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Model for IBD Care. A Guideline for Consistent Reliable Care

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Diagnostic and therapeutic interventions are appropriate and recommended for a very large percentage of children and adolescents with Crohn's disease and ulcerative colitis.[1]

■ Complete Diagnostic and Initial Evaluation:

- Complete blood cell count (CBC), erythrocyte sedimentation rate (ESR), and serum albumin
- Esophagogastroduodenoscopy with biopsy and colonoscopy with biopsy
- Imaging of the small intestine (upper gastrointestinal [GI] and small bowel series; or computed tomography [CT] scan with oral and intravenous [IV] contrast; or magnetic resonance imaging [MRI] with contrast enhancement; or capsule endoscopy)[2]
- Other studies as indicated

Extent of Disease: documentation of disease location (esophagus, stomach, duodenum, jejunum, ileum, right colon, transverse colon, left colon, rectum, perineum)

Crohn's Disease Phenotype: based on the Montreal classification (non-stricturing, non-penetrating; penetrating; or stricturing)

Severity: Physician Global Assessment (quiescent, mild, moderate, severe)

Visit frequency: it is recommended that each patient be examined and evaluated at least once every 6 months (≤ 200 days)

■ Treatment with 5-ASA:

When using the following medications, recommended doses are as follows:

1. Mesalamine 80 (60-100) mg/kg/day up to 4.8 g/day for active colitis
2. Mesalamine at least 30 (30-100) mg/kg/day up to 4.8 g/day for maintenance of quiescent or inactive colonic disease
3. Sulfasalazine 70 (50-80) mg/kg/day up to 4 g/day for active colitis
4. Sulfasalazine at least 25 (25-80) mg/kg/day up to 4 g/day for maintenance of quiescent or inactive colonic disease

■ Treatment with Prednisone:

1. Prednisone is indicated for induction of remission. Long-term treatment with prednisone can induce significant adverse effects and has not been shown to be effective for maintenance of remission.
2. To induce remission the oral dose of prednisone is 1 mg/kg/d, rounding up to the

1 The guidance in this document does not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

2 In patients with left-sided ulcerative colitis (distal to the splenic flexure) in whom the terminal ileum is normal on colonoscopy, not performing small bowel imaging and/or esophagogastroduodenoscopy is also consistent with the ImproveCareNow Model of Care.

■ Nutritional and Growth Assessment:

Status	Definition
Nutritional status at risk	Weight percentile changed lower by one isobar or Weight stable (no gain) or 1% to 9% loss (involuntary) Body mass index <10th percentile for age (adjust for prednisone treatment)
Nutritional failure	Weight percentile changed lower by two isobars or Weight loss ≥ 10% Body mass index <3rd percentile for age (adjust for prednisone treatment)
Nutritional status satisfactory	Not at risk or failure
Growth status at risk	Height percentile changed lower by one isobar or Height percentile <10th percentile for age or Height velocity <10th percentile for age
Growth failure	Height percentile changed lower by two isobars or Height percentile <3rd percentile for age or Height velocity <3rd percentile for age
Growth satisfactory	Not at risk or failure

nearest 5 mg, up to 40 to 60 mg per day, for 1 to 4 weeks.

3. Taper prednisone and discontinue it within 16 weeks after treatment has been initiated.
   a. Prednisone resistance is defined as an inadequate improvement after 2 to 4 weeks of treatment.
   b. Prednisone dependence is present when a patient, who initially improves in response to such treatment, develops a recurrence when the dose is being tapered or within 6 months after prednisone is discontinued.

■ Treatment with Thiopurines:

1. Prior to initiation of a thiopurine, determine thiopurine methyltransferase (TPMT) genotype or phenotype.
2. Choose a starting dose of azathioprine or 6-mercaptopurine (6MP) based on TPMT. Should TPMT activity be:
   a. absent or very low, do not use a thiopurine.
   b. intermediate, start azathioprine at 1.0 to 1.5 mg/kg/day or 6MP 0.5 to 0.75 mg/kg/day.
   c. normal to high, start azathioprine at 2.0 to 3.0 mg/kg/day or 6MP 1.0 to 1.5 mg/kg/day.
3. For a maintenance dose of thiopurine use either at least the starting dose as defined above, or base the dose on blood concentrations of thiopurine metabolites or evidence of toxicity.
4. Monitor CBC and alanine aminotransferase (ALT) for evidence of toxicity.
5. For patients treated with a thiopurine, when disease is moderately or severely active it is recommended that the 6-TGN level be measured (if not done in the previous 90 days).

■ Treatment with Methotrexate:

1. For induction of remission the recommended dose of methotrexate is 15 mg/m^2 (up to 25 mg/m^2) intramuscularly (IM), subcutaneously (SQ) or orally once a week.
2. For maintenance of remission the recommended dose of methotrexate is 10 to 15 mg/m^2 (up to 15 to 25 mg/m^2) IM, subcutaneous or oral once a week.
3. Folic acid supplementation is recommended in a dose of 400 µg or 1 mg per day.
4. Monitor CBC and ALT for evidence of toxicity.

■ Treatment with Infliximab:

1. It is recommended that a skin test (PPD) and/or a chest radiograph for tuberculosis be obtained before initiation of infliximab therapy.
2. For induction of remission it is recommended that infliximab 5 mg/kg IV (or rounding

up to the nearest 100 mg) be used as an initial dose, with repeated doses of 5 mg/kg IV 2 and 6 weeks later (0, 2, 6 weeks).
3. For initial maintenance of remission it is recommended that infliximab 5 mg/kg IV (or rounding up to the nearest 100 mg) be given every 8 weeks.
4. For patients treated with infliximab, when disease is moderately or severely active it is recommended that the infliximab trough level be measured (if not done in the previous 180 days).

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