North Central London
Joint Formulary Committee

Ulcerative Colitis Acute Flare Management Pathway

Document control

Date	Version	Amendments
Nov 2024	1.0	Pathway developed in accordance with national guidance and evidence base

Groups / Individuals who have overseen the development of this guidance:	NCL HCD Team, Specialist Clinicians and pharmacists, NCL Joint Formulary Principal Pharmacist
Groups which were consulted and have given approval:	NCL wide consultation (NCL Formulary Pharmacists, NCL Specialist Clinicians, NCL ICB), NCL Joint Formulary Committee (Nov 2024)
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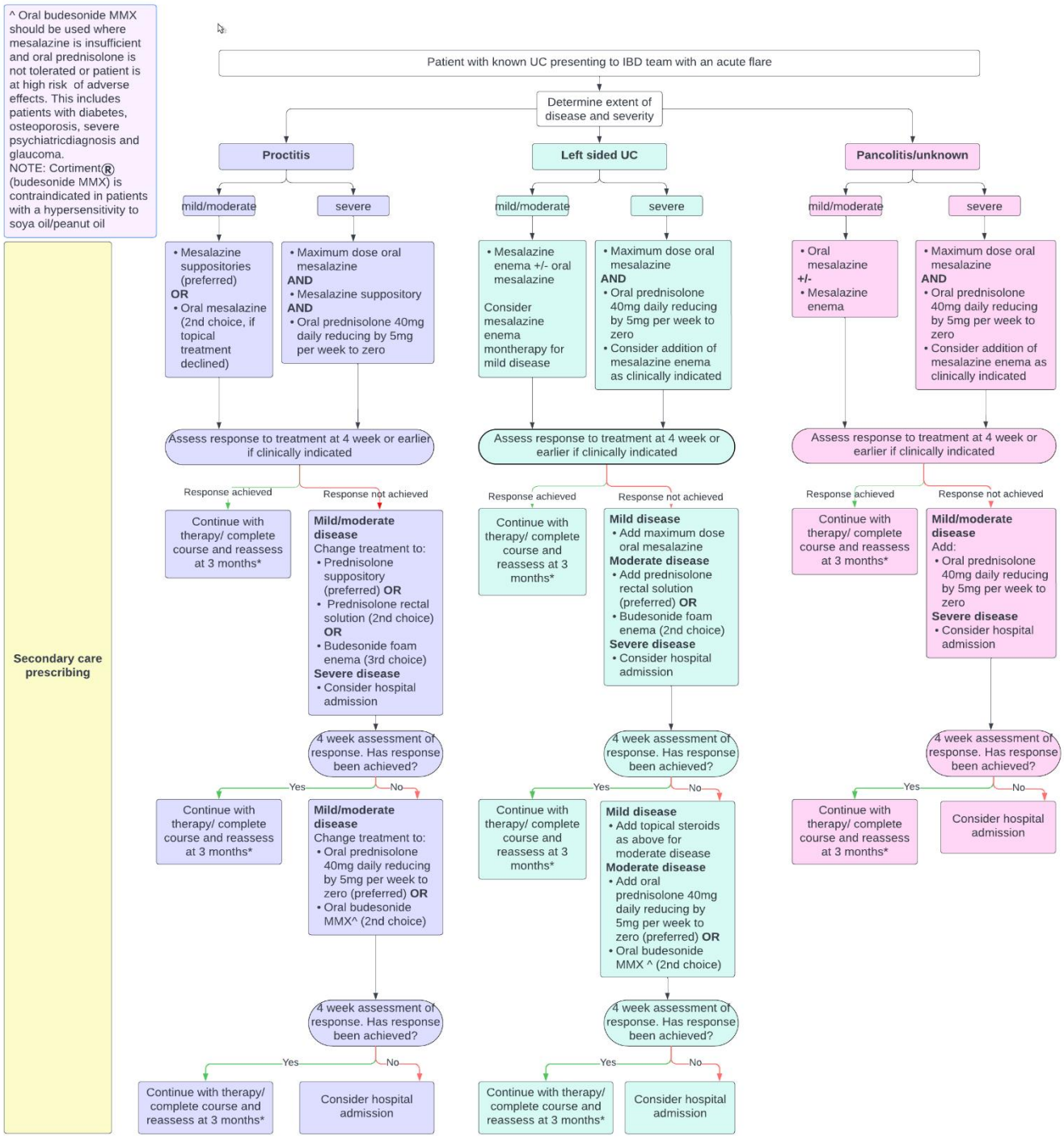
Ulcerative Colitis Acute Flare Management Pathway



Primary care prescribing

- If at 3 months desired response is not achieved, specialist to review and consider hospital admission where clinically indicated. If desired response achieved at 3 months, specialist to determine if remission has been achieved and decide on maintenance treatment. Specialist to communicate treatment plan with GP so maintenance treatment can be prescribed in primary care. Choice of therapy for maintenance treatment are as follows:

Proctitis
1st choice: Mesalazine suppositories (daily or intermittent)
2nd choice: Oral mesalazine (if patient does not wish to use suppositories)

Left sided UC
Oral mesalazine

Pancolitis/ unknown
Oral mesalazine

Table 1: Drug and dosing information

Green: 1st line options Amber: 2nd line options Grey: Non preferred products

Drug	Available strengths	Acute flare dosing information	Maintenance dosing information	Additional information
Mesalazine oral therapy – PRESCRIBE BY BRAND				
Octasa® MR gastro resistant tablets	400mg, 800mg, 1600mg	*For 400mg and 800mg tablets:* 2.4–4.8g daily in divided doses, alternatively dose of 2.4g daily may be given as a single dose. *For 1600mg tablets:* Up to 4.8g once daily, dose to be adjusted according to response, alternatively up to 4.8g daily in 2–3 divided doses, dose to be adjusted according to response	*For 400mg and 800mg tablets:* 1.2–2.4g once daily, alternatively 1.2–2.4g daily in divided doses. *For 1600mg tablets:* 1.6g once daily. Please note increased risk of adverse effects with once daily dosing.	Preferred oral mesalazine brand due to low cost. Octasa® is released in the ileum, colon and rectum
Pentasa® MR tablets	500mg or 1g	Up to 4g once daily, alternatively up to 4g daily in 2–3 divided doses	2g once daily.	Restricted to use in patients with absorption difficulties. Pentasa® is released in the duodenum and jejunum.
Pentasa® modified release granules	1g, 2g, 4g	Up to 4 g once daily, alternatively up to 4g daily in 2–4 divided doses	2g once daily.	Restricted to those patients with swallowing difficulties.
Non-formulary: Asacol® MR gastro-resistant tablets Salofalk® gastro-resistant tablets Mezavant XL tablets Salofalk® gastro-resistant modified release granules				
Mesalazine suppository (for isolated rectal disease)				
Octasa® suppository	1g	1g once daily, to be administered preferably at bedtime.	1g once daily, to be administered preferably at bedtime.	Preferred mesalazine suppository due to low cost.
Non-formulary: Salofalk® suppository Pentasa® suppository				
Mesalazine rectal enemas				
Pentasa® mesalzine enema	1g/100ml	1g once daily, dose to be administered at bedtime.	1g once daily, dose to be administered at bedtime.	
Salofalk® foam enema	1g/application	2g once daily, dose to be administered into the rectum at bedtime, alternatively 2g daily in 2 divided doses	Unlicensed for maintenance regimes. Used in the management of acute flares only.	
Salofalk® enema	2g/59ml	2g once daily, dose to be administered at bedtime.	2g once daily, dose to be administered at bedtime.	Restricted to those patients who require a 2g dose and for whom retention of a higher volume of Pentasa® enema (1g in 100ml) would be problematic

Steroid rectal preparations				
Prednisolone rectal solution	20mg/100ml	1 metered application 1–2 times a day for 2 weeks, continued for further 2 weeks if good response, to be inserted into the rectum, 1 metered application contains 20mg prednisolone	N/A	Note: Prednisolone rectal foam enema is no longer used due to increased costs.
Prednisolone sodium phosphate suppository	5mg	5mg twice daily, to be inserted into the rectum morning and night, after a bowel movement	N/A	Preferred in patients with proctitis. Suppositories are preferred for isolated rectal disease.
Budenofalk® foam enema	2mg/application	1 metered application once daily for up to 8 weeks. 1 metered application is equivalent to budesonide 2mg	N/A	Budesonide foam enemas are more costly than prednisolone rectal solution. Restricted to use in patients unable to administer prednisolone rectal solution successfully
Non-formulary products: Entocort® budesonide enema				
Oral steroids				
Prednisolone tablets	5mg	40mg daily, reducing by 5mg every week to zero.	N/A	Enteric coated tablets are not recommended as there is no evidence they are gastroprotective nor provide additional benefits. Standard prednisolone tablets can be dispersed in water.
Budesonide MMX (Cortiment®) modified release tablets	9mg	9 mg once daily for up to 8 weeks, dose to be taken in the morning	N/A	Restricted to use in patients where mesalazine is insufficient AND either - Oral prednisolone is not tolerated due to adverse effects **OR** - Patient is at high risk of adverse effects. This includes patients with diabetes, osteoporosis, severe psychiatric diagnosis and glaucoma **NOTE: Budesonide MMX is contraindicated in patients with hypersensitivity to soya oil/peanut oil.**

Additional information

Budesonide MMX or Budenofalk® foam enema may be considered in patients experiencing adverse effects with prednisolone.

Definition of disease severity and response (Walsh *et al* 2014) **–**

- Remission ≤ 2
- Mild disease: SCCAI 3 - 5
- Moderate disease: SCCAI 6 – 11
- Severe disease: SCCAI ≥ 12

Please note the Truelove and Witts disease assessment is used to define severe disease and the need for hospital admission

Other considerations - Oral corticosteroids should be co-prescribed with calcium and vitamin D supplementation

References

British Society of Gastroenterology consensus guidelines on the management of inflammatory bowel disease in adults 2019

European Crohn´s and Colitis Organisation Guidelines on Therapeutics in Ulcerative Colitis: Medical Treatment

Walsh AJ, Ghosh A, Brain AO *et al* 2014. Comparing disease activity indices in ulcerative colitis. Journal of Crohn's and Colitis, v8, 318 - 325

North Central London Joint Formulary Committee minutes, September 2023

North Central London Joint Formulary Committee minutes, March 2019