The guideline applies to patients with:
- More than 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

Guideline Goal
- Standardize inpatient management of IBD related severe colitis
- Identify patients who may need early appropriate medical therapy
- Efficient use of healthcare resources
- Minimize costs associated with care
- Identify, treat, and minimize associated complications
- Ease the transition from inpatient to outpatient care to minimize recurrent admissions

Algorithm 1. Initial Inpatient Management – Admission Day
Order set – OSU IP GE: Admission Inflammatory Bowel Disease

- **Acute Severe Ulcerative Colitis**
  - Rule out C. difficile
  - **History and physical**
    - Document amount of rectal bleeding
    - Frequency of bowel movements per 24 hour period
    - Severity of abdominal pain
    - Distention of the abdomen

- **Diagnostic Tests**
  - Stool workup
    - Molecular enteric panel,
    - Ova and Parasite (O/P)
    - C. Diff PCR toxin

- **Laboratory Tests**
  - All patients: CBC, Chem 6, Hepatic Function Panel, C Reactive Protein (CRP), Erythrocyte sedimentation rate (ESR), serum magnesium, pre-albumin
  - Pregnancy test for women of child bearing age
  - If not obtained in past year: Thiopurine methyltransferase (TPMT - OSU Lab), Tuberculosis (TB) QuantiFERON® (or place purified protein derivative (PPD)) and chronic viral hepatitis panel

- **Imaging**
  - Abdominal x-ray and/or CT abdomen/pelvis based on clinical appearance, lab results, and recent imaging.
    - Consider imaging if severe pain, nausea, vomiting, fever, or significant abdominal tenderness

- **Medications**
  - Start IV Steroids: Order Methylprednisolone (40mg) daily if no infectious signs or symptoms
  - Start IV fluids
  - Minimize opioids and anti-diarrheal
  - Order DVT prophylaxis as part of order set unless contraindicated (NOTE: hematochezia is not a contraindication for pharmacological prophylaxis in the setting of severe IBD unless there is hemodynamic instability)

- **Consults**
  - Gastroenterology
  - Colorectal Surgery if colonic dilation on imaging, severe abdominal pain, guarding, and/or concern for perforation

**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.

See Page 2 for additional recommendations on hospital day 2-7
Daily Management
- Interval history & physical with abdominal exam
- Calculate Travis Index to determine disease severity
- Check on prior authorization status for outpatient Infliximab
- Review medication list; minimize narcotics and discontinue anti-diarrheal
- Labs: CBC, CMP, CRP/ESR
- Abdominal x-ray IF abdominal pain, distention, or established colonic dilation (for monitoring)
- For ulcerative colitis may therapy consider rectal topical therapy if significant fecal urgency present
- Colorectal surgery and GI daily notes
- Continue 40 mg IV steroids (methylprednisolone)
- DVT prophylaxis
- Diet based on patient tolerance and planned procedures/imaging

Hospital Day 2
- Consider a flexible sigmoidoscopy with biopsies to access CMV infection and severity of disease.
  - Pathology should be sent for a RUSH review (confirm CMV PCR ordered)
  - If no improvement, continue current management.
  - If patient dramatically improves (stool number reduced by 75%, less blood, AND CRP level reduced by 75% of day 1 or <10), switch to oral prednisone (40 mg daily) make a discharge plan for outpatient follow up in the OSU IBD Center.
  - See the “Discharge Criteria”
  - Do not discharge for at least one additional day on oral steroids to evaluate response.
  - 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
- May need to consider PICC line and TPN to optimize nutrition and absorption
- Review pathology biopsies from flexible sigmoidoscopy.
  - If CMV present, Consult ID for consideration of possible treatment of CMV colitis versus possible innocent bystander
  - Outpatient infliximab authorization should have already been obtained by today.
  - 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
  - Patient may be a candidate for cyclosporine or tacrolimus. Criteria for using these agents will be determined by inpatient consult GI attending.

Hospital Day 4
- Follow daily management recommendations
- If the patient is not agreeable with surgery:
  - Start Infliximab 5 mg/kg IV
  - Start Prednisone 40 mg orally daily followed by taper 10 mg per week and
  - Stop IV methylprednisolone
  - Keep the patient NPO (in case the patient needs an emergent surgery)
  - Once the patient starts infliximab, the patient should remain in hospital for at least 48-72 hours for monitoring response to the medical rescue therapy (bowel symptoms and CRP).
  - If the patient is clinically worsening, discuss with colorectal surgery.
  - For patients who are not agreeable to surgery or medical rescue therapy, or who are not a surgery candidate, continue IV methylprednisolone (40mg IV daily).

Hospital Day 5-7
- Follow daily management recommendations
- If the patient is clinically worsening, contact surgeon.
- If the patient improves or the patient’s condition is unchanged, continue current management plan and outpatient follow up in the OSUWMC IBD Center Clinic.
  - Patient will receive the 2nd infliximab infusion 2 weeks from initial dose induction.
  - Start Azathioprine (50 mg) oral daily unless contraindicated per GI Team.

Discharge Criteria
- 1-2 bowel movements per day
  - ≤ 4 bowel movements in 24 hours
  - No blood
- CRP value trending down (at least 75% reduction from day 1 value or <10)
- Abdominal pain has significantly improved
- Tolerates a soft diet
- Abdominal distension has resolved

Follow-up
- GHN IBD appointment: Set up 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

• Average time from admission to GI consult order
• Percent of patients with Daily CRP
• Percent of patients with C. diff toxin assay
• Percent of patients receiving DVT prophylaxis
• Average time from admission to Infliximab administration
• Length of stay
• Readmissions within 30 days for colitis

Order Sets

• OSU IP GE: Admission Inflammatory Bowel Disease

Authors

• Anita Afzali MD, MPH
• Madalina Butnariu, MD
• Edward Levine, MD
• Marty Meyer, MD
• Jeff Wenzke, MD

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.

Copyright © 2017. The Ohio State University Wexner Medical Center. All rights reserved. No part of this document may be reproduced, displayed, modified, or distributed in any form without the express written permission of The Ohio State University Wexner Medical Center.