crohn's colitis

Name of Clinical Care Pathway

Suspected IBD outpatient flare

Objective

Optimal management of IBD flare

Patient Population

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

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PACE Inflammatory Bowel Disease Clinical Care Pathways

Highlight Box

The completed assessment will be used to triage patient symptoms to determine the degree of urgency. Good clinical judgement, assessment skills and knowledge of IBD will be utilized in consultation with the physician or nurse practitioner to determine further treatment or assessment required

Introduction

An IBD flare is the reappearance of disease symptoms. This CCP is intended to support clinicians in outpatient settings with their decision-making process when faced with concerns for a flare. Please see the steps mentioned below.

1. Complete the Harvey Bradshaw Index (HBI) or Partial Mayo (pMayo) with the patient; if the patient has IBDU (IBD unclassified), an HBI will be used.
2. Communicate the completed assessment to the responsible physician/nurse practitioner (NP) within the following timelines (see Table 1).

Table 1: Timelines for patient assessment

Timeline	Patient Assessment Guidelines	Mode of communication
Urgent/Emergent	Patient requires immediate intervention/investigation or may not be able to wait only until the next day in the following cases: • Abdominal pain that is not relieved with any intervention • Nausea/vomiting • Profuse rectal bleeding • New fistula with an elevated temperature • Elevated temperature, not improved by intervention • Elevated temperature while on biologic therapy • Sudden/unexplained change in health status • Extensive bloating and pain or unable to pass stool for 48 hours (obstruction) • Perianal pressure, pain and swelling	Page and speak with the physician / NP directly If plan to admit – refer to your IBD admission – patient care orders
Semi-urgent	Patient is able to wait for 2-3 days for intervention/investigation in the following cases: • Fistula draining – old site • Fecal incontinence/urgency • Up at night with diarrhea • More frequent diarrhea • Bloating • Fatigue • Change in daily activity	Send email or EMR message to physician / NP

3. Under the direction of the physician/NP, or standard operating procedure process laboratory/diagnostic imaging investigations based on the assessment:
   a. IBD Flare Lab Requisition (CBC, FER, NA, K, CL, ALB, ALP, ALT, CRP, AST).
   b. Stool C. *diff* and culture and sensitivity (if diarrhea present (PACE QPI 1)
   c. Stool Fecal Calprotectin (if available)
   d. Ova and Parasite should be added if the patient has recently travelled, was camping, or was exposed to well water
   e. X-ray of abdomen with 3 views if the patient is experiencing bloating, abdominal pain, nausea, vomiting.
   f. If the introduction of a biologic is considered, see Induction of Advanced Therapy for pre-biologic work-up

4. Deliver requisitions to the patient by one of the following methods:
   a. Fax requisition to the patient's closest laboratory/radiology centre
   b. Send the requisition to the patient via email, standard mail, or fax
   c. Give the requisitions to the patient if the patient is present in clinic

5. Patient is to contact the clinic once testing is complete.
6. Review the results with the physician/NP to determine further investigations, follow-up, or treatment change.

Caution: "Although x-rays have a moderate sensitivity for the detection of high-grade small bowel obstruction, they are less useful in differentiating small from a large bowel obstruction and differentiating partial obstruction from ileus. Follow-up abdominal CT is generally required".

Physician Guided:

8. Consider the following imaging:
   a. CT enterography/ MR enterography U/S: when patient present with abdominal pain to right upper quadrant, history of abscess/stricture. Surgery referral if needing EUA, seton placement, drainage of abscess, resection
   b. Abdominal ultrasound or Point-of-care Intestinal Ultrasound (where available)
   c. MRI pelvis: if new fistula or pain
   d. Endoscopy depending on history to document disease extent and severity
   e. Urgent surgery referral for assessment

9. If the patient:
   a. Has moderate to severe active disease, and infection has been ruled out
   b. Previously had good response to Corticosteroids (40 mg -60 mg per day for >14 days) with no or minor side effects (PACE QPI 3)
   c. Had not required two or more courses of systemic steroids in the last year (PACE QPI 7) Consider Corticosteroids tapering course and refer to: Initiation and Tapering of Corticosteroids
   d. If the patient has left-sided disease add rectal therapy of 5 ASA supps or foam or 5 ASA or steroid enemas.

10. If the patient is on biologics, consider antibody serum levels, dose escalation or rescue dose.
    a. Consider therapeutic drug monitoring if the patient is on biologic therapy.

11. If the patient is on Azathioprine (stable dose for 1 month or following a change in dose) (6TG & 6MMP Therapeutic Levels)

12. Decide on the timeline for a follow-up clinic/virtual visit or telephone to initiate care.

References

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