Inflammatory Bowel Disease

Telephone Triage

Questions to ask:

1. Does the patient have Crohn’s Disease, Ulcerative Colitis, or Indeterminate Colitis
2. Does the patient have an ostomy?
3. Stooling pattern: normal frequency versus current frequency, stool consistency, waking to defecate, blood in stool, tenesmus, urgency, ostomy output
4. Abdominal pain?
   If yes, description of pain to include: location, duration, frequency, severity, quality and nocturnal presence. Are there alleviating or aggravating factors? Is this the “typical” pain the patient has with a flare, or does this feel different?
5. Constitutional symptoms: recent fever, nausea or vomiting, change in appetite, fatigue/energy level
6. Extra intestinal manifestations: joint pain, mouth sores, eye pain, rash
7. Current medications: what meds are they taking, what doses, are they adherent
   a. Patients on long term or high dose steroids, oral immunomodulators (MXT, AZA, 6MP) and anti-tNF medications (Infliximab, Adalimumab, Certolizumab, Natalizumab) are at higher risk for infection, perforation, etc and may be seen sooner
8. Relevant past medical history: Has the patient had a recent procedure, any previous surgery, any previous complications (abscess, obstruction, fistula…)? When were they last seen by GI?
9. Any recent illness exposure? School, home

Red Flags:** referral to ED/PCP/sooner clinic visit if available

1. Severe abdominal pain: increased concern if following endoscopic procedure, surgery, or is clearly localized to one specific region
2. Bilious vomiting, abdominal distention
3. Persistent (unexplained) fever
4. Significant hematochezia
5. Signs/Symptoms of dehydration (no urine output in >6 hours, dry cracked lips, lethargy)
6. Change in symptoms with change in medication (ie: vomiting with 6-mercaptopurine or weaning medication such as Prednisone)

Treatment Goals: Remission of inflammation, Avoidance of complications, or early recognition/treatment if complications arise.
Advice:

1. May be appropriate to monitor symptoms for a few days if symptoms are mild and do not worsen. Close phone follow up may be necessary. Make sure they know how to reach GI after hours/weekends
2. Take all medication as prescribed
3. Avoid Ibuprofen, can take Acetaminophen
4. Encourage fluids to avoid dehydration
5. Non-irritating diet if able to hold down solids
6. If parents are concerned and symptoms are severe, family may need to bring child to the ED if unable to be seen by GI
7. Further testing may be necessary. This may include labs, stool studies, imaging studies or EGD/Colon depending on the severity of the symptoms.

Teaching:

1. Infections can occur in a patient with IBD, so symptoms may just need to run the course. Follow up with PCP may be more appropriate than with GI especially if there are systemic symptoms of illness (ex URI, pharyngitis)
2. Continue medications as prescribed unless symptoms started at the onset of a new medication. May need to take medication with food to avoid nausea. May need to change the time of day the medication is taken if symptoms occur. (ie: if Methotrexate causes nausea when taken in the morning, try taking at night)
3. If symptoms are intermittent, tracking frequency, time of day, and associated factors (eating, defecating) may help establish a pattern
4. Refer to any facility based teaching tools that may have been given to family with more specific guidelines of when to call. This may include the IBD Self-management Handbook or the book Your Child with Inflammatory Bowel Disease.

Possible Causes:

The cause of Inflammatory Bowel Disease is not known. It is currently thought that IBD occurs when an environmental trigger causes a deregulation in immune response in a genetically predisposed individual. Inflammatory Bowel Disease is a chronic inflammatory disease. Inflammation occurring as a result of Crohn’s disease may occur anywhere in the GI tract, from mouth to anus, and therefore can present with a variety of symptoms. Ulcerative Colitis is confined to the large intestine. In approximately 10% of patients, there is an overlap in symptoms and diagnostic testing that make it difficult to differentiate between Crohn’s Disease and Ulcerative Colitis. These patients are given the diagnosis of Indeterminate Colitis. Even with appropriate medical therapy, a patient may experience a flare in disease symptoms.