

CROHN'S DISEASE

Definitions

Clinical remission:

Resolution of symptoms (stool frequency ≤ 3 /day, no bleeding and no urgency)

Endoscopic remission:

Absent or minimal endoscopic lesions

No response:

No clinical improvement within 2-3 weeks of corticosteroid therapy, or up to 12 weeks of anti-TNF therapy

Relapse:

Flare of symptoms associated with evidence of inflammation as determined by CRP, fecal calprotectin, MR or CT enterography, endoscopy or ultrasound and absence of viral/bacterial infection

Recurrence:

The reappearance of lesions after surgical resection

Steroid-resistant:

Patients who have active disease despite prednisolone of up to 0.75 mg/kg/day over a period of 4 weeks

Steroid-dependent:

Patients who are either

- Unable to reduce steroids below the equivalent of prednisolone 10 mg/day within 3 months of starting steroids without recurrent active disease, or
- Who have a relapse within 3 months of stopping steroids

Treatment Algorithm for Crohn's Disease

Provide patients with Crohn's Disease proper education and advice on smoking cessation, drug adherence and fertility

Assess extent and severity using endoscopy ± MR or CT enterography

Mild ileal/ileocolonic

5-ASA

Clinical remission

Lack of response/worsening symptoms

Continue + regular follow-up

Moderate ileal/ileocolonic

Steroid/budesonide taper over 6-8 weeks¹

Re-evaluate in 2-4 weeks

Remission

Stop + follow-up consider 5-ASA if colonic disease

Re-evaluate in 3-6 months

Recurrent symptoms, need new course of CS, relapse when tapering CS < 10mg (steroid-dependent) or within 3-6 months of stopping CS

Steroids/budesonide taper + start AZA/6MP/MTX

Relapse or suboptimal response

Severe/extensive luminal disease
Fistulizing disease
Severe perianal disease²

Exclude/drain abscess

Anti-TNF therapy +/- AZA/6MP/MTX

Re-evaluate 8-12 weeks after initiation

Loss of response

No response

Go to Algorithm A

Consider alternative emerging therapy surgery

1. Corticosteroids (CS) taper: From 40-60mg/d to 0mg/day over 6-8 weeks by 5-10mg/wk.
2. consider surgery/GYN consult for perineal disease consider adding 5-ASA in colonic disease as chemoprevention.

Consider referral to a multidisciplinary IBD service
AZA: Azathioprine
MTX: Methotrexate
6MP: 6-Mercaptopurine

ULCERATIVE COLITIS

Definitions

Clinical remission:

Resolution of symptoms (stool frequency \leq 3/day, no bleeding and no urgency)

Endoscopic remission:

Absent or minimal endoscopic lesions

Relapse:

Flare of symptoms (blood in stool, tenesmus, diarrhea) with or without evidence of mucosal inflammation and in the absence of concomitant infection

Steroid-resistant:

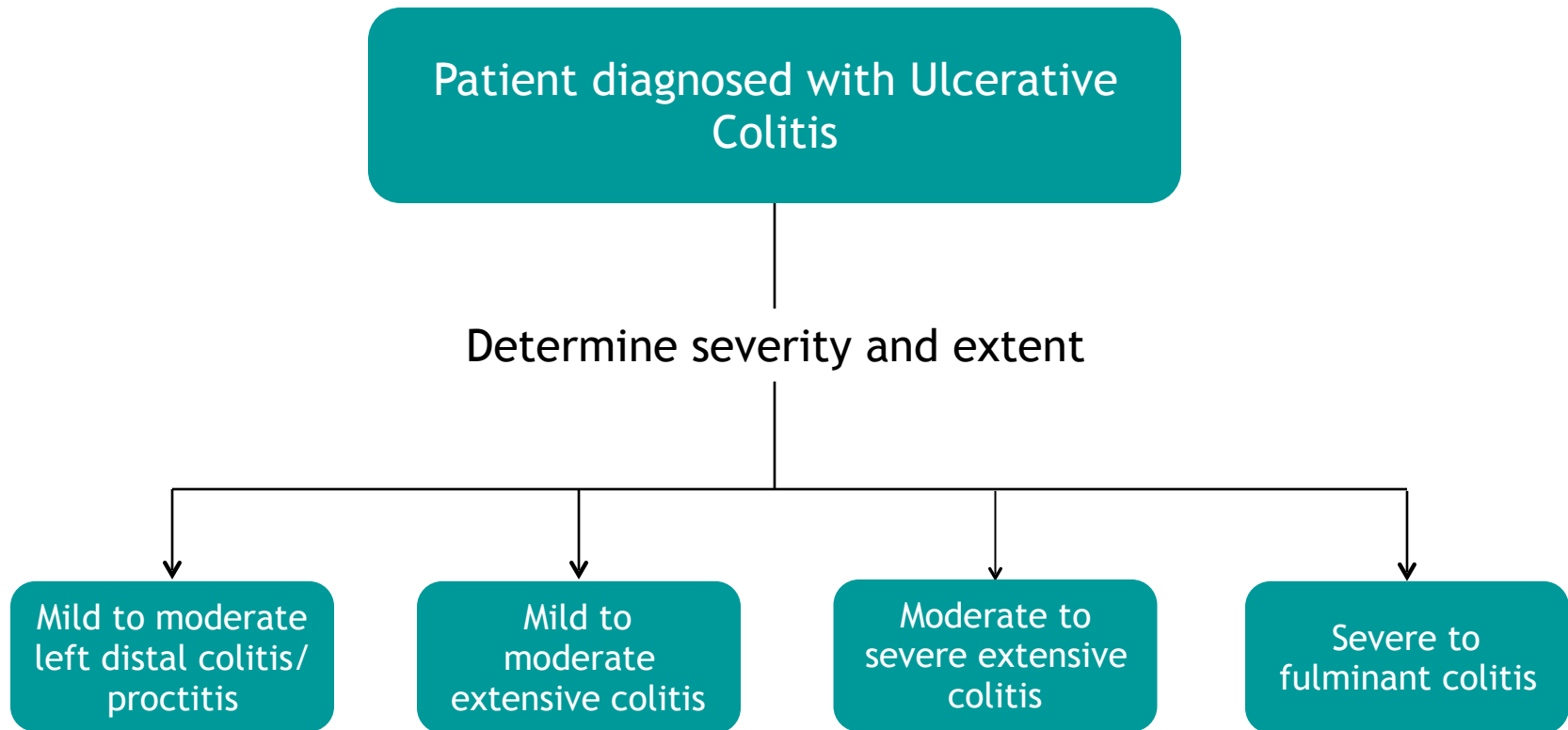
Patients who have active disease despite prednisolone of up to 0.75 mg/kg/day over a period of 4 weeks

Steroid-dependent:

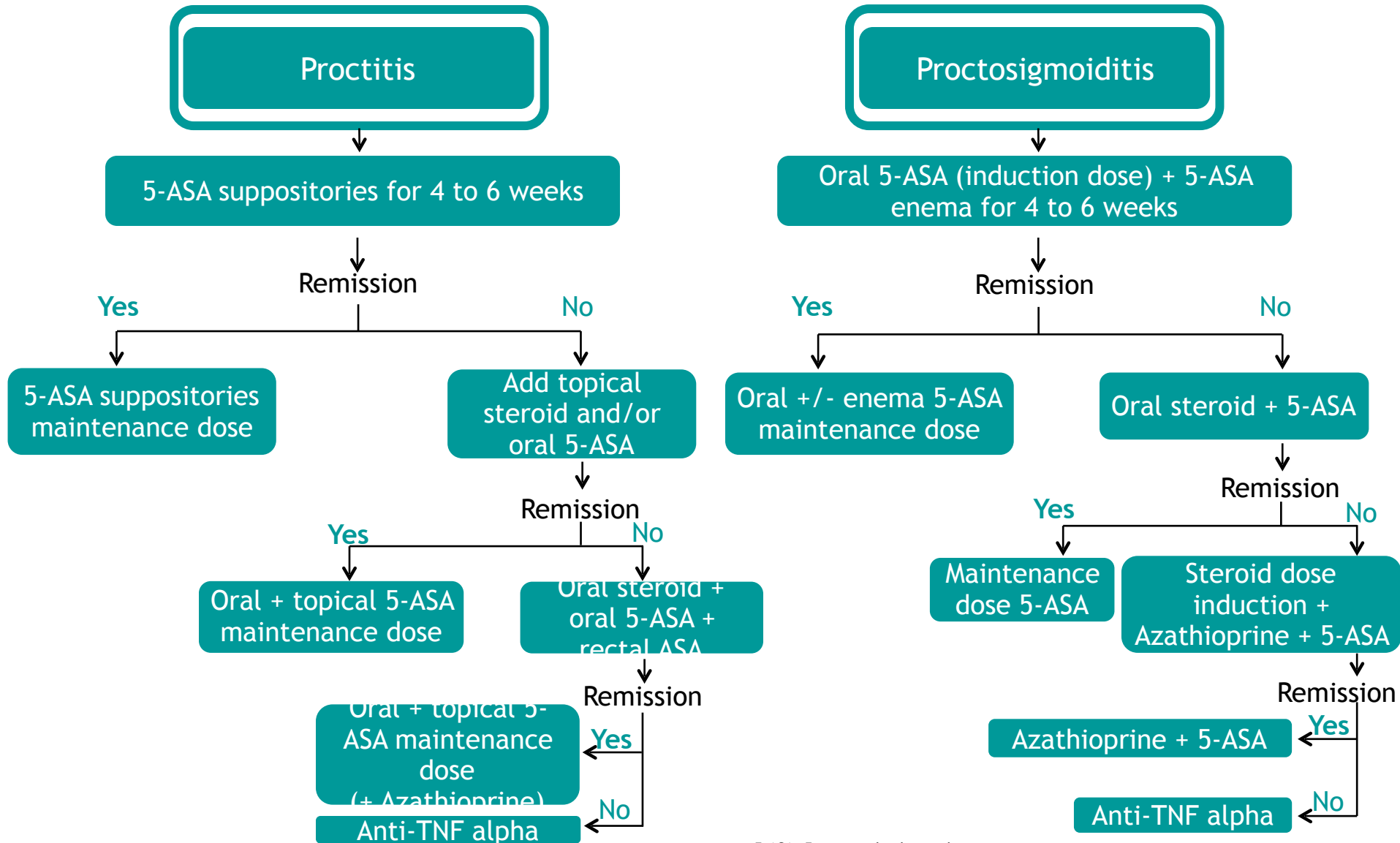
Patients who are either:

- Unable to reduce steroids below the equivalent of prednisolone 10 mg/day within 3 months of starting steroids, without recurrent active disease, or
- Who have a relapse within 3 months of stopping steroids

Treatment Algorithm for Ulcerative Colitis

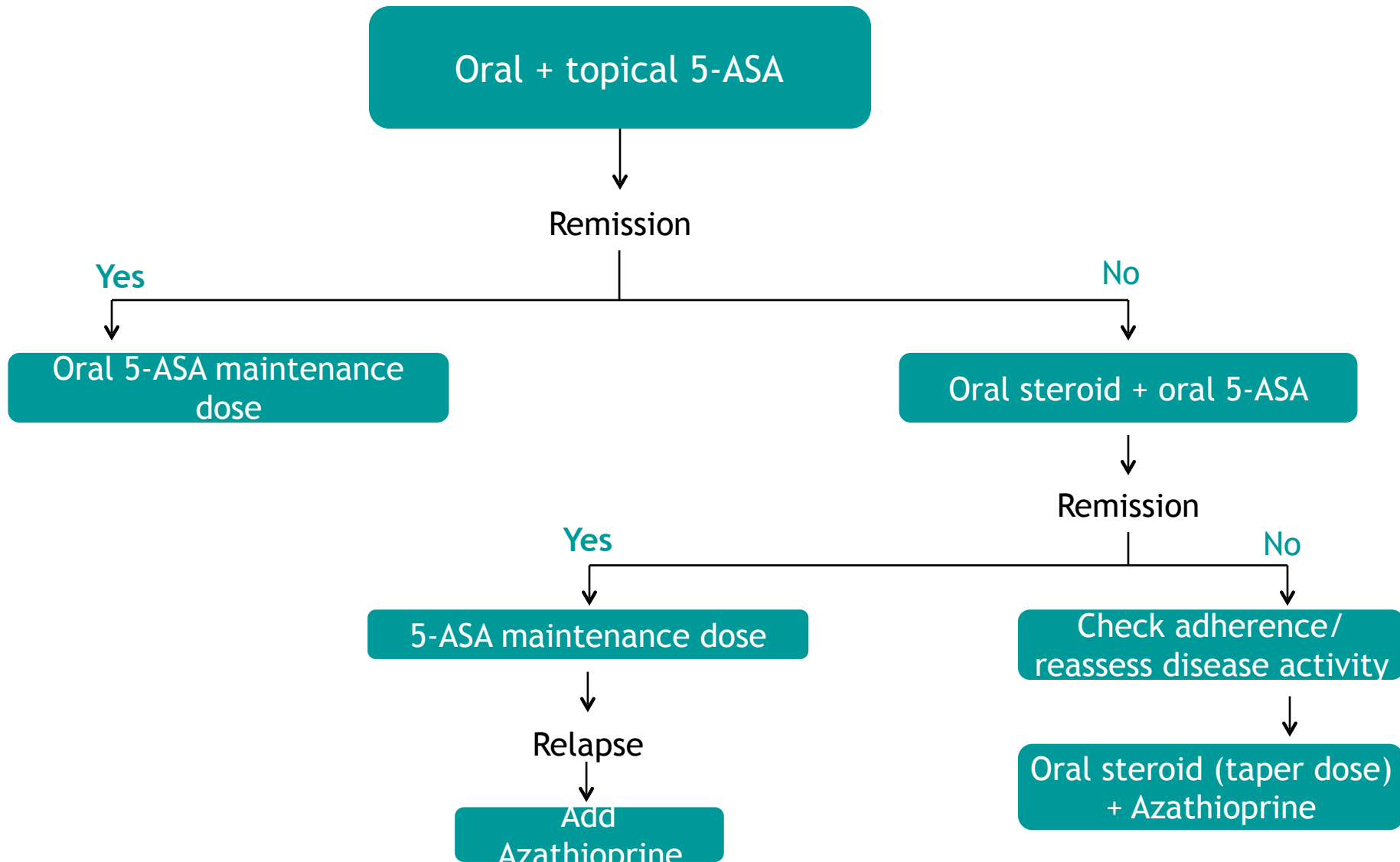


Mild to Moderate Distal Colitis

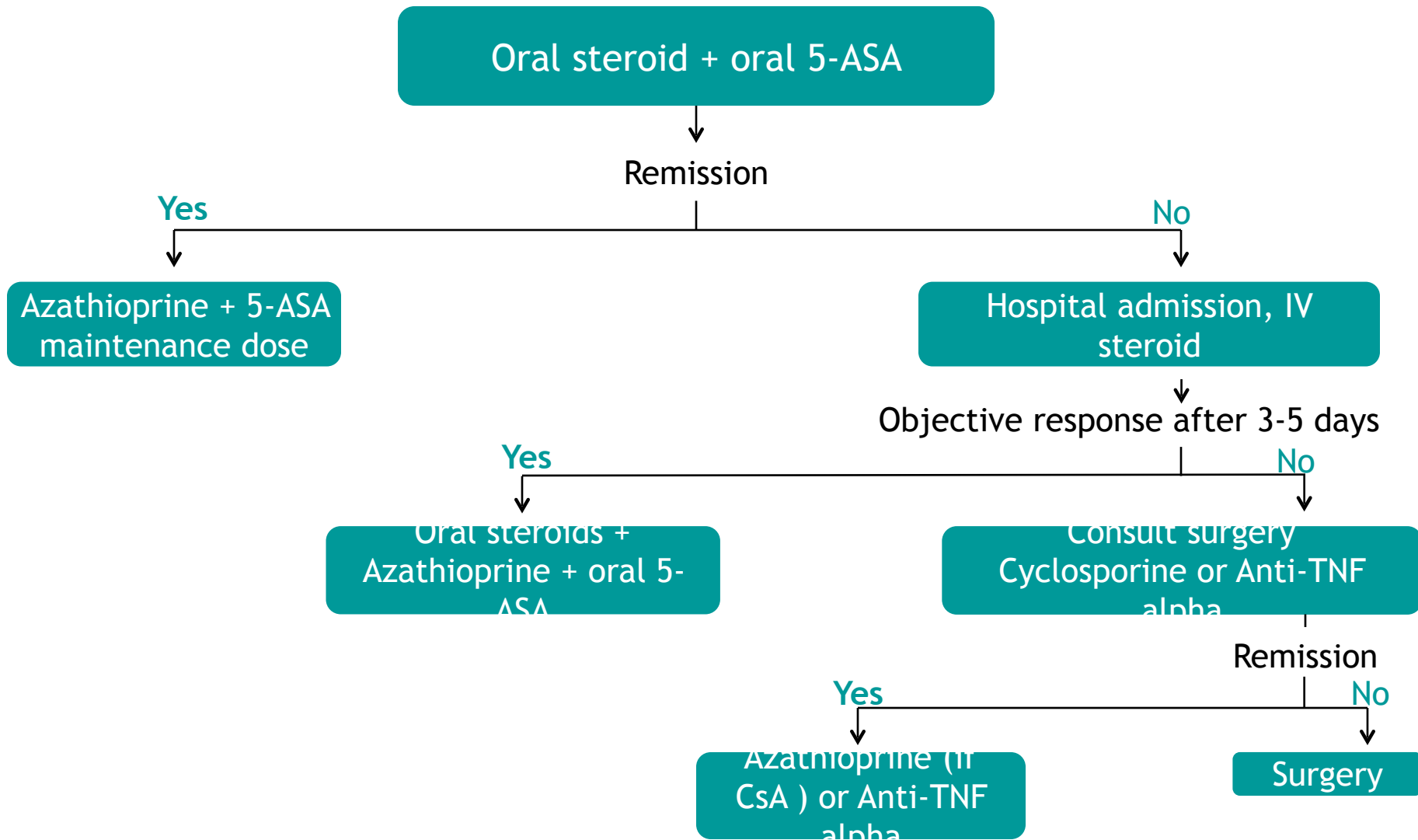


5-ASA: 5-aminosalicylic acid

Mild to Moderate Extensive Colitis



Moderate to Severe Extensive Colitis



Severe to Fulminant Ulcerative Colitis

IV steroid + initiate DVT prophylaxis
+ consult surgery

Objective response 3rd day

Yes

Oral steroid (taper dose)
+ Azathioprine

No relapse

Azathioprine + 5-
ASA maintenance
dose

Recurrence or
steroid-resistant or
steroid-dependent

Anti-TNF
alpha + 5-ASA

No

Anti-TNF alpha or
Cyclosporine (CsA)

Remission

Yes

Anti-TNF alpha or
Azathioprine (if CsA)

No

Surgery

Algorithm A: Loss of Response to 1st Anti-TNF Agent

Evaluate for inflammation and complications

Inflammation
No complication

No Inflammation
No complication

No Inflammation
complication

Inflammation
complication
(eg. Abscess)

Consider check
ADA and trough level (TL)

Symptomatic
treatment

Specific treatment
for complication

Stop biologic,
surgical evaluation,
completely drain abscess

Low ADA
Low TL

High ADA
Low TL

Low ADA
Adequate TL

Increase dose
and/or decrease
interval

Increase dose and/or
decrease interval, add
immunomodulator or
switch to 2nd anti-TNF

Switch to 2nd
anti-TNF or
switch to agent
from a different
class