South East London Area Prescribing Committee:

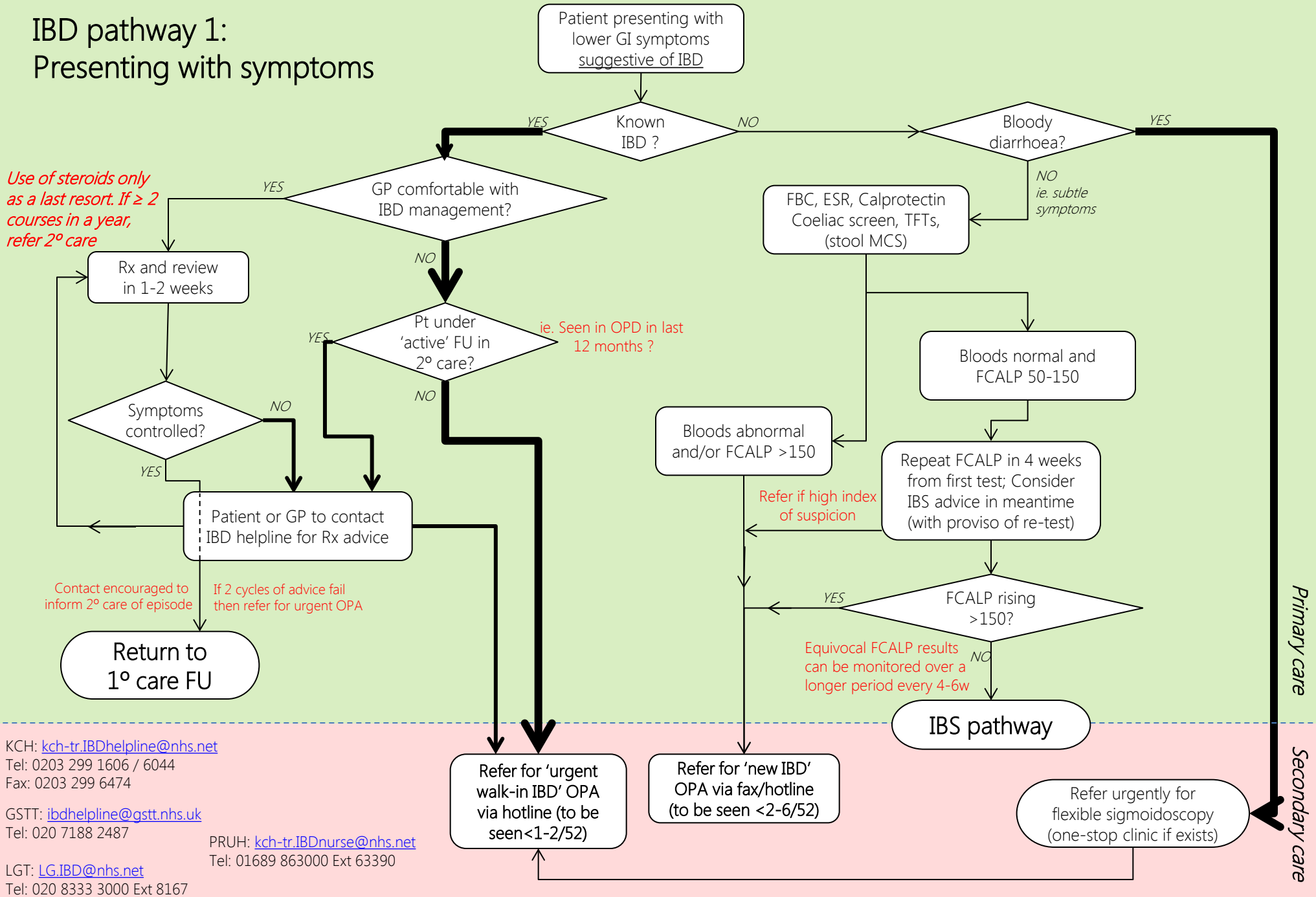
Primary & Secondary Care Inflammatory Bowel Disease Pathway February 2018

Developed by: South East London IBD Pathway Development Group

Approved: February 2018 Review date: February 2019 or sooner if evidence/practice changes

South East London Area Prescribing Committee. A partnership between NHS organisations in South East London: Bexley, Bromley, Greenwich, Lambeth, Lewisham and Southwark Clinical Commissioning Groups (CCGs) and GSTFT/KCH /SLAM/ & Oxleas NHS Foundation Trusts/Lewisham & Greenwich NHS Trust

IBD pathway 1:
Presenting with symptoms



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IBD pathway 2: ULCERATIVE COLITIS
Mesalazine (5asa) pathway

Patients with Crohn's disease experiencing flare-ups should be discussed with secondary care. Entocort (Budesonide MR) 9mg od for 4-6/52 may be used for mild or moderate Crohn's if ileocaecal location.

Patient with known UC with flare of symptoms Taking mesalazine only

CHECK / ENCOURAGE ADHERENCE
- Typically 55% are adherent -

http://www.nice.org.uk/guidance/cg76/chapter/key-principles

Newly diagnosed patient

MAY NEED DISEASE-MODIFYING THERAPY EG. AZATHIOPRINE

≥ 2 flares in last 6/12? — *YES*

NO

Severity of this flare?

Yearly faecal calprotectin tests are useful for monitoring disease activity. Faecal calprotectin > 250 should prompt discussion with secondary care.

CONTACT SECONDARY CARE AT ANY STAGE IN THIS PATHWAY

Consider minimising tablet burden with high strength formulations if not already

MILD
BO 1-3x per day +/- blood
No systemic symptoms

MODERATE
BO 4-6x per day with blood
No systemic symptoms

SEVERE
BO >6 per day with blood
Fever, tachycardia, hypotension

On rectal 5asa therapy alone (enema or supps)

On zero or maintenance dose (2.4g Asacol/Mezavant/Octasa 1.5g Salofalk, 2g Pentasa)

On maximum dose (4.8g Asacol/Mezavant/Octasa 3g Salofalk, 4g Pentasa)

Add oral 5asa at maximum dose and strength

Increase to maximum dose 5asa; Consider adding rectal therapy

Consider adding Clipper (beclometasone) 5mg OD for max 4 weeks

Rectal ('topical') therapies can be sole treatment
- ***Enema added for 'left-sided'***
- ***Suppository for 'proctitis'***
- ***Enema can be added if 'pancolitis'***

2/52 review if Rx changed. Symptoms controlled? — *YES*

NO

Continue maximal therapy for 8/52 then reduce to maintenance unless evidence of disease activity

Any steroids in last 12 months? — *NO*

Prescribe prednisolone 40mg OD reducing by 5mg per week to zero with Ca+vitD suppl OD

WILL NEED DISEASE-MODIFYING THERAPY EG. AZATHIOPRINE

YES

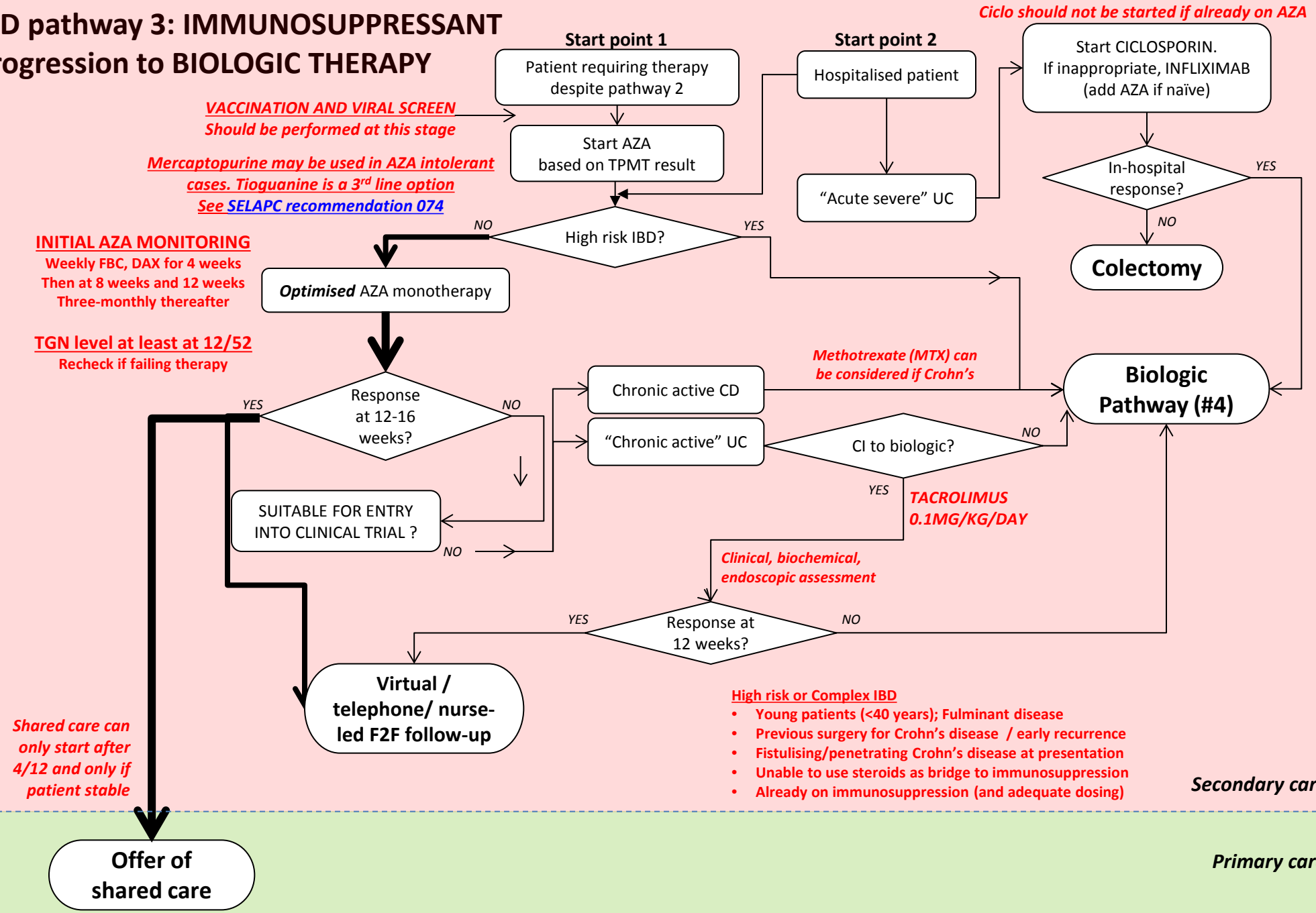
Advice from IBD helpine and/or refer for urgent OPA via helpline(<2/52)

Call Gastro SpR on-call
Admit via Medical team
Seen by IBD Cons within 48h

Primary or secondary care

Secondary care

IBD pathway 3: IMMUNOSUPPRESSANT progression to BIOLOGIC THERAPY



IBD pathway 4: BIOLOGIC THERAPY

There are Acute Trust guidelines available for ciclosporin dosing and monitoring; In general therapy is a bridge to immunosuppressant and is inappropriate for maintenance >6/12

Patient requiring biologic therapy from pathway 3

UC | **Clinical Trial?** | **CD**

- *The most appropriate and cost-effective biologic will be selected according to NICE guidance for CD*
- ***Expect 20% of local population of CD in this arm***
- *The proportion of patients will be higher in tertiary care (population outside LSLBGB)*

Commissioning is not sought for experimental therapy

Acute severe UC from pathway 3

CICLOSPORIN Max 6/12 | **INFLIXIMAB** 3 infusions

Inducing remission may require 10mg/kg infusions, but will not continue as routine maintenance

Chronic active UC from pathway 3

ADALIMUMAB | **GOLIMUMAB** | **INFLIXIMAB** | **VEDOLIZUMAB**

Choice should take into account cost and informed patient preference, unless clinically inappropriate

1st line | 2nd or 3rd line

ADALIMUMAB | **INFLIXIMAB** | **USTEKINUMAB** | **VEDOLIZUMAB**

Remission once stable on AZA?

YES

NO

NO

Remission for acute severe UC defined by Mayo <2 when steroid-free

If on IFX, give one further scheduled dose

If on ciclosporin, switch to alternative biologic as above

Dose optimisation or drug-switching must be discussed in IBD MDM
Reassessment may be at 4-8 weeks after change, dependent on dosing frequency
Where patients are optimised, respond, are de-escalated and then relapse, this section 're-sets' and another agent can be tried.

YES

Response at 12-16 weeks?

NO

Possible to dose-optimise based on drug/Ab level/clinical response?

YES

NO

YES

Continue scheduled Rx
Virtual / telephone/ nurse-led F2F follow-up

Suitable for clinical trial?

NO

Switch biologic

NO

Possible to dose-optimise based on drug/Ab level/CR?

NO

Remission at 12 months?

YES

Remission for biologic cessation is defined as asymptomatic and biochemical and/or endoscopic and/or radiologic evidence of healing

Consider stopping biologic therapy

Secondary care