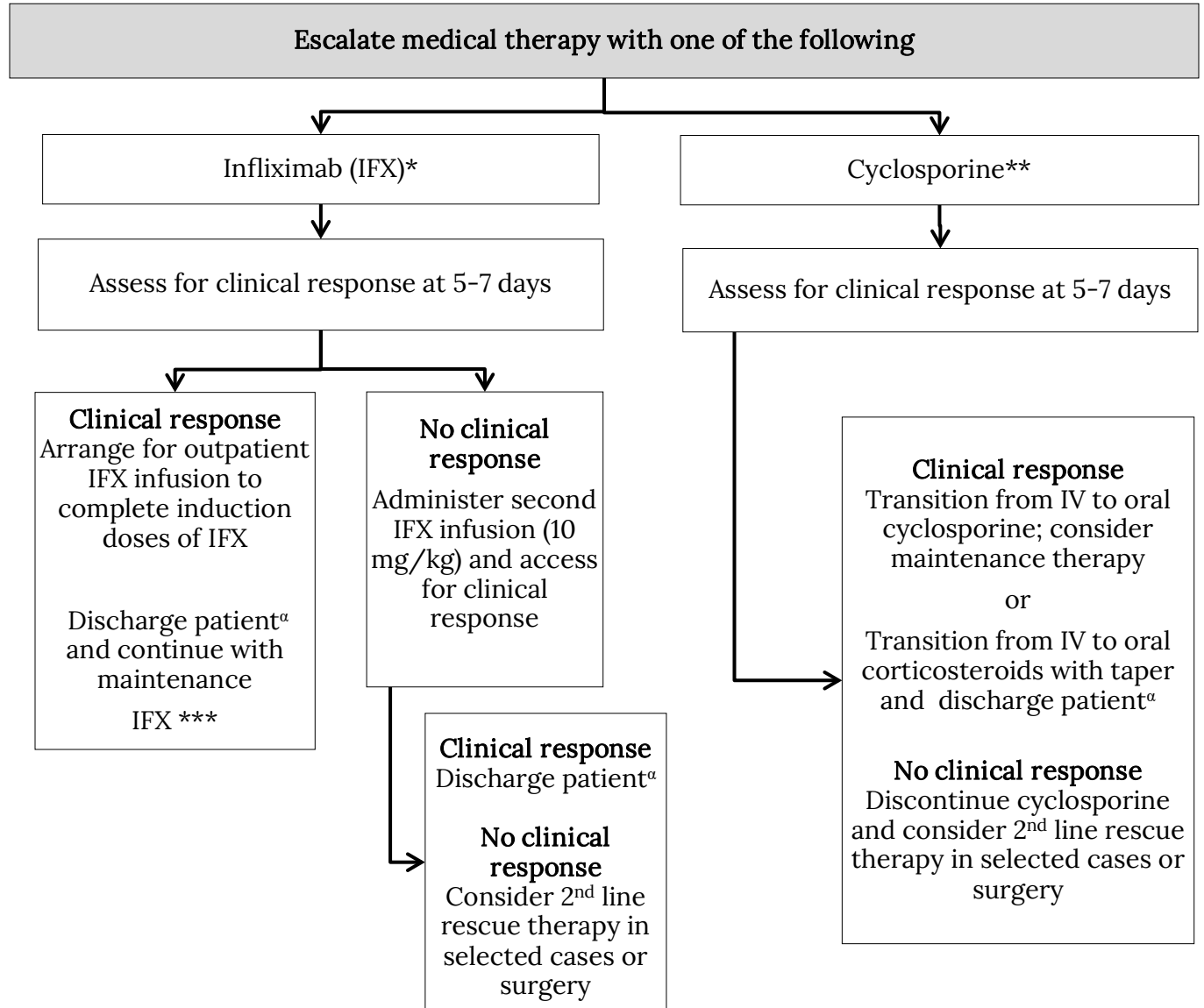


### Discharge patient from hospital, ensuring:

- 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
- (Near) normalization of CRP
- Discuss follow-up plans
- Consider an outpatient therapy plan regarding initiation of maintenance therapy

## Flowchart 3.2: Clinical response not observed after receiving IV corticosteroids

If clinical response is not observed 3-4 days after initiation of IV corticosteroids, escalate medical therapy or move forward with surgery.



Upadacitinib 45 mg may be considered as 2nd line rescue therapy, after failure of IV corticosteroids, or 3rd line, after infliximab or cyclosporine failure. Given the lack of controlled data, we recommend a case-by-case discussion with an IBD expert center if this option is considered.

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\*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.

α 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
- (Near) normalization of CRP
- Discuss follow-up plans
- Consider an outpatient therapy plan regarding initiation of maintenance therapy

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

## References

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