crohn's colitis

Initiation and Tapering of Corticosteroids

(prednisone, budesonide, budesonide-mmx)

Objective

To minimize the risk of repeated corticosteroid use for the treatment of IBD.

Patient Population

Adult patients (>18 years) with a known diagnosis of IBD.

Highlight Box

Corticosteroids should only be used for short-term induction therapy to treat acute IBD flares.

Introduction

Corticosteroids are an effective induction short-term therapy for acute flares of IBD but are associated with significant morbidity and inadequate disease control when used for prolonged periods. Strategies to minimize adverse events and a long-term plan for alternative (and more appropriate) maintenance therapy are required.

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

* Steroid dependent - patients who initially respond to steroids but lose response during taper or shortly after completion of steroid taper; therefore, requiring additional steroids to control symptoms.

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. Mental health should also be considered prior to starting steroid therapy and should be discussed with the patient and significant others.
2. Corticosteroid treatment should be considered in conjunction with a maintenance agent: azathioprine (immunomodulator), mesalamine (5-ASA), or biologic. (PACE QPI 23)
3. At the initiation of corticosteroid treatment, ensure that the patient is supplied with:
    a. Patient information sheets for the corticosteroid they are prescribed: Corticosteroids Patient Information Sheet, Prednisone Tapering-Patient instructions, Budesonide Patient Information Sheet, & Budesonide-mmx Patient Information Sheet) (PACE QPI 22)
    b. IBD Flare labs and fecal calprotectin to be completed at baseline and in 3 months to allow for assessment of response

   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. Instruct the patient to call the GI clinic if not improving or if initially improving and then a loss of response.

   Complete an assessment (e.g. telephone visit) and Harvey Bradshaw Index (HBI) or Partial Mayo (pMayo) to ensure response and identify steroid refractory* patients (PACE QPI 15).

   a. If there is a significant subjective improvement in IBD symptoms and HBI <5 or pMayo <1:
      - Continue with steroid taper
      - Send a message to support staff to make a follow-up appointment at 4 months
   b. If there is not an adequate response, then optimize therapy – see Therapy decision tree protocols and complete pre-biologic workup Biologic Induction Protocol.

5. Issue one corticosteroid prescription taper of three months maximum only. No repeats.

Support Staff

1. Arrange clinic follow-up at 4 months.

References

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