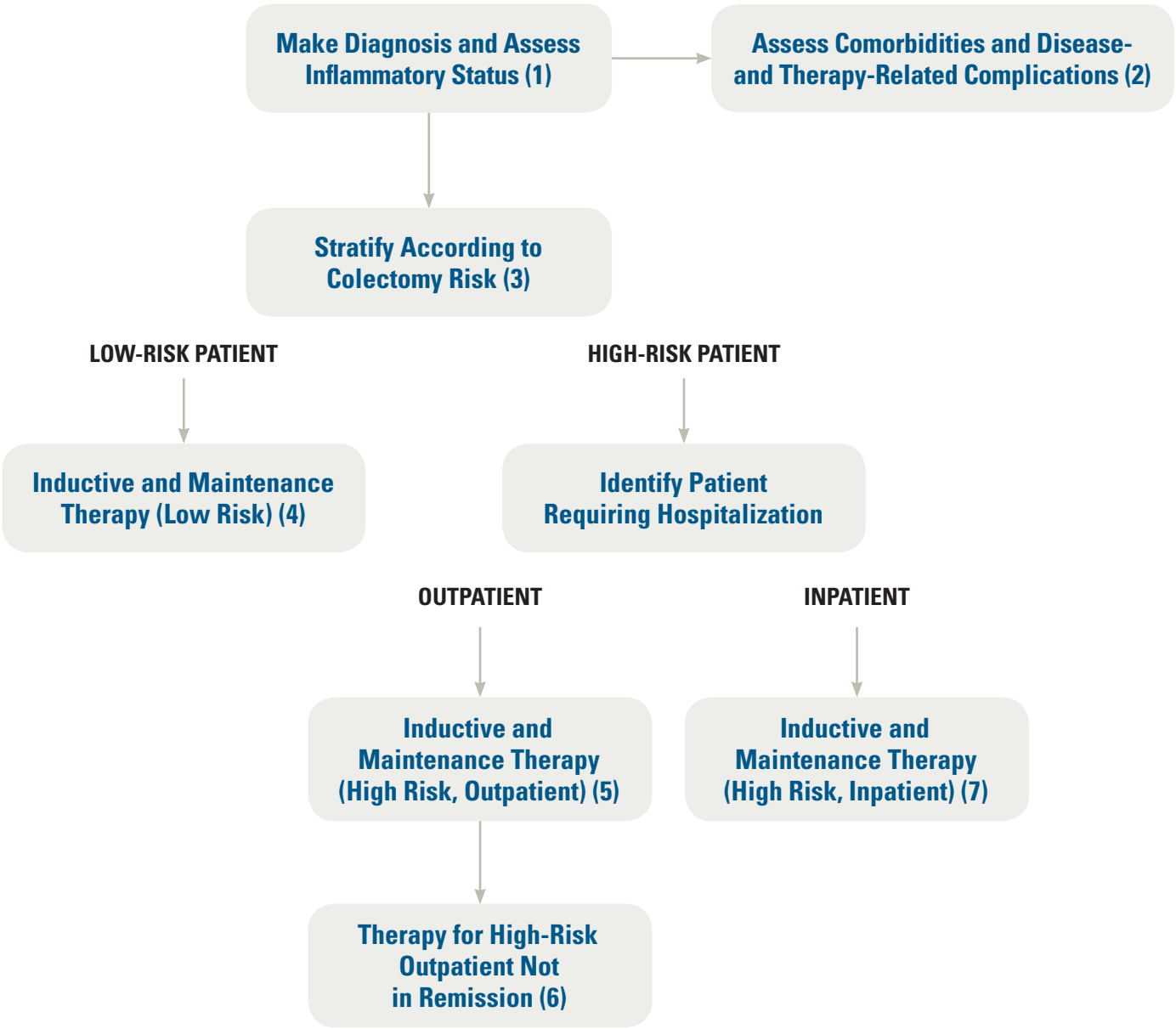
IDENTIFICATION, ASSESSMENT AND INITIAL MEDICAL TREATMENT OF

Ulcerative Colitis
CLINICAL CARE PATHWAY



Review online at **www.gastro.org/ucdecisiontool**.

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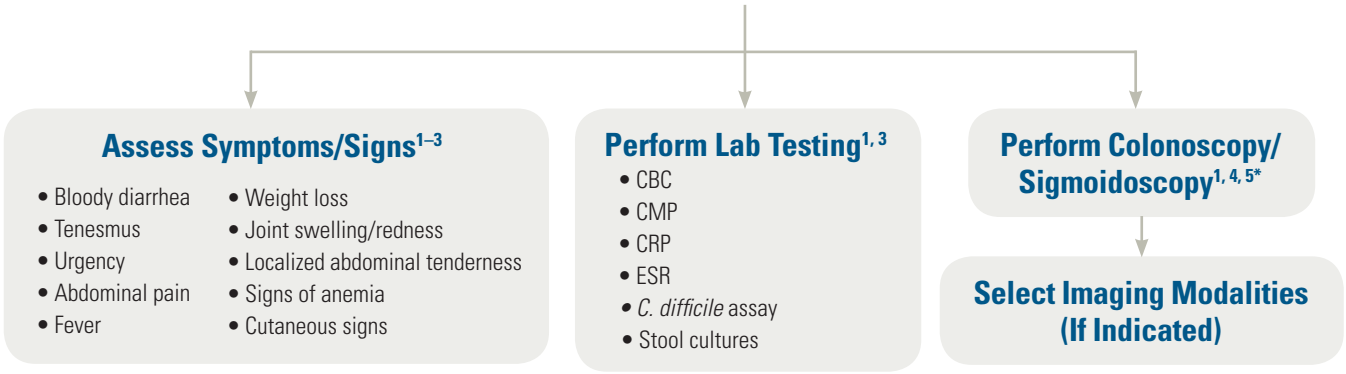
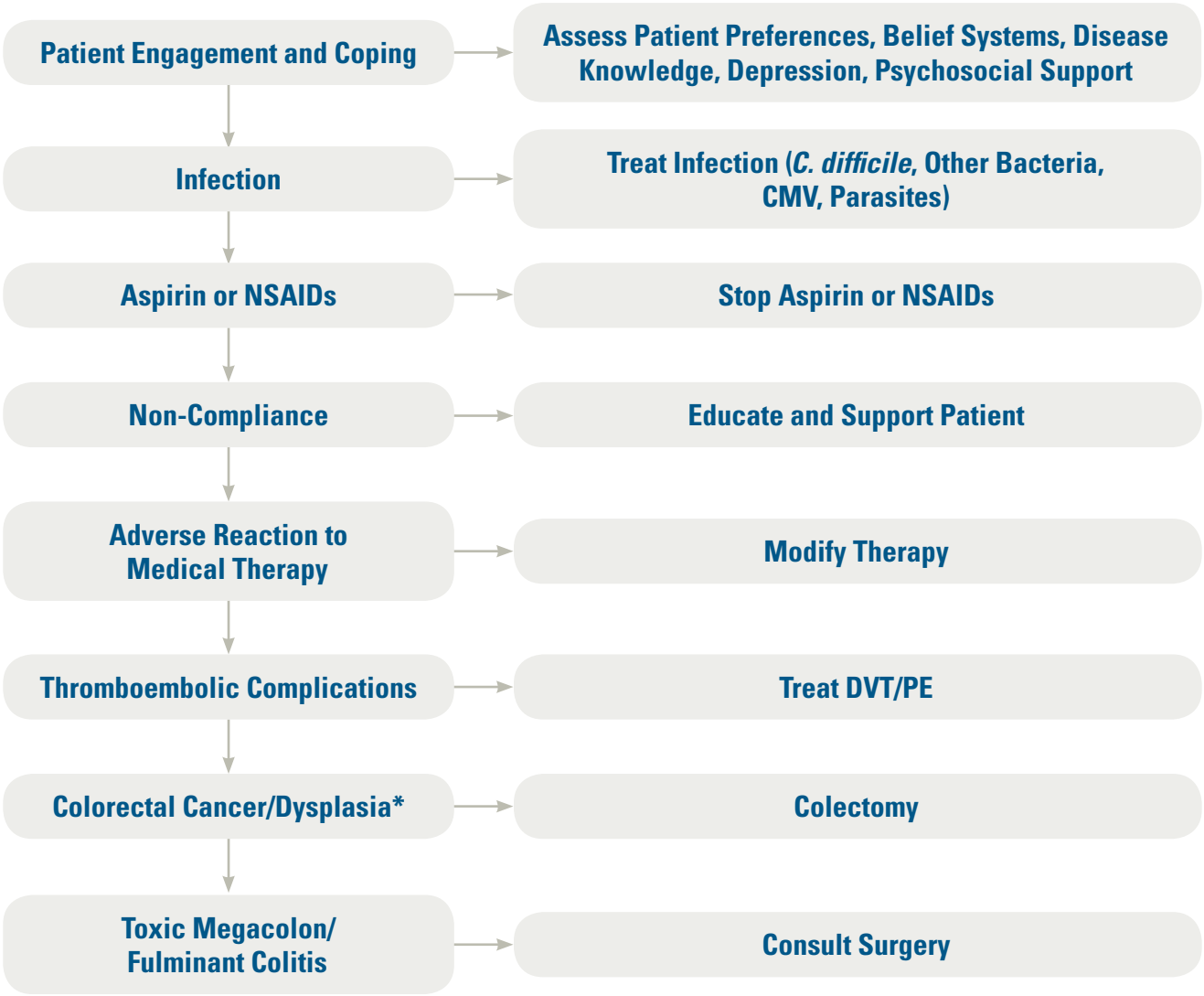
395-006PNQ_15-1

MAKE DIAGNOSIS AND ASSESS INFLAMMATORY STATUS (1)



* In patients with severe colitis, flexible sigmoidoscopy is safer and preferred over colonoscopy.[4, 5]

ASSESS COMORBIDITIES AND DISEASE AND THERAPY-RELATED COMPLICATIONS (2)



*Colectomy is recommended for: 1) endoscopically unresectable polypoid high-grade or low-grade dysplasia, 2) invisible high-grade dysplasia on random biopsies, and 3) invisible low-grade dysplasia on random biopsies if the dysplasia is found (a) at more than one site (multifocal dysplasia), (b) on more than one occasion (repetitive dysplasia), and/or (c) at the time of initial screening colonoscopy (prevalent dysplasia).[6]

STRATIFY ACCORDING TO COLECTOMY RISK (3)

Identify Patient at Low Risk for Colectomy

- Limited anatomic extent
- Mild endoscopic disease

Identify Patient at High Risk for Colectomy

- Extensive colitis[7–10]
- Deep ulcers[11]
- Age <40[8]
- High CRP and ESR[8, 12, 13]
- Steroid-requiring disease[8, 9, 12, 14]
- History of hospitalization[9]
- *C. difficile* infection[15]
- CMV infection[16]

INDUCTIVE AND MAINTENANCE THERAPY (LOW-RISK) (4)

Inductive Therapy

- Oral 5ASA[17, 18] and/or
- Rectal 5ASA[18] and/or
- Oral budesonide[19] or prednisone[20] and/or
- Rectal steroids[21, 22]

Rectal 5ASA is first line therapy in distal UC[23]

REMISSION

Maintenance Therapy

- Maintenance with oral 5ASA and/or rectal 5ASA[17, 18, 24]
- Taper steroid over 60 days

NO REMISSION

RELAPSE

Inductive and Maintenance Therapy (High Risk, Outpatient) (5)

Inductive and Maintenance Therapy (High Risk, Outpatient) (5)

INDUCTIVE AND MAINTENANCE THERAPY (HIGH RISK, OUTPATIENT) (5)

Induction Therapy

- Short course of steroids with initiation of thiopurine[19, 20]

REMISSION

Maintenance Therapy

Options:

- Thiopurine[23,31] and taper steroids over 60 days
- Anti-TNF, with or without thiopurine[26,29,32]
- Vedolizumab, with or without thiopurine or methotrexate[30]

- Anti-TNF with or without thiopurine[25–29] *,** → Continue anti-TNF, with or without thiopurine[26, 29, 32]
- Vedolizumab, with or without immunodulator[30] *** → Continue vedolizumab, with or without immunomodulator[30]

NO REMISSION

RELAPSE

Therapy for High-Risk Outpatient Not in Remission (6)

Therapy for High-Risk Outpatient Not in Remission (6)

* Combination therapy with a thiopurine is more efficacious than anti-TNF monotherapy[25] and should be considered, especially in patients who have failed one or more anti-TNF agents.

** Extrapolating from data in Crohn's disease, methotrexate may be used instead of thiopurines to decrease anti-TNF immunogenicity.[33,34]

*** Extrapolating from data with anti-TNF agents, thiopurines and methotrexate may be used to decrease vedolizumab immunogenicity.

THERAPY FOR HIGH-RISK OUTPATIENT NOT IN REMISSION (6)

Options:
- Anti-TNF +/- thiopurine*,**
- Vedolizumab +/- immunomodulator***
- Thiopurine (optimize 6TGN concentrations)
- Proctocolectomy

(6A)

Failure to Respond to Prednisone

OR

Anti-TNF With or Without Thiopurine

Vedolizumab With or Without Immunomodulator

(6B)

Failure to Maintain Steroid-Induced Remission on Thiopurine

Subtherapeutic 6TGN
(<230 pmol 6-TGN/8×10^8 RBCs)

Increase Dose and Recheck Metabolites◊

Therapeutic 6TGN
(>230 pmol 6-TGN/8×10^8 RBCs)

Switch to Anti-TNF or Vedolizumab

(6C)

Loss of Response to Anti-TNF

Subtherapeutic Level No or Low Ab
- Increase dose and/or decrease interval
- Consider adding immunomodulator[35]

Subtherapeutic Level High Ab
- Switch within class

Therapeutic Level
- Switch to vedolizumab with or without immunomodulator

(6D)

Loss of Response to Vedolizumab

Increase Dose to 300 mg Every 4 Weeks[36]

NON-RESPONSE

Switch to Anti-TNF With or Without Thiopurine

* Combination therapy with a thiopurine is more efficacious than anti-TNF monotherapy[25] and should be considered, especially in patients who have failed one or more anti-TNF agents.

** Extrapolating from data in Crohn's disease, methotrexate may be used instead of thiopurines to decrease anti-TNF immunogenicity.[33,34]

*** Extrapolating from data with anti-TNF agents, thiopurines and methotrexate may be used to decrease vedolizumab immunogenicity.

◊ The addition of allopurinol (while decreasing the thiopurine dose to 1/4 of the previous dose) may be considered at centers with experience with this approach and recognizing the risks of severe myelosuppression and infection.

INDUCTIVE AND MAINTENANCE THERAPY (HIGH RISK, INPATIENT) (7)

Inductive Therapy*

Options:
- IV steroids[3, 5, 23, 37]
- Infliximab
- IV cyclosporine[36]

IV STEROIDS

IV steroid-induced remission maintenance options:
- Thiopurine
- Anti-TNF, with or without Thiopurine**, ✖
- Vedolizumab, with or without immunomodulator✚

IV steroid failure options:
- Infliximab[5, 23, 39–41]
- Cyclosporine[5, 23, 40–42]
- Colectomy[5, 23]

INFLIXIMAB

Infiximab-induced remission maintenance:
- Infliximab with or without Thiopurine[5,**, ✖]

Infliximab failure✦
- Colectomy[5, 23]

IV CYCLOSPORINE

IV Cyclosporin-induced remission maintenance options:
- Start thiopurine[5]
- Anti-TNF, with or without Thiopurine**, ★
- Vedoluzimab, with or without immunomodulator✚

IV cyclosporine failure✦
- Colectomy[5, 23]

* All hospitalized patients should receive prophylaxis for venous thromboembolism.[5, 43–44]

** Combination therapy with a thiopurine is more efficacious than anti-TNF monotherapy[25] and should be considered, especially in patients who have failed one or more anti-TNF agents.

✖ Extrapolating from data in Crohn's disease, methotrexate may be used instead of thiopurines to decrease anti-TNF immunogenicity.[33, 34]

✚ Extrapolating from data with anti-TNF agents, thiopurines and methotrexate may be used to decrease vedolizumab immunogenicity.

✦ Sequential rescue therapy (IFX-CSA or CSA-IFX) may be considered for select patients only in centers with experience with this approach and recognizing the risks of severe infection and death.[23]

Clinical care pathways are formulated by an expert physician panel through the review of existing clinical practice guidelines and systematic reviews. For pathway decisions points where no guidelines or systematic reviews exist, recommendations are made based on review of the available data. The clinical care pathways are not created using the GRADE methodology.

AUTHORS

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SOURCE

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