**South East London Area Prescribing Committee:**

# Primary & Secondary Care Inflammatory Bowel Disease Pathway July 2019

**Developed by:** South East London IBD Pathway Development Group

## Contents:




**Approved:** June 2019

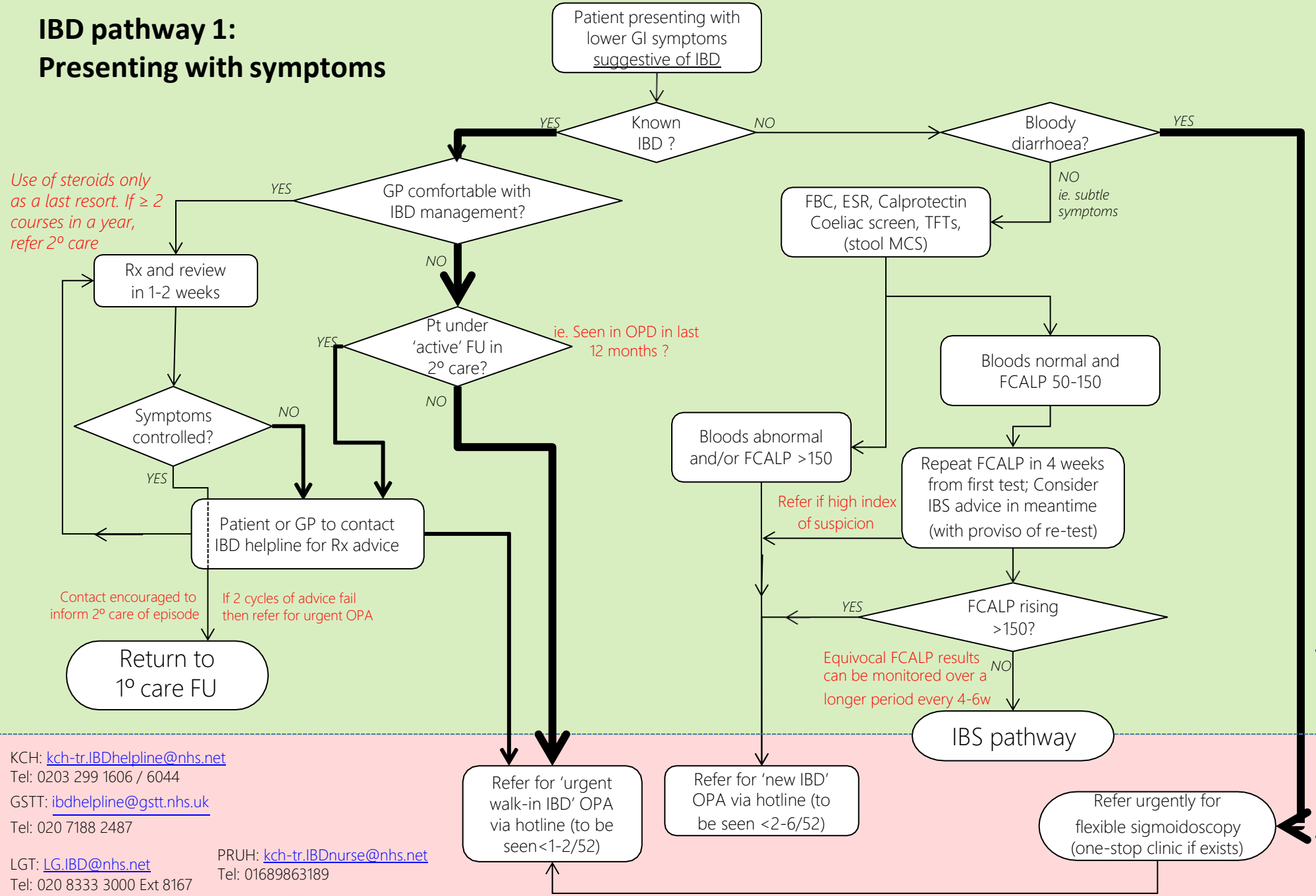
**Review date:** June 2020 or sooner if evidence/practice changes





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*

Severity of this flare? — *NO*

***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 Octasa™/Mezavant ™ 1.5g Salofalk ™, 2g Pentasa ™)

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

**Mesalazine – choice of oral preparation**

*The 1st line oral mesalazine preparation is Octasa™ MR.* ***Nb:*** *Oral Asacol ™ MR is not included in the SEL Joint Medicines Formulary and should usually be switched to Octasa™ MR. Other oral preparations should not be considered interchangeable and should* ***not normally be switched in primary care****.*

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*

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

*NO*

Any steroids in last 12 months? — *NO*

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

*YES*

***WILL NEED DISEASE-MODIFYING THERAPY EG. AZATHIOPRINE***

**Advice from IBD helpline 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

*Ciclo should not be started if already on AZA*

**Start point 1**

Patient requiring therapy despite pathway 2

**Start point 2**

Hospitalised patient

Start CICLOSPORIN.
If inappropriate, INFLIXIMAB
(add AZA if naïve)

***VACCINATION AND VIRAL SCREEN***
***Should be performed at this stage***

Start AZA
based on TPMT result

***Mercaptopurine may be used in AZA intolerant cases. Tioguanine is a 3rd line option***
***See SEL APC recommendation 074***

"Acute severe" UC

In-hospital response? — YES

NO

**Colectomy**

**INITIAL AZA MONITORING**
**Fortnightly FBC, LFTs for 6 weeks**
**Then at 8 weeks and 12 weeks**
**Three-monthly thereafter**

High risk IBD? — NO / YES

***Optimised*** AZA monotherapy

**TGN level at least at 12/52**
**Recheck if failing therapy**

Response at 12-16 weeks? — YES / NO

*Methotrexate (MTX) can be considered if Crohn's*

Chronic active CD

"Chronic active" UC

**Biologic Pathway (#4)**

SUITABLE FOR ENTRY INTO CLINICAL TRIAL ? — NO

Response at 12 weeks? — YES / NO

**Virtual / telephone/ nurse-led F2F follow-up**

***Shared care can only start after 3/12 and only if patient stable***

**Offer of shared care**

**High risk or Complex IBD**

- **Young patients (<40 years); Fulminant disease**
- **Previous surgery for Crohn's disease / early recurrence**
- **Fistulising/penetrating Crohn's disease at presentation**
- **Unable to use steroids as bridge to immunosuppression**
- **Already on immunosuppression (and adequate dosing)**

***Secondary care***

***PROBIOTICS are not recommended for treatment of IBD, except for pouchitis, when use should be directed by secondary care. Probiotics are not available on NHS prescription and patients will normally need to purchase these themselves.***

***Primary care***

# 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** | **Consider Clinical Trial** | **CD**

*Commissioning is not sought for experimental therapy*

- *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)*

**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*** **INFLIXIMAB*** **GOLIMUMAB** | **TOFACITINIB** See MHRA advice (May 2019) | **VEDOLIZUMAB**

*Biosimilar available

*Choice should take into account cost (including service related) and informed patient preference, unless clinically inappropriate*

1st line | 2nd or 3rd line

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

***Switching of stable patients is clinically inappropriate***

Remission once stable on AZA?

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

NO — If on IFX, give one further scheduled dose

NO — If on ciclosporin, switch to alternative biologic as above

*Dose optimisation or drug-switching must be discussed in IBD MDM;* ***Consider surgery. Consider if a clinical trial would be suitable at each point of the pathway prior to switching drug.*** *If patients are optimised, respond, de-escalated and relapse in the future, this section 're-sets'.* ***Where patients are dose escalated they will be subject to regular review so that de-escalation of dose can be considered.***

Response at 12-16 weeks?

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

NO — Possible to dose-optimise based on drug/Ab level/clinical response?

YES — (back to Response at 12-16 weeks?)

NO — **Switch drug (see notes above)**

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

Remission at 12 months?

YES — **Consider stopping or de-escalating biologic therapy**

NO — Possible to dose-optimise based on drug/Ab level/CR?

NO — (back to Switch drug)

***Secondary care***

# **Pathway 5:** Iron deficiency treatment pathway for patients with Inflammatory Bowel Disease (IBD)

An additional check of Hb after 2–4 weeks of iron supplement treatment can be carried out to assess clinical response and adherence. If Hb in normal range and iron stores replenished, consider discontinuing treatment after 12 weeks, and check 3 monthly for recurrence of anaemia for first year, then 6 monthly.
Note that lowest effective dose has been documented and should be uptitrated as tolerated.

Key:

- Management in Primary care
- Management in Secondary care

Confirmed iron deficiency
Ferritin < 20 g/L or
Iron saturations < 15%
or
For active disease, ferritin < 100 g/L
Iron saturations < 15%

Hb

Hb >100 g/L

Commence one of the following oral iron supplements:
ferrous fumarate start at 210mg OD, increase up to TDS
ferrous sulphate start at 200mg OD, increase up to TDS
ferrous gluconate start at 300mg BD, increase up to 600mg TDS
**Titrate to maximum dose tolerated for 12 weeks**

Repeat Hb, ferritin, iron studies, CRP in 12 weeks

If intolerant trial of sodium feredetate start at 5 ml BD, increase up to 10 ml TDS
Titrate slowly to maximum dose tolerated

If intolerant commence ferric maltol 30mg BD first prescription from Gastro specialist

Primary Care to take over prescribing

If intolerant organise iron infusion

Hb <70g/L

Iron infusion urgently +/- blood transfusion

Repeat Hb (not ferritin or iron studies) in 2 weeks

Hb 70-100g/L

Iron infusion (or blood transfusion in selected patient group)

Repeat Hb (not ferritin or iron studies) in 8 weeks

**Advice to patients to improve adherence to oral iron treatment**

Adverse effects usually settle down with time.

Iron preparations can be taken after food to reduce gastro-intestinal side-effects.

Reduce the dose frequency to one or two tablets daily

Oral iron should be taken 2 hours apart from other medication

Further information can be found on SEL APC recommendation