Acute Inflammatory Bowel Disease (IBD) checklists

You might be asked to clerk patients with acute IBD in the Assessment Suite (Acute Medical Unit) or when they are admitted directly to the gastroenterology ward (e.g. if the consultant is admitting them directly from clinic) during your acute medical rotation. If you work on the gastroenterology ward you will also need to review patients with acute IBD daily.

IBD includes Crohn's disease and ulcerative colitis. The management of these two, chronic, immune mediated inflammatory diseases are different, although in the acute setting the assessment is similar.

This short guideline contains checklists to help you. However, you are not expected to manage these patients on your own and if you are ever unsure of anything please seek senior support (gastro SpR in hours and Medical SpR out of hours are your first points of contact).

If you find these useful, please feel free to copy these and make them into shortcuts on eRecord.

If you have 2 minutes spare, please let us know what you think of this guideline (use link or QR code): https://forms.gle/vRVkRNaYtkxmQ5Wx6

Admission checklist

1. **Bloods:** FBC, U&E, CRP, Bone profile, Magnesium, LFTs, Coag, Ferritin
2. **Stool: culture, *C. difficile*, parasites/ova/cysts, faecal calprotectin**
3. **Imaging: CXR/CT Abdomen Pelvis (to rule out toxic megacolon if suspected**)
4. **IV hydrocortisone 100mg QDS** + bone protection (e.g. Adcal)
5. **VTE prophylaxis:** LWMH (Tinzaparin) +/- TEDs - should be prescribed even if rectal bleeding
6. Analgesia considerations – if possible, avoid opiates. If absolutely necessary, use short acting oramorph, rather than long acting codeine or tramadol. Antimotility agents (e.g. ondasetron, opiates, loperamide) can increase the risk of toxic megacolon.
7. Consider antibiotics if suspected perianal abscess, sepsis, perforation or suspected enteric pathogen as cause of colitis
8. Urgent imaging (e.g. CT) or flexible sigmoidoscopy are usually indicated, but please discuss with med SpR/gastro SpR /consultant before requesting
9. Gastro referral if patient admitted to Assessment Suite + book Gastro bed
10. Consider surgical review if there is: suspected or confirmed perforation, bowel obstruction, toxic megacolon (dilated colon >5.5cm at TC) or perianal abscess/sepsis
11. Consider dietician referral if there is a history of weight loss
12. Ensure stool chart in place. This should be patient-self completed, as this is more accurate. Stool frequency is the most sensitive predictor of treatment efficacy.

If you are worried about the patient or they start to deteriorate, please discuss with gastro SpR/consultant urgently.

If you are doing the daily junior ward round on the gastroenterology ward, you can use the following checklist:

Daily Gastro ward review checklist

The aim is to assess response to treatment.

1. Check CRP, FBC, U&Es, bone profile 2.
   Check stool frequency
3. If patient develops abdominal tenderness, fever, tachycardia, rising inflammatory markers - discuss with senior urgently and consider urgent imaging (CT AP)
4. Consider parenteral iron for treatment of iron deficiency anaemia
5. Patients should have a daily review by gastro registrar or consultant to assess response to treatment

Check if every patient has had the following 'one off' investigations:

One off investigations:

- **Pre-biologic screen** if consultant thinking about starting patient on one (BBV – HIV, HBV, HCV, VZV/EBV IgG, TB interferon-gamma release assay/CXR)
- **Thiopurine methyltransferase (TPMT)** test if never been on thiopurine medications and might be started on them

Criteria to seek surgical review on the ward

This is only for your information and to know what to look out for. If you are considering seeking a surgical review, please discuss with gastro SpR/consultant first. Referring to surgery is done by calling the General surgery SpR on call via switchboard.

- Suspected perforation or obstruction
- Perianal abscess and/or sepsis
- Toxic megacolon on imaging
- Failure of medical therapy
    - Patient continues to be systemically unwell despite steroids
    - >8 bowel movements per day OR 3-8 bowel movements + CRP > 45 by day 3 of admission with severe acute colitis

Discharge checklist

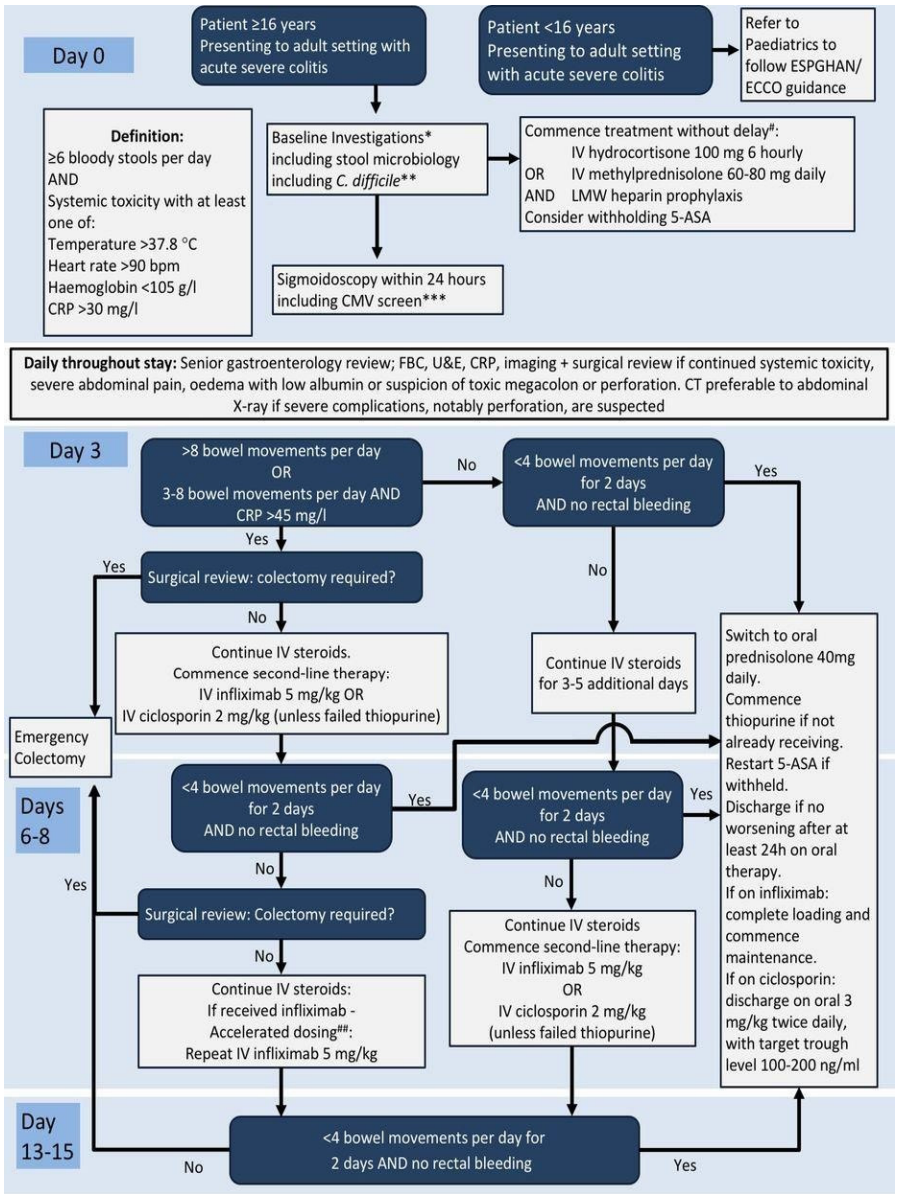
The decision to discharge should be made by a gastro SpR or consultant

1. Systemically well, bowel symptoms improving, inflammatory markers falling
2. Weaning course of steroids + bone protection – Calcichew 500mg BD and Colecalciferol 800 day
3. Ensure OP follow up in place under the correct consultant
4. Ensure patient has appointment for MDCU (medical day case unit) for further loading doses of biologic (if started in hospital)
5. Ensure OP investigations booked e.g. CT/MRI/endoscopy
6. Ensure has contact details for IBD specialist nurses
7. If triple immunosuppression (i.e. steroids >20mg + immunomodulator + biologic) ensure PCP prophylaxis with co-trimoxazole *(unless on methotrexate - combined folate antagonism)*

Further resources

ECCO algorithm for acute severe colitis - http://www.e-guide.ecco-ibd.eu/algorithm/acute-severe-colitis

Acute severe colitis flowchart (for reference)- https://gut.bmj.com/content/68/Suppl_3/s1.long



Additional Notes

* Baseline investigations: full blood count, CRP, urea & electrolytes, liver function tests, magnesium; stool infection screen & *Clostridium difficile*; radiology (abdominal X-ray or CT); screening tests for second-line therapy including hepatitis B and C virus, HIV, and VZV (if no history of chicken pox, shingles or varicella vaccination), Screening for tuberculosis with clinical risk stratification stratification, chest X-ray and interferon-gamma release assay

** If *C. difficile* diagnosed, treat with oral vancomycin 500 mg 6 hourly for 10 days and continue steroids

*** Flexible sigmoidoscopy with biopsies for urgent histology including specific assessment for CMV. Deep ulceration is associated with poor outcome. If CMV colitis diagnosed, treat with IV ganciclovir 5 mg/kg 12-hourly for 3-5 days then oral valganciclovir 900 mg 12-hourly for 2-3 weeks. Take advice from virology regarding immunosuppressive therapies

Do not delay steroids while awaiting stool culture results

Accelerated dosing is beneficial, but the optimal dosing regimen is unclear

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