Title: INITIATION AND TAPERING OF CORTICOSTEROIDS (Prednisone, budesonide, budesonide-MMX)

Objective: To minimize the risk of repeated corticosteroids

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

IBD Provider:

1. Screen for (and correct) general osteoporosis risk factors – malnutrition, inflammation, smoking, and lack of weight-bearing exercise. Consider bone mineral density where appropriate.
2. Initiate pre-biologic workup - see BIOLOGIC INDUCTION PROTOCOL.
3. At the initiation of corticosteroid treatment, ensure that the patient is supplied with:
   a. Patient information sheets for the corticosteroid he/she is prescribed (#1, #2, #3, #4, & #5) (PACE QPI 22,23)
   b. IBD Flare labs and fecal calprotectin to be completed at baseline and in 14 weeks (#6)
   c. Instructions to take 500 mg of elemental calcium (dietary sources) and vitamin D 2000 IU QD for the duration of corticosteroid therapy (PACE QPI 27)
4. Complete an assessment (eg. telephone visit (#7) and HBI (#8) or Partial Mayo (#9) at 2-4 weeks to ensure response and identify steroid refractory* patients (PACE QPI 15). Alternatively, instruct patient to call if not improving or if initially improving and then a loss of response.
   ➢ If there is a significant subjective improvement in IBD symptoms and HBI <5 or Partial Mayo <1:
     a. continue with steroid taper
     b. send message to support staff to make follow-up appointment at 16 weeks
   ➢ If there is no adequate response, then optimize therapy – see Therapy decision tree protocols.
5. Issue one corticosteroid prescription of three months only. No repeats.
6. To be given in conjunction with a maintenance agent: azathioprine (immunomodulator), mesalamine (5-ASA), Biologic.

Support Staff:

1. Arrange clinic follow-up at 16 weeks.

*Steroid refractory – patients whose symptoms never responded to corticosteroids and those who respond initially but develop recurrence while continuing treatment.