Inflammatory Bowel Disease Standardized Care Protocols

Title: Suspected IBD outpatient flare

Objective: Optimal management of IBD flare

Patient population: Adult patients (>18 years) with known diagnosis of IBD

1. Gather information using the Inflammatory Bowel Disease Patient Phone Consultation form (#1).
2. Utilize the information collected to complete the Harvey Bradshaw Index (#2) or Partial Mayo (#3) with the patient; if the patient has an undetermined diagnosis, an HBI will be used.
3. Communicate the completed assessment to the responsible physician /nurse practitioner within the following timelines:

Timeline	Patient Assessment Guidelines	Mode of communication
Urgent/Emergent	Patient requires immediate intervention/investigation or is able to wait only until the next day in the following cases: - abdominal pain that is not relieved with any intervention - nausea/vomiting - profuse rectal bleeding - new fistula with an elevated temperature - elevated temperature, not improved by intervention - elevated temperature while on biologic therapy - sudden/unexplained change in health status - extensive bloating and pain or unable to pass stool for 48 hours (obstruction)	- page and speak with the physician / NP directly - if plan to admit – refer to "Hospital BD ADMISSION policy
Routine	Patient is able to wait for 2-3 days for intervention/investigation in the following cases: -fistula draining – old site - fecal incontinence/urgency - up at night with diarrhea - more frequent diarrhea - bloating - fatigue - change in daily activity	- send email or EMR message to physician / NP

4. Under the direction of the physician process laboratory/diagnostic imaging investigations based on the assessment:
    a. IBD Flare Labs (#4) (CBC, FER, NA, K, CL, ALB, ALP, ALT, CRP, AST).
    b. Stool C. *diff* and culture and sensitivity (if diarrhea present) (#5). (PACE QPI 1)
    c. Stool Fecal Calprotectin (if available) (#6).
    d. Ova and Parasite should be added if patient has recently travelled, was camping or exposed to well water (#7).
    e. X-ray of abdomen with 3 views if the patient is experiencing bloating, nausea, vomiting.
    f. Hepatitis B and C testing if negative results are not documented (#8)
5. Deliver requisitions to the patient by one of the following methods:
    a. fax requisition to the patient's closest laboratory/radiology centre
    b. send the requisition to the patient via email, standard mail or fax
    c. give the requisitions to the patient if the patient is present in clinic
6. Email the patient to contact the clinic once testing is complete.
7. Review the results with the physician to determine further investigations, follow-up or treatment change.

Caution: ''Although x-rays have a moderated sensitivity for the detection of high-grade small bowel obstruction, they are less useful in differentiating small from large bowel obstruction and differentiating partial obstruction from ileus. Follow up abdominal CT is generally required''.

Physician Guided:

8. Consider the following imaging:
    a. *CT enterography (#9)/ MR enterography (#10)/ U/S : when patient present with abdominal pain to right upper quadrant, history of abscess/stricture*
    b. *Abdominal ultrasound if available (#11)*
    c. *MRI pelvis (#12): if new fistula or pain*
    d. *Endoscopy depending on history to document disease extent and severity*
9. If the patient:
    a. Has moderate to severe active disease
    b. Previously had good response to Corticosteroids (40 mg per day for >14 days) with no or minor side effects (PACE QPI 3)
    c. Had not required two or more courses of systemic steroids in the last year (PACE QPI 7)

Consider Corticosteroids tapering course and refer to ''INITIATION AND MAINTENANCE OF CORTICOSTEROIDS" protocol.

10. If the patient is on biologics, consider antibody serum levels as per algorithm:
    a. Infliximab – [min. 14 weeks after 1st initiation]. Once the requisition is generated, you must attach the Infliximab Level Order Form(#13 & #14).
    b. Adalimumab – [min 14weeks after 1st initiation] (#15 & #16).
    c. Golimumab – [min 6 weeks after 1st initiation]
    d. *Vedolizumab – [emerging data]*
    e. *Ustekinumab- [emerging data]*

11. If patient is on Azathioprine (stable dose for 4 weeks or following change in dose), consider 6-TG and 6-MMP levels (#17 & #18).

12. Decide on the timeline for a follow-up clinic visit or telephone to initiate care.

REFERENCES:

Maglinte D. et al. Radiology of small bowel obstruction: contemporary approach and controversies. Abdominal Imaging. 2003; 30(2):160-78