Ulcerative Colitis - Severe - Full Clinical Guideline

Reference No: CG-GASTRO/2015/004

1. Summary

This is a practical guideline and check list for assessing and treating inpatients with severe Ulcerative Colitis (UC)

2. Introduction

Ulcerative Colitis is a form of idiopathic inflammatory bowel disease. Patients with severe disease should be admitted to hospital and this document provides guidance on medical management and monitoring

3. Aim and Purpose

To offer guidance for all clinical staff treating adult patients with severe ulcerative colitis admitted to Royal Derby Hospital.

4. Definitions

UC – ulcerative colitis

5. Guideline

Definition of severe ulcerative colitis (UC)

6 or more bloody stools per day and at least one of the following

- temperature greater than 37.8 C
- pulse >90 per minute
- haemoglobin less than 105 g/L
- ESR >30mm/Hr

Admission

All patients admitted with severe UC should be admitted to ward 305/304 under the care of gastroenterology, or to a colorectal surgery ward e.g. 309

Investigations

- Bloods, FBC, U&C, CRP, LFT, Mg++, lipids
- CXR/AXR
- Stool culture and sensitivity and Clostridium difficile; travel history
- Endoscopic assessment – flexible sigmoidoscopy <24 hours with biopsy for CMV (Cytomegalovirus).

Treatment

- Steroids - **Intravenous hydrocortisone 100 mg qds** this not should not be delayed for culture results.
- Oral 5-ASA can be continued but do not start new therapy until in remission.
- Antibiotics should not be routinely prescribed.
- Bone prophylaxis **Adcal D3 2 daily** in <65years,or **bisphosphonate** >65years
- Thromboprophylaxis – **enoxaparin 40mg od** regardless of whether mobile or not
- IV fluid therapy to correct **dehydration**, with at least **60mmol potassium per day.** Patients are highly prone to hypokalaemia due to the diarrhoea and steroid therapy and this requires close attention – particularly if surgery being considered
- Drugs to Avoid - anticholinergic, antidiarrhoeal agents, NSAIDs and opioids which risk precipitating colonic dilatation.
- For analgesia use rectal / PO / IV paracetamol.
- Proximal constipation - Treat proximal constipation if present in distal disease: often requires regular laxatives e.g. Movicol (NB lactulose may effect 5-ASA release kinetics)

Daily Review,

- Review of temperature, pulse, respiration, BP
- Abdominal examination
- Stool charts,
- Daily bloods –FBC, U&E, CRP,
- Daily AXR unless clear improvement

Once admitted to gastro ward, following tests, unless results available <1 year

- TB risk assessment
- Viral screen, HBV, HCV, HIV, VZ antibodies, EBV antibodies
- TPMT

Referrals

- Surgical referral; Consultant Gastroenterologist will advise on method of contact and whether to contact general surgeon on call, if colorectal team not on call.
- Dietician (no role for parenteral nutrition or placing patient nil by mouth

Second-line therapy

A decision should be made on day 3 i.e. between 48 and 72 hours of admission whether or not the patient has responded to intravenous steroid.

Consider second line therapy

- Day 3 >8 stools per day or a CRP> 45.
- Day 7 >3 stools per day or passing stool with visible blood.
    - Surgery (request CT abdomen if considering surgery)
    - Ciclosporin
    - Infliximab 5 mg/kg at 0, 2 and 6 weeks.

Ciclosporin regime – see Clinical Guidelines "Ciclosporin in UC – Clinical Guideline"

- Liaise with ward pharmacist
- IV ciclosporin should be used at a dose of 2mg/kg per 24 hours given in 250 ml normal saline over 24 hours.
- Check levels after 36-48 hours, and adjust the dose if necessary to achieve drug level of 100-200 micg/l.
- Send 5ml of blood sample in EDTA bottle to biochemistry. Blood levels are measured at RDH Tuesdays and Fridays

The choice of second-line therapy should be personal to and personalised for the individual patient and should consider patient choice and the long-term treatment strategy. If azathioprine has previously been used optimally (2.5mg/kg or proven therapeutic TGN levels) and failed then either surgery, anti-TNF therapy, or vedolizumab may be needed in the long-term. Calcineurin inhibitors such as tacrolimus and ciclosporin are generally not used longer than for six months because of the risk of renal damage.

Second-line therapy failure

Surgery is the recommended course of action rather than switching to further second-line therapies. CT abdomen if considering surgery

Second line therapy success

- Patients responding to second-line therapy should be transitioned to a thiopurine unless they have previously failed adequate thiopurine therapy (see Azathioprine IBD – Clinical Guideline to ensure adequate dose previously given).
- Patients responding to second-line therapy who have failed thiopurine therapy should be considered for long-term therapy with proven alternative drugs.

Remission

If improvement is seen all treatments should be switched to oral form on Day 5-7.

- Oral prednisolone 40 mg od one week, thereafter weaning by 5 mg per week .
- Oral ciclosporin (“Neoral” or ”Capimmune”) 4-6mg/kg per day. Check level at 1 week
- Consider commencing azathioprine or MP (Consultant decision)
- Ciclosporin is usually used as a bridge to azathioprine or MP treatment and should aim to stop ciclosporin after 3 months when azathioprine/ MP at full dose.
- Oral 5-ASA (e.g. Pentasa 4g/day start prior to discharge or 2 weeks after acute flare up.
- Patients should be reviewed **two weeks** after discharge in the out-patient clinic and be given details of IBD helpline in case of problems.

Prophylaxis and infections

- PCP prophylaxis with co-trimoxazole 960 mg 3 times/week or alternative if allergic should be used in patients on triple immunosuppression (e.g. steroid plus thiopurine plus infliximab).
- CMV, if this is found it should be treated with IV ganciclovir 5 mg/kg twice a day for 3 to 5 days and then with oral valganciclovir.

Patients who are not immune to EBV especially young men should only be given thiopurines after careful consideration and IBD MDT discussion. This is because of the risk of haemophagocytic syndrome and hepatosplenic T-cell lymphoma.

6. References

Guidelines for the management of inflammatory bowel disease in adults Mowat C, Cole A, Windsor A, et al. Gut (2011). doi:10.1136/gut.2010.224154 (http://www.bsg.org.uk/images/stories/docs/clinical/guidelines/ibd/ibd_2011.pdf)

Ulcerative colitis: Management in adults, children and young people (http://www.nice.org.uk/guidance/CG166)

Second European evidence-based consensus on the diagnosis and management of ulcerative colitis Part 2:Current management Journal of Crohn's and Colitis (2012) 6, 991–1030 (http://dx.doi.org/10.1016/j.crohns.2012.09.002)

8. Documentation Controls

Development of Guidelines:	Dr A Cole Consultant Gastroenterologist
Consultation With:	Colorectal Surgeons Consultant Gastroenterologists
Approved By;	IBD MDT 1/3/19 Medical Division 7/3/19
Review Date:	7/3/22 3 years - Extended to April 2024
Key Contact:	Dr Cole, Consultant Gastroenterologist
Keywords:	Ulcerative Colitis UC Colitis IBD