**ACUTE SEVERE COLITIS (ASC) PATHWAY**

***= yes = no***

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**Guide to daily inpatient management decisions**

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| **TOP TIPS**   * ASC is a medical and surgical emergency. Patients need urgent inpatient assessment & treatment. * Between 9 and 45% of patients with ASC require inpatient colectomy. It is important to prepare your patient for this possibility. * ASC patients need **multi-disciplinary care from Day 0**, ideally delivered by Gastroenterology & Colorectal Surgery. Smaller centres have different models of care, such as General Medicine (with gastroenterology oversight) & General Surgery. Stoma, colorectal & IBD specialist nurses as well as dieticians are invaluable team members. Know what your centre can offer. Review local guidelines for ASC, and consider early discussion & transfer to a multi-disciplinary centre for inpatient ASC care. * The inpatient stay is frequently > 7 days | |
| warning-sign-red-50 | **RED FLAGS in ASC**  **Pain** – be concerned about perforation  **Signs of toxicity and sepsis** (tachycardia, fever, abdominal pain) = deterioration or perforation. Arrange:  Stat gastroenterology / senior physician input  Stat surgical review  CT abdo  IVABx |

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| **INTRODUCTION: WHEN TO THINK OF ASC?** | | | | | | |
| ASC can affect a patient with a known background of Inflammatory Bowel Disease (IBD) – ulcerative colitis (UC) or Crohn’s disease (CD). ASC can be the first presentation of IBD to medical care too. It can often affect younger patients who can appear well, then develop complications quickly. Take ASC seriously from the start.  Symptoms of ASC include:  Diarrhoea  PR bleeding  Abdominal discomfort  Fevers  Weight loss  Be mindful that these symptoms have a broad differential diagnosis, such as infective colitis, ischaemic colitis, medication induced colitis & diverticulitis. | | | | | | |
| If in doubt, seek early senior specialist advice to get the diagnosis right. ASC is an emergency, and important to rule in or rule out. This Pathway is only for the management of ASC. It is designed to provide a day-by-day guide to providing timely care to patients with this medical and surgical emergency, and escalating care when appropriate. Once the diagnosis is confirmed, print this pathway, and place in the patient’s clinical record. | | | |  | | |
| |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **SUMMARY: Step-up treatment for ASC** | | | | | | | | **Day 0:**  **Assessment +**  **Start Rx** | **Day 1** | **Day 2** | **Day 3:**  **Decision Day** | **Day 4** | **Day 5** | **Day 6**  **& beyond** | |  | | |  | | If rescue therapy fails:  COLECTOMY | Post-op care  Arrange follow up | | Not in remission-  RESCUE THERAPY | RESCUE THERAPY | Remission -  Arrange follow up | Discharge with treatment & follow up | | Full assessment  IV Steroids | Daily review  IV Steroids | Daily review  IV steroids | **In remission**  continue IV steroids | continue IV steroids for 5 days | Discharge with treatment  & follow up | |   **Day 0 – Admit to hospital & confirm ASC diagnosis** | | |  | | |  |
| **DAY 0 - PRESENTATION TO HOSPITAL** | | | | | | |
| **The admitting doctor’s role in ASC is to build rapport with the patient, take an accurate history, complete an accurate exam, and kick start investigation and treatment.**  **HISTORY**  Recent travel/sick contacts/NSAID use  Duration & severity of symptoms (see below)\*  **EXAM**  Signs of systemic toxicity / sepsis\*  Abdominal exam for peritonism  Fluid balance / dehydration  Rectal examination - perianal disease (fistula, collection, fissure)  **INVESTIGATIONS**  Bloods:  FBC.  ESR - day 0 ESR important for the Truelove & Witt score, specifically request your lab process the ESR  Biochemistry including:   * Renal function * Electrolytes including CRP, Ca, Mg, PO4. * Ferritin, B12/Folate if anaemic * LFTs including Albumin * Coagulation profile   Blood gas if septic – assess lactate  Arrange 3x stool specs – MC&S and C.difficile testing is vital. Calprotectin useful (“Australia Day” score)  Blood cultures if febrile  Group and Hold  AXR. Look for:   * Colonic dilatation *(>/= 5.5cm)* * Toxic megacolon *(diameter >/= 6cm or caecum >9cm and systemic toxicity)* * Small bowel fluid levels and mucosal islands | | | | | | |
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| |  | | --- | | **Day 0: Calculate TRUELOVE & WITTS criteria for acute severe colitis:** | | ≥6 bloody stools/24h | | **PLUS one** or more of the following signs of systemic toxicity: | | Heart Rate > 90 bpm  Temperature > 37.8oC  Haemoglobin > 105 g/l  ESR > 30 mm/hr | |  | |  | **“AUSTRALIA DAY” score (research tool)**  Faecal calprotectin (FC) ……………ug/g  CRP ] CRP: Alb ratio (CAP) ……..  Albumin ]  TOTAL SCORE: …………………..  *Patients with FC >1395ug/L & CAR >1.34 on admission failed IV steroids* | | | | | |
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| **Days 0, 1 & 2 – start & monitor ASC treatment**  **ASC DIAGNOSIS CONFIRMED: proceed with pathway**  **Not ASC – STOP PATHWAY** | | | | | | |
| **DAY 0: START & MONITOR TREATMENT** | | | | | | |
| **IV fluids** – replace fluid loss & electrolytes especially potassium  Chart intravenous steroids to induce remission - **Methylprednisone 60mg IV daily**  **Colifoam enemas** (hydrocortisone acetate) 10% One PR daily  if toxic dilatation on AXR or Temperature >37.8C - **IV antibiotics** (e.g. cefuroxime & metronidazole)  **Stop and avoid** anticholinergic, antidiarrhoeal agents, opioid drugs. These risk precipitating colonic dilatation. Stop NSAIDs. Stop usual IBD treatment (can be restarted later)  **DVT PROPHYLAXIS:** ASC patients high risk for DVT/PE. Rectal bleeding is **NOT** a contraindication  **40mg SC Enoxaparin** for most patients  **CARE PLAN:**  Bowel chart on e-Vitals.  Help your patient fill out the **SCCAI score sheet each day** \*\* – this influences when to escalate treatment  Nutrition assessment /dietician review. Can eat & drink unless advised by surgical team.  Contact gastroenterology team. Inform surgical team.  Admit patient to ward under gastroenterology service  Refer to IBD Nurse\* | | | | | | |
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| **DAYS 1 & 2 –ONGOING MANAGEMENT** | | | | | | |
| History – use SCCAI + Stool Chart\*\*. Ask about fever, frequency, bleeding and pain  Examination – vital signs (fever/tachycardia). Abdominal pain/tenderness. Fluid balance.  **DAILY MANAGEMENT DECISIONS:**  Morning bloods including FBC, U+Es, albumin & CRP. Higher risk of hypokalemia due to diarrhoea and steroids.  Fluids: Maximise oral intake. IV fluids if not tolerating oral intake or requires potassium.  Order AXR if deteriorating or initial film suggesting dilatation.  Refer for flexi-sigmoidoscopy and request biopsies for CMV  Refer to the surgical team (general or colorectal) for daily review  Nutrition review: maximise oral nutrition and fluid, may need dietician review.  warning-sign-red-50If clinical deterioration ( increasing pulse/temperature, abdominal pain/tenderness, mega-colon on AXR, deteriorating blood tests, severe PR bleeding with drop in Hb) ay any stage, then seek immediate specialist help regarding treatment escalation | | | | | | |
| **Complete a Biologic / immunomodulator pre-screen (if not done within the past 12 months):**  **TB testing** - QuantiFeron Gold & CXR  **Viral hepatitis testing**: Hepatitis A & C antibodies, Hepatitis BsAg, anti-surface antibody & anti-core antibody  **Virus testing**: Varicella (VZV) and CMV serology, HIV antibody. Consider MMR  **Enzyme analysis**: TPMT (to guide use of azathioprine)  Serum magnesium, non-fasting lipids | | | | | | |
| **Day 3 – Decision Day – In remission or not?** | | |  | |  | |
| **DAY 3- DECISION DAY – Is this patient in remission? Continue on steroids OR step up to rescue therapy?** | | | | | | |
| warning-sign-red-50**An important decision is required today. If your patient has achieved remission, continue on IV steroids. If remission is partial or has not been achieved, a prompt senior decision about medical or surgical rescue therapy must be made. It is everyone’s responsibility to make sure the plan is implemented.** | | | | | | |
| Approximately 2/3 of patients with ASC achieve complete or partial remission with corticosteroid treatment, and 1/3 (UC) will **not** respond. Intravenous steroids are generally given for up to 5 days. There is no benefit beyond 7–10 days. Here are some tools to help predict response:  Do SCCAI score\*\*: If insignificant SCCAI improvement by Day 3, choose Rescue Therapy (see orange box).  **Check the stool frequency and CRP Day 3:**  stool frequency of >8/day OR  Stool frequency of 3-8 +  CRP>45mg/l  One of the above predicts the need for surgery in 85% of cases. Refer for surgical review + input from colorectal nurse /stoma therapist to prepare your patient for the high likelihood of colectomy.  Some patients with ASC also have a **complicating infection**, such as CMV or C. difficile. Management requires a delicate balance of immune suppression with anti-microbial / anti-viral treatment. Liaison with an Infectious Diseases physician is frequently required.  If your patient’s SCCAI score is improving, then continue with 5 days of Methylprednisolone. If not, then plan rescue therapy. | | | | | | |
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| **Is rescue therapy needed?** | | |  | |  | |
| **RESCUE THERAPY:** Gastroenterology (Medical) & Surgical teams work together to guide the best rescue therapy for your patient.  **Medical rescue options in New Zealand for ASC:** | | | | | | |
| Infliximab (IFX) – 5mg/kg IV stat OR  Cyclosporin (CyCA) – refer to local protocols to prescribe  Assess daily for response to therapy  **Some centres may have access to drug trials**  **Surgical rescue:**  Colectomy | | | | | | |
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| warning-sign-red-50 **FAILURE OF MEDICAL RESCUE THERAPY:**  If medical rescue fails, the next step is Colectomy … NOT switching rescue therapies*.*  *Some centres who use IFX and achieve a partial response offer another inpatient IFX infusion, such as 10mg/kg. This decision must be patient centred, individualised and made at a senior level.* | | | | | | |
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| **Days 4-6 – Assess daily. Continue or adapt the plan**   |  | | --- | | **DAYS 4-6 DAILY MANAGEMENT DECISIONS:** | | **Key question: has this patient achieved and maintained clinical remission?**  **History** – continue daily SCCAI + Stool Chart\*\*. Ask about fever, frequency, bleeding and pain  **Examination** – vital signs (fever/tachycardia). Abdominal pain/tenderness. Fluid balance. | | **Morning bloods** including FBC, U+Es, albumin & CRP. Higher risk of hypokalemia due to diarrhoea and steroids.  **Daily senior decision** – is the plan working or not? Is there a complicating infection?  If rescue therapy has achieved remission, then start follow up & discharge plan  warning-sign-red-50 **FAILURE OF MEDICAL RESCUE THERAPY:**  If medical rescue fails, the next step is Colectomy … NOT switching rescue therapies*.*  *Some centres who use IFX and achieve a partial response offer another inpatient IFX infusion, such as 10mg/kg. This decision must be patient centred, individualised and made at a senior level.* |   **Discharge planning** | | |  | |  | |
| **FOLLOW-UP & DISCHARGE PLAN -** | | | | | | |
| IBD is a life-long condition. ASC patients need close clinic follow up.  50% of patients with ASC who do not completely respond to steroids will need colectomy within 1 year.  20% of patients with ASC who do completely respond to steroids will still need colectomy in their lifetime.  Send referral for urgent **gastroenterology clinic 2 weeks** after discharge.  If IFX used, need to arrange **further infusions** at 2 & 6 weeks. Check local protocols & services of CycA  Carefully prescribe maintenance therapy - e.g. **azathioprine**  Prescribe 8 week course of tapering **oral steroids (40mg, drop by 5mg per week)**  Bone protection: Consider **calcium and vitamin D**, in some cases bisphosphonates are appropriate.  PJP prophylaxis: If patients are on **triple immunosuppression** with corticosteroids, infliximab and azathioprine/6MP OR are on cyclosporine then prescribe **PJP prophylaxis**, e.g. cotrimoxazole 960mg 3x per week | | | | | | |

**Appendix – phone numbers and SCCAI**

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| **IMPORTANT PHONE NUMBERS – insert your local contacts here.** |
| * General Medical Registrar * Gastroenterology registrar * Gastroenterologist * Surgical registrar……………………………………………………. * General surgeon / colorectal surgeon ……………………. * IBD Nurse………………………………………………………………. * Stoma therapist / Colorectal nurse ……………………….. * Dietician ……………………………………………………………….. |

Simple Clinical Colitis Activity Index \*\*

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| **Circle the score most appropriate to answer each question.** | | | | | | | | |
| Days of symptoms i.e. Day 1 is first day in hospital | | **Before/at Admission** | **Day**  **1** | **Day**  **2** | **Day 3** | **Day 4** | **Day 5** | **Day 6** |
| **Day time stool frequency:**  How many bowel motions have you had during the day time each day? | 1-3 BMs | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 4-6 BMs | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| 7-9 BMs | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| >9 BMs | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| **Nocturnal stool frequency:**  How many have you got out of bed to pass a bowel motion each night? | 1-3 nocturnal BM | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| >4 nocturnal BM | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| **Continence:**  When you feel the need to go to the toilet there has been: | Full control with no urgency | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| A need to hurry to toilet | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Need to immediately defaecate | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Faecal incontinence | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| **Blood:**  How much blood in the stools? | None | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Trace | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Occasional frank/obvious blood | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Usually frank blood | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| **Wellbeing:**  How was your wellbeing over the last week? | Very well | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Slightly below par | 1 | 1 | 1 | 1 | 1 | 1 | 1 |
| Poor | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Terrible | 3 | 3 | 3 | 3 | 3 | 3 | 3 |
| **Total score** | |  |  |  |  |  |  |  |