GRI protocol for management of acute severe colitis (V33 May 201)

Truelove & Witt's criteria define these patients
(n.b. differentials include UC, CD, infection, ischaemia, diverticulitis)

- Bowels open >6 per 24 hrs

+ any one of

- Hb<10.5
- Pyrexia
- Pulse >90
- ESR>30

Investigations

- History & examination
- 4 hrly obs
- Stool chart
- Stool C&S/C diff toxin × 3 (on admission)
- K^+, CRP & albumin (daily)
- AXR (on day one and daily thereafter if colonic dilatation noted)
- Urgent unprepared sigmoidoscopy & urgent biopsies (ideally <24 hrs of admission,)
  Referral to consultant gastroenterologist and to consultant colorectal surgeon & stoma care sister (at the earliest convenience)

Management

- NBM & IVI
- Avoid antidiarrhoeals, NSAIDs & opiates
- LMWH prophylaxis
- IV antibiotics (if known Crohn's colitis, pyrexial or colonic dilatation on AXR)
- IV corticosteroid : **Methylprednisolone 30mg twice daily**

Day 3 post admission - risk stratification

1. Travis criteria
SF>8/24hrs or SF>3 and CRP>45
(85% of these patient will require a colectomy)

2. Ho score (see table opposite)
score of 0-9 predicts the risk of failing medical therapy; low (score 0-1,11% risk), intermediate (score 2-3, 45% risk) & high (score ≥4, 85% risk)

Table 4. Integer risk score attributable to each category derived from the coefficients of the logistic regression equation

Variables	Score
Mean stool frequency	
< 4	0
4 ≤ 6	1
6 ≤ 9	2
> 9	4
Colonic dilatation	4
Hypoalbuminaemia	
< 30 g/L	1

Overall risk core = [score attributable to mean stool frequency (0, 1, 2 or 4)] + [presence of colonic dilatation (0 or 4)] + [presence of hypoalbuminaemia (0 or 1)]. Minimum score = 0, maximum score = 9.

HIGH RISK: Travis criteria met, Ho score ≥ 4 &/or 'broken through' azathioprine/equivalent immunosuppression

⇨ discussion with consultant colorectal surgeon/gastroenterologist & stoma sister re urgent colectomy

INTERMEDIATE RISK: Ho score intermediate risk (2-3)

⇨ discussion with patient regarding colectomy versus 2nd line medical therapy. If, after appropriate counselling, patient not willing to consider surgery, then decisions regarding potential 2nd line therapy should be taken only after discussion with the consultant gastroenterologist.

If responding to medical Rx, then start oral & topical 5ASA. The switch from IV to oral steroid will be decided by the managing consultant.