Ulcerative Colitis - Severe - Summary Clinical Guideline

Ref No CGS-GASTRO/2015/004

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

Exclusion of infection

- Stool culture and sensitivity and Clostridium difficile; travel history

Admission
All patients admitted with severe UC should be admitted to ward 305 (or 304 if no beds) under care of gastroenterology or to a colorectal surgery ward 309

Investigations

- Bloods, FBC, U&C, CRP, LFT, Mg++, lipids
- CXR/AXR
- Endoscopic assessment – flexible sigmoidoscopy <24 hours with biopsy for CMV.

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, 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 gut rest by fasting).

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 5 ml 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 ~~could~~ considering switching to 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
- Patients responding to second-line therapy who have failed thiopurine therapy should be considered for long-term therapy with proven alternative drugs.

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 5mg /kg twice a day for 3 to 5 days and then with oral valganciclovir.

<u>Remission</u>
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.