Background / Key Aspects of Care

- These IBD management guidelines are based on recent recommendations in the gastroenterology literature.
- They provide a guideline/template for healthcare providers at OSUWMC to:
  - Standardize inpatient management of IBD related severe colitis
  - Identify patients who may need rescue therapy
  - Preserve healthcare utilization of resources
  - Minimize costs associated with care
  - Identify, treat, and minimize associated complications
  - Preserve value of healthcare delivery
  - Ease the transition from inpatient to outpatient care to minimize recurrent admissions

- **These IBD management guidelines should be utilized in patients who have:**
  - > 6 bowel movements per day with frequent hematochezia
  - Signs of toxicity such as:
    - Temperature > 99.5°F
    - Heart rate > 90 bpm
    - Hemoglobin < 10 g/dL
    - CRP > 10
  - Abdominal tenderness
  - Features of thumb printing/edematous colonic wall noted on imaging

**Note:** For patients who have already been on anti-TNF medication prior to admission, whether the patient will receive inpatient anti-TNF medication, for instance infliximab, would be individual case dependent. However, for these patients, colorectal surgery team should be called for consultation as early as possible.

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**Algorithm 1. Inpatient Management of Inflammatory Bowel Disease-Severe Colitis**

### Admission Day

- **History and physical**
  - Document amount of rectal bleeding
  - Frequency of bowel movements per 24 hour period
  - Severity of abdominal pain
  - Distention of the abdomen
- **Consult gastroenterology**
- **Stool workup:**
  - Stool culture
  - Ova and Parasite (O/P)
  - C. Diff PCR toxin
- **Labs:**
  - **All patients:** CBC, Chem 6, Hepatic Function Panel, C Reactive Protein (CRP), serum cholesterol, serum magnesium
  - Pregnancy test for women of child bearing age
  - **If not obtained in past year:** Thiopurine methyltransferase (TPMT), Tuberculosis (TB) QuantiFERON® (or place purified protein derivative (PPD)) and chronic viral hepatitis panel
- **Imaging:**
  - Abdominal x-ray
  - CT abdomen/pelvis: If having severe pain, leukocytosis (WBC >10x10⁹), nausea, vomiting, fever, or significant tenderness
- If colonic dilation on imaging, leukocytosis, severe abdominal pain, guarding, and/or concern for perforation consult colorectal surgery.
- Initiate IV methylprednisolone 16 mg IV Q8H if no infectious signs or symptoms
- IV fluids; Minimize opioids and anti-diarrheals
- DVT prophylaxis
- Diet based on patient’s tolerance

See page 2 for recommendations on hospital day 2-7.
Algorithm 1. Inpatient Management of Inflammatory Bowel Disease-Severe Colitis, Continued

**Hospital Day 2**
- Continue IV steroids
- Interval history and physical
- **Calculate Travis Index**
  - > 8 bowel movements per day OR > 2 bowel movements per day with a CRP > 45 mg/L
  - **Positive Travis Index**: > 85% PPV of colectomy
- Perform a flexible sigmoidoscopy with biopsies to access CMV infection and severity of disease. Pathology should be sent for a **RUSH** review.
- If no improvement, continue current management.
- If patient dramatically improved (stool number reduced by 75%, less blood), switch to oral prednisone (40 mg daily) and make a discharge plan for outpatient follow up in the OSU IBD Center. Please see the “Discharge Criteria” on page 3.
- If the patient is clinically worsening or has any concerns of acute abdomen call **colorectal surgery team** and **gastroenterology consult team** to make recommendations regarding management.

**Hospital Day 3**
- Follow daily management recommendations on page 3.
- Continue IV steroids
- Interval history and physical
- Review pathology biopsies from flexible sigmoidoscopy; if CMV present, proceed with treatment.
- If the patient has abdominal distension, obtain abdominal x-ray.
- If the patient has improved, continue current management. Prepare patient to switch to oral prednisone (40 mg daily) on the next day and make a discharge plan for outpatient follow up in the OSU IBD Center. Please see the “Discharge Criteria” on page 3.
- If the patient has not improved or condition has been unchanged, determine the patient disease severity by calculating Travis Index.
- If patient meets Travis index criteria, patient will need **PRIOR AUTHORIZATION** for outpatient infliximab.
  - Prior authorization is not required for inpatient administration of infliximab
- GI consult team will place smartphrase “.IBDIP” in progress note to facilitate review for inpatient infliximab
- For ulcerative colitis, patient may be a candidate for cyclosporine. Criteria for using cyclosporine will be determined by inpatient consult GI attending.

**Hospital Day 4**
- Follow daily management recommendations on page 3.
- Interval history and physical
- If the patient is agreeable with surgery, please discuss with colorectal surgery.
- If the patient is not agreeable with surgery, please start infliximab or cyclosporine:
  - Infliximab 5mg/kg IV once OR
  - Cyclosporine 2mg/kg divided into bid IV AND
  - Start Prednisone 40mg orally daily followed by taper 10mg per week and stop IV methylprednisolone 20mg IV tid AND
  - Keep the patient NPO (in case the patient needs an emergent surgery)
- For patients who are not agreeable to surgery or medical rescue therapy, continue IV methylprednisolone (16mg IV Q8H).
- **Once the patient starts infliximab, the patient should remain in hospital for at least 48 hours for monitoring response to the medical rescue therapy.**

**Hospital Days 5-7**
- Follow daily management recommendations on page 3.
- Interval history and physical to assess response to rescue therapy
- If the patient is clinically worsening, please contact surgeon.
- If the patient improves or the patient’s condition is unchanged, please continue current management plan.
Management

Daily Management while in hospital
- Interval history and physical with daily abdominal exam
- Calculate Travis Index
- Review medication list; minimize narcotics and discontinue anti-diarrheals
- Labs:
  - CBC
  - Chem 6
  - LFTs
  - CRP
  - Albumin
- Imaging:
  - Abdominal x-ray if abdominal pain, distention, or established colonic dilation (for monitoring)
- For UC therapy consider rectal topical therapy if significant fecal urgency present
- Colorectal surgery and gastroenterology following with daily notes
- DVT prophylaxis

Discharge Planning

Discharge Criteria
- 1-2 bowel movements per day
  - ≤ 4 bowel movements in 24 hours
  - No blood
- Abdominal pain has significantly improved
- Tolerates a soft diet
- Abdominal distension has resolved
- GHN IBD appointment:
  - Setup follow-up 2 weeks after discharge in the IBD Center
    - 614-293-6255
- Outpatient IBD Infliximab guidelines/transition of care:
  - Refer to IBD outpatient transition guidelines for questions regarding Infliximab infusions and outpatient care
- If questions regarding infusion/outpatient care please call GHN Division nursing staff:
  - 614-366-8165

References

Quality Measures
- Order set use
- Average time from admission to consult order placed (general surgery, gastroenterology)
- Percent of patients with daily C-Reactive protein (CRP)
- Percent of patients with C. diff toxin assay
- Percent of patients with flex biopsy
- Percent of patients imaged within 24-hours of admission (X-ray abdomen, CT abdomen/pelvis)
- Percent of patients receiving DVT prophylaxis (SCD, heparin, enoxaparin)

Order Sets
- Please order the IBD inpatient order set upon admission.
  - Order set: IBDInpatient
- With the order set, admission labs will be ordered automatically.
- If the patient has not had a TPMT level, chronic hepatitis panel, and TB QuantIFERON® within the past year, please select these labs as part of the admission labs.
- For imaging, please select abdominal x-ray or CT abdomen/pelvis based on clinical appearance, labs, and recent imaging.
- Select DVT prophylaxis as part of the order set unless there are contraindications.
- Choose diet type based on patient tolerance and planned procedures/imaging.

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Guideline Approved


Disclaimer: Clinical practice guidelines and algorithms at The Ohio State University Wexner Medical Center (OSUWMC) are standards that are intended to provide general guidance to clinicians. Patient choice and clinician judgment must remain central to the selection of diagnostic tests and therapy. OSUWMC’s guidelines and algorithms are reviewed periodically for consistency with new evidence; however, new developments may not be represented.

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