

CLINICAL PRACTICE UPDATES

AGA Clinical Practice Update on Inpatient Management of Adults With Inflammatory Bowel Disease: Expert Review



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DESCRIPTION: Patients with inflammatory bowel disease (IBD) often require hospitalization for medically refractory IBD or IBD-related complications. However, despite the increasing availability of effective medical therapies, inpatient IBD care remains challenging, as evidenced by the variation in hospital-acquired complications, delays in surgery, and high 30-day readmission rates. Therefore, this Clinical Practice Update Expert Review is intended to provide Best Practice Advice on the evaluation and management of hospitalized adult patients with IBD. We have developed Best Practice Advice statements to address 13 key clinical issues. **METHODS:** This Expert Review was commissioned and approved by the American Gastroenterological Association (AGA) Institute Clinical Practice Updates Committee and the AGA Governing Board to provide timely guidance on a topic of high clinical importance to the AGA membership and underwent internal peer review by the AGA Institute Clinical Practice Updates Committee and external peer review through standard procedures of *Gastroenterology*. These Best Practice Advice statements were drawn from a review of the published literature and from expert opinion. Because systematic reviews were not performed, these Best Practice Advice statements do not carry formal ratings of the quality of evidence or strength of the presented considerations.

BEST PRACTICE ADVICE STATEMENTS

BEST PRACTICE ADVICE 1: Prompt hospitalization should be considered for adult patients with IBD who present with severe disease refractory to outpatient treatment when there is high suspicion for an IBD-related complication, such as intestinal obstruction or intra-abdominal abscess, or when there is significant nutritional risk or failure to thrive. **BEST PRACTICE ADVICE 2:** The initial management of hospitalized adult patients with IBD should include supportive care. **BEST PRACTICE ADVICE 3:** The initial management of hospitalized adult patients with IBD should include an evaluation for IBD-related complications and concomitant infections. **BEST PRACTICE ADVICE 4:** Hospitalized adult patients with IBD should have their disease activity assessed with both biomarkers and endoscopic evaluation, when indicated. **BEST PRACTICE ADVICE 5:** Hospitalized adult patients with IBD should receive prophylactic anticoagulation for prevention of venous thromboembolism. **BEST PRACTICE ADVICE 6:** Hospitalized adult patients with severe ulcerative colitis should be counseled on the potential need for colectomy and should have a timely referral for surgical consultation. **BEST PRACTICE ADVICE 7:**

Hospitalized adult patients with severe ulcerative colitis should receive initial treatment with intravenous corticosteroids at a methylprednisolone 60-mg daily dose equivalent. **BEST PRACTICE ADVICE 8:** Hospitalized adult patients with severe ulcerative colitis should be monitored for treatment response within 72 hours of medical treatment initiation. **BEST PRACTICE ADVICE 9:** Preparations should be made for initiating rescue therapy in hospitalized adult patients with severe ulcerative colitis who are not responsive to intravenous corticosteroid treatment. **BEST PRACTICE ADVICE 10:** In hospitalized adult patients with Crohn's disease and intestinal obstruction, medical treatment with intravenous corticosteroids should be considered when there is evidence of active inflammation. **BEST PRACTICE ADVICE 11:** In hospitalized adult patients with Crohn's disease and an intra-abdominal abscess, treatment should include infection control with abscess drainage (depending on size and location) and systemic antibiotics, as well as decision making regarding further medical or surgical management. **BEST PRACTICE ADVICE 12:** Hospitalized adult patients with Crohn's disease and active perianal symptoms should have a multidisciplinary treatment approach involving both medical and surgical care. **BEST PRACTICE ADVICE 13:** Stability of treatment response should be achieved before discharge, and a clear discharge transition plan established.

Keywords: Hospital Care; Ulcerative Colitis; Crohn's Disease; Acute Severe Ulcerative Colitis; ASUC.

Inflammatory bowel diseases (IBDs), including ulcerative colitis (UC) and Crohn's disease (CD), are chronic inflammatory conditions that affect the gastrointestinal tract and can lead to substantial bowel damage, disability, and impaired health-related quality of life. Approximately 2.4–2.7 million people in the United States

Abbreviations used in this paper: ASUC, acute severe ulcerative colitis; CD, Crohn's disease; CMV, cytomegalovirus; CRP, C-reactive protein; CT, computed tomography; ESR, erythrocyte sedimentation rate; IBD, inflammatory bowel disease; JAK, Janus kinase; MR, magnetic resonance; TNF, tumor necrosis factor; UC, ulcerative colitis; VTE, venous thromboembolism.

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and 6.8 million people worldwide live with IBD.¹⁻³ In the United States, the hospitalization rate for UC is 8.2–12.4 per 100,000 people and for CD it is 9.3–17.1 per 100,000 people annually.^{4,5} Overall, IBD-specific hospitalizations are becoming less frequent as more effective outpatient medical therapies become available.^{6,7} However, it can be challenging to manage hospitalized patients with medically refractory IBD or IBD-related complications, as evidenced by the variation in hospital-acquired complications, delays in surgery, and high 30-day readmission rates.⁸⁻¹¹ Therefore, this Clinical Practice Update is intended to provide Best Practice Advice on the evaluation and management of hospitalized adult patients with IBD.

Best Practice Advice 1: Prompt hospitalization should be considered for adult patients with IBD who present with severe disease refractory to outpatient treatment when there is high suspicion for an IBD-related complication, such as intestinal obstruction or intra-abdominal abscess, or when there is significant nutritional risk or failure to thrive.

There are no standard admission criteria for patients with IBD. However, there are several clinical presentations for which inpatient IBD care should be considered to allow for expedited multidisciplinary evaluation, intravenous medical treatment, or surgical intervention. These presentations include uncontrolled inflammation that is not responding to outpatient medical therapy, difficult-to-treat symptoms, and suspicion for current or impending IBD-related complications¹² (Figure 1).

Traditionally, patients who develop acute severe UC (ASUC) require urgent hospitalization for exclusion of infection, prompt treatment with intravenous corticosteroids, and consideration for expedited initiation of steroid-sparing immune therapy. ASUC has been defined by the Truelove and Witts criteria¹³ as presenting with 6 or more bloody bowel movements daily and at least 1 systemic sign, such as tachycardia (heart rate >90 beats/min), fever (temperature >37.8°C), anemia (hemoglobin <10.5 g/dL), or an elevated erythrocyte sedimentation rate (ESR, >30 mm/h). These criteria predict risk of progression to colectomy; rates rise from 8.5% to 48% based on the number of criteria met.^{13,14} Although not traditionally included in this criteria, C-reactive protein (CRP) has a shorter half-life than ESR and is more responsive to changes in acute inflammation.^{15,16} Therefore, CRP has replaced ESR as a real-time inflammatory biomarker and predictor of colectomy, often guiding admission decisions. In recent years, the widespread use of steroid-sparing immune therapies with rapid onset of action (eg, infliximab) and access to ambulatory treatment units has made outpatient treatment of severe IBD more feasible. Therefore, patients are now more likely to be hospitalized with IBD that is refractory to multiple steroid-sparing immune therapies than for an acute fulminant ASUC presentation.

Patients who are suspected of having a bowel obstruction, bowel perforation, or intra-abdominal abscess or abscesses require hospitalization for evaluation and medical and/or surgical management (see Best Practice Advice statements 9–11). Hospitalization in this setting facilitates

a multidisciplinary approach, allowing timely access and coordination among gastroenterologists, surgeons, and other key clinicians (eg, dietitian and interventional radiologist) to meet patients' specific needs. Similarly, patients with dehydration and electrolyte derangements, short bowel syndrome, uncontrolled pain, severe anemia requiring transfusions, or severe malnutrition requiring enteral or parenteral nutrition require hospitalization for expedited evaluation, initiation of treatment, and safe discharge planning.

Best Practice Advice 2: The initial management of hospitalized adult patients with IBD should include supportive care.

Patients hospitalized with IBD-related symptoms or complications should undergo a standard assessment with an IBD-tailored history, physical examination, and laboratory testing (including evaluation for anemia, CRP and/or fecal calprotectin, and if not recently obtained, preparatory laboratory tests for anticipated medication initiation, including fasting lipid panel before cyclosporine or Janus kinase (JAK) inhibitors, and assessments for both latent tuberculosis and hepatitis B infection (Figure 1). An assessment for latent tuberculosis may include either a tuberculin skin test or interferon gamma release assay with preference based on test availability and patient factors (eg, interferon gamma release assay preferred if Bacillus Calmette-Guérin vaccinated).¹⁷ All patients should receive supportive care including intravenous hydration and electrolyte repletion, treatment for acute anemias, and pain control as needed. Clinicians should screen all hospitalized adult patients with IBD for malnutrition using validated screening tools (eg, Malnutrition Universal Screening Tool) and refer to a dietitian for a complete malnutrition evaluation, as indicated.¹⁸ Patients should also be screened for vitamin deficiencies, in particular vitamin B12 and vitamin D, and iron deficiencies. Administration of intravenous iron treatment may be considered for patients with IBD when oral iron treatment may be less effective, such as in the setting of active inflammation, moderate to severe anemia (especially hemoglobin <10 g/dL), or intolerance to oral iron.¹⁹ Data suggest that 1 in 4 hospitalized patients with IBD receive inadequate pain control.²⁰ Therefore, pain management in IBD should include management of the underlying factors (ie, nasogastric decompression in case of bowel distention from obstruction, drainage of abscess, and effective treatment of underlying inflammation), a sequential stepped approach, shared decision making on the risks and benefits of different analgesic strategies, and use of neuromodulators as appropriate.²¹ Neuro-modulators, including tricyclic antidepressants, serotonin-norepinephrine reuptake inhibitors, and mirtazapine have all demonstrated tolerability and efficacy in treating chronic gastrointestinal pain. In contrast, opioids carry a potential risk of adverse effects, including narcotic bowel syndrome and addiction, and should generally be avoided in the treatment of IBD-related pain, if possible.^{21,22} Nonsteroidal anti-inflammatory drugs should be used with caution, given the potential for exacerbating intestinal ulceration.^{23,24}

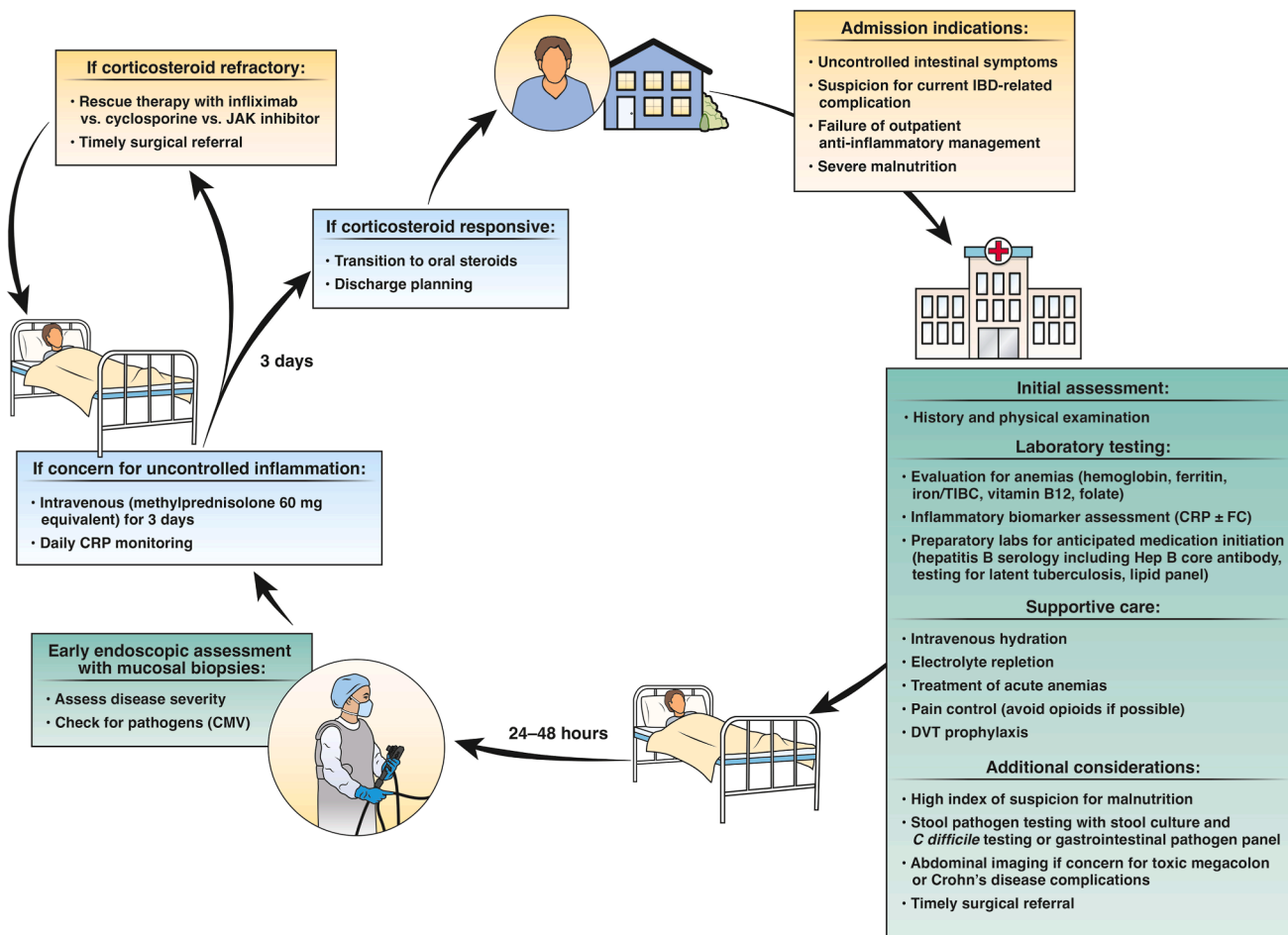


Figure 1. Flow diagram of the inpatient evaluation and management of IBD-related inflammation.

Best Practice Advice 3: The initial management of hospitalized adult patients with IBD should include an evaluation for IBD-related complications and concomitant infections.

The symptoms of a substantial proportion of patients with IBD are driven by gastrointestinal infections, most commonly *Clostridioides difficile*. Therefore, patients hospitalized with diarrhea should undergo stool pathogen testing with stool culture and *C difficile* toxin testing using a 2-step approach (eg, initial screening with glutamate dehydrogenase antigen assay, followed by a toxin enzyme immunoassay or nucleic acid amplification test). Evaluation for cytomegalovirus (CMV) infection is also important in patients with worsening gastrointestinal symptoms, systemic toxicity, or lack of response to corticosteroids (see Best Practice Advice 4). In patients with UC, when there is a concern for toxic dilatation or megacolon, a timely abdominal film and/or computed tomography (CT) abdomen and pelvis with intravenous contrast and discussion with colorectal surgery is indicated, given the high risk of morbidity. In patients with CD who present with nausea and vomiting or pain concerning for a bowel obstruction or intra-abdominal abscess (particularly when CRP is elevated out of proportion to gastrointestinal luminal symptoms), cross-sectional imaging (magnetic

resonance [MR] or CT) with intravenous contrast is indicated for further evaluation. There is also evolving experience and evidence for intestinal ultrasound as a diagnostic or monitoring tool for suspected bowel obstruction.²⁵

Best Practice Advice 4: Hospitalized adult patients with IBD should have their disease activity assessed with both biomarkers and endoscopic evaluation, when indicated.

Several objective serologic biomarkers of inflammation can be used to assess disease activity at presentation, including CRP, leukocyte count, platelet count, and albumin (Figure 1). These laboratory markers are not specific to IBD and can be elevated in the context of other precipitants, including extraintestinal inflammatory conditions or infection. However, despite the lack of specificity, an initial CRP assessment on admission is valuable in predicting the risk of colectomy and, therefore, directing initial treatment. CRP ≥ 1.2 mg/dL (or ≥ 12 mg/L) has an 85% positive predictive value, sensitivity of 95%, and accuracy of 82% for capturing patients with an ESR >30 mm/h, as in the Truelove and Witt criteria for ASUC.²⁶ Therefore, in hospitalized patients presenting with 6 or more bloody bowel movements daily and 1 or more systemic signs (ie, anemia, fever, and tachycardia), a CRP ≥ 1.2 mg/dL should trigger

the initiation of intravenous corticosteroids in the absence of contraindications. Serum albumin is a negative acute phase reactant; a high serum CRP to albumin ratio is therefore independently predictive of active disease.²⁷ Fecal calprotectin is a stool-derived biomarker that is sensitive to measuring inflammation in the gastrointestinal tract and strongly correlates with endoscopic disease activity. Although calprotectin can help to detect gastrointestinal-specific inflammation, processing may take up to 7 days, limiting its clinical utility in the inpatient setting. However, a baseline admission measurement may be valuable as a benchmark for later trending.

Early endoscopic examination is important for assessing the presence and severity of inflammation and obtaining mucosal biopsies to rule out alternative or comorbid diagnoses, including a CMV infection (Figure 1). A flexible sigmoidoscopy using a limited bowel preparation with tap water enemas or even no preparation is often sufficient to assess for colonic inflammation. However, a complete colonoscopy may be indicated in select cases, such as for patients with isolated Crohn's ileitis or when suspicion for right-sided pathology is high. Early colonoscopy or flexible sigmoidoscopy within 48 hours of admission has been found to decrease length of stay and decrease hospital costs.²⁸ Furthermore, in the presence of systemic toxicity, lack of response to corticosteroids, or ASUC, a CMV infection should be excluded by means of mucosal biopsies and histologic examination (ie, H&E stain with immunohistochemistry for CMV).²⁹ The diagnosis of CMV can be challenging, given a high rate of nonpathogenic CMV detection. However, in select cases, CMV can drive IBD symptoms, leading to high rates of colectomy and comorbidity without appropriate treatment.³⁰ A serum CMV polymerase chain reaction and immune titers can be obtained in patients for whom there is a concern for CMV infection (eg, systemic symptom, fever, and/or transaminitis), but is neither indicated in all hospitalized patients nor sufficient to rule out CMV. Treatment for CMV should be limited to patients with clinically active IBD who have high-density histologic CMV involvement (ie, 5 or more inclusions) and are not responsive to corticosteroid treatment.^{30,31}

Best Practice Advice 5: Hospitalized adult patients with IBD should receive prophylactic anticoagulation for prevention of venous thromboembolism.

Hospitalized patients with IBD are 2 times as likely to be diagnosed with venous thromboembolism (VTE) as patients without IBD.^{32–34} Although the mechanisms underlying VTE in IBD have not been fully elucidated, inflammation and corticosteroid use both contribute to a hypercoagulable state.³² Prophylactic anticoagulation has been found to be effective at reducing VTE events despite increasing the risk of major bleeding, with a number needed to treat of 35 compared with a number needed to harm of 114.³⁵ Therefore, all hospitalized patients with IBD and without absolute contraindications should receive prophylactic anticoagulation with subcutaneous low-molecular-weight heparin or fondaparinux. The lack of clinician knowledge on the risk of VTE as well as safety concerns is often identified as the reason for suboptimal

use of prophylactic anticoagulation in hospitalized patients with IBD.^{36,37} The decision of whether to continue prophylactic anticoagulation after hospital discharge should be considered on an individual basis for patients who are at especially high risk of developing VTE, such as recent surgery (within 3 months), active malignancy, lower limb trauma, immobilization, or thrombophilia, although there are insufficient data to support this practice.³⁴

Best Practice Advice 6: Hospitalized adult patients with severe UC should be counseled on the potential need for colectomy and should have a timely referral for surgical consultation.

Overall, 10% of hospitalized patients with UC will require surgery.³⁸ Although medical management of IBD is the initial first-line treatment in the absence of peritonitis or bowel ischemia, it is important to anticipate the potential need for surgery and discuss this with patients, assess and monitor surgical risk, and engage the surgical team early during hospitalization. Toxic megacolon is a highly morbid complication of IBD that presents with acute colonic dilation (ie, >6 cm dilation of the transverse colon and loss of haustral pattern) and should be suspected in the context of systemic toxicity without intestinal obstruction. Toxic megacolon can be precipitated by infection (eg, *C difficile* or CMV), antimotility agents, or electrolyte derangements, and often requires emergent surgery. Timely surgical consultation and multidisciplinary care can reduce mortality and improve patient satisfaction with care.^{39,40} Therefore, transfer to a high-volume IBD center should be considered for patients who are initially managed in a community hospital but do not respond to medical treatment or are at risk of developing an IBD-related complication. Although perioperative stress-dose corticosteroids are sometimes administered to patients with prolonged corticosteroid use to prevent complications related to secondary adrenal insufficiency, recent systematic review data suggest there is no beneficial role to this practice.^{41,42} An enhanced recovery after surgery protocol should be followed to reduce perioperative complications.^{43,44}

Best Practice Advice 7: Hospitalized adult patients with severe UC should receive initial treatment with intravenous corticosteroids at a methylprednisolone 60-mg daily dose equivalent.

The first-line therapy for many hospitalized patients with severe UC is still intravenous corticosteroids, which are efficacious for initial disease response and can predict the need for colectomy. Intravenous corticosteroids offer benefit over outpatient oral corticosteroids, but there may be situations in which corticosteroids are contraindicated and other inpatient treatments (eg, infliximab) or surgery are required instead. The optimal dosing of intravenous corticosteroids is methylprednisolone 40–60 mg or equivalent delivered via bolus, split throughout the day, or continuous infusion. A greater than methylprednisolone 60-mg daily dose equivalent confers no additional benefit, while increasing the risk of adverse effects.⁴⁵ It is the authors' general practice to use methylprednisolone 60 mg daily in 2 or 3 divided doses. However, doses as low as methylprednisolone 40 mg daily or equivalent can be

considered in patients at high risk of corticosteroid-related adverse events. Initiation of corticosteroids should not be delayed while awaiting the results of pathogen testing (eg, *C difficile* or CMV) and should not be discontinued if these pathogens are detected and treatment for the pathogens initiated concurrently.²² Although existing data for inpatient infliximab, cyclosporine, and emerging data on JAK inhibitors for induction treatment have all been in conjunction with intravenous corticosteroids, there is ongoing interest in more limited use of intravenous corticosteroids or corticosteroid avoidance strategies (eg, JAK inhibitor monotherapy for induction treatment).

Best Practice Advice 8: Hospitalized adult patients with severe UC should be monitored for treatment response within 72 hours of medical treatment initiation.

The short half-life of serum CRP (ie, 19 hours) makes it valuable in assessing day-to-day treatment response in the inpatient setting.^{26,46} In ASUC, corticosteroid treatment response can be assessed by means of evaluating changes in stool frequency and CRP on day 3 of corticosteroid treatment, and is predictive of future colectomy (this is known as the Oxford criteria).⁴⁷ Clinical data suggest that 85% of patients with UC receiving 3 days of corticosteroids who continue to have either 8 or more bowel movements daily or 3–8 bowel movements daily with a CRP >4.5 mg/dL will require colectomy.⁴⁷ Continuing intravenous corticosteroid treatment beyond 7 days in the setting of nonresponse provides no incremental benefit at the expense of the risk of complications and mortality.^{48,49} Bedside intestinal ultrasound can also be used to monitor inpatient treatment response. Data suggest that significant changes in bowel wall thickness can be seen on intestinal ultrasound as early as 48 hours after corticosteroid initiation in treatment responders, although the feasibility and impact of intestinal ultrasound and its prognostic value in inpatient IBD care need to be further elucidated.⁵⁰

Best Practice Advice 9: Preparations should be made for initiating rescue therapy in hospitalized adult patients with severe UC who are not responsive to intravenous corticosteroid treatment.

Hospitalized patients with severe UC should have their treatment plan re-evaluated and preparations for rescue or salvage therapies initiated early in the admission (Figure 1). After initiation of intravenous corticosteroids, medication options include infliximab, cyclosporine, and JAK inhibitors.²⁴ The choice of rescue and salvage therapy will depend on prior inadequate treatment responses, inflammatory burden, evidence of protein-losing colopathy (when small molecules like cyclosporine or JAK inhibitor may be preferred), and the comfort and experience of the treating physician. The optimal infliximab dosing for ASUC is not yet known. There is emerging data that accelerated infliximab dosing may not be more effective than standard infliximab dosing for ASUC. In a recent multicenter study of hospitalized adult patients with ASUC, there was no significant difference in clinical response at day 7 for patients who received an intensified infliximab strategy (initial dosing of infliximab 10 mg/kg, followed by a second dose

within the first 7 days for nonresponse) vs standard infliximab induction strategy (initial dosing of infliximab 5 mg/kg).⁵¹ Furthermore, there was no significant difference in clinical response at day 14 or colectomy at 3-month follow-up for patients who received accelerated induction (infliximab 5 mg/kg at weeks 0, 1, and 3) vs standard induction (infliximab 5 mg/kg at weeks 0, 2, and 6).⁵¹ However, these findings cannot necessarily be generalized to all patients with ASUC; therefore, we continue to consider accelerated infliximab dosing (eg, 10 mg/kg rather than 5 mg/kg induction) for patients at risk of infliximab treatment failure secondary to protein-losing colopathy (ie, low albumin, high CRP, and deep colonic ulcers). Similarly, the optimal dose of JAK inhibitors for ASUC treatment is not yet known, although both standard (eg, tofacitinib 10 mg twice daily and upadacitinib 45 mg daily) and off-label, high-intensity inpatient doses (eg, tofacitinib 10 mg 3 times daily for 9 doses, upadacitinib 30 mg twice daily) have been used effectively with reasonable safety profiles.^{52,53} Patients initiating JAK inhibitors should receive a vaccination against varicella zoster, but treatment initiation should not be delayed at the expense of vaccination.⁵⁴ The recombinant vaccine can be administered after the JAK inhibitor is started and the patient is discharged from the hospital.

Best Practice Advice 10: In hospitalized adult patients with CD and intestinal obstruction, medical treatment with intravenous corticosteroids should be considered when there is evidence of active inflammation.

Patients with CD and intestinal obstruction often present with abdominal distention, nausea, and vomiting, without stool or gas passage. In the absence of signs of peritonitis or bowel ischemia, patients should be managed initially with bowel rest, nasogastric decompression, and intravenous fluid and electrolytes (Figure 2). CT abdomen and pelvis with intravenous contrast (without oral contrast) is usually sufficient to evaluate for bowel obstruction, determine whether the obstruction is due to an intestinal stricture (whether fibrotic or inflammatory) or intra-abdominal adhesions, and rule out perforation.^{55,56} If an intestinal stricture is predominantly fibrotic or complicated by perforating disease or abscess or abscesses, surgery is indicated. Alternatively, if bowel inflammation is present, most guidelines recommend intravenous corticosteroids; however, some retrospective studies suggest that corticosteroids do not reduce length of stay or the need for surgery.⁵⁷ Surgical guidelines recommend tapering to prednisone 20 mg daily equivalent preoperatively if possible to reduce risk of postoperative infectious complications.⁵⁸ Several prospective studies also suggest that intestinal strictures may be responsive to adalimumab, especially intensive (ie, weekly) treatment.^{59,60} Although evidence is limited, there is no clear role for endoscopic dilation in the setting of acute intestinal obstruction. After resolution of an acute obstruction, both CT and MR enterography are reliable for determining the severity of an intestinal stricture, stricture length, and degree of proximal bowel dilation. The bowel wall thickness at the level of the stricture is associated with severity, and the degree of

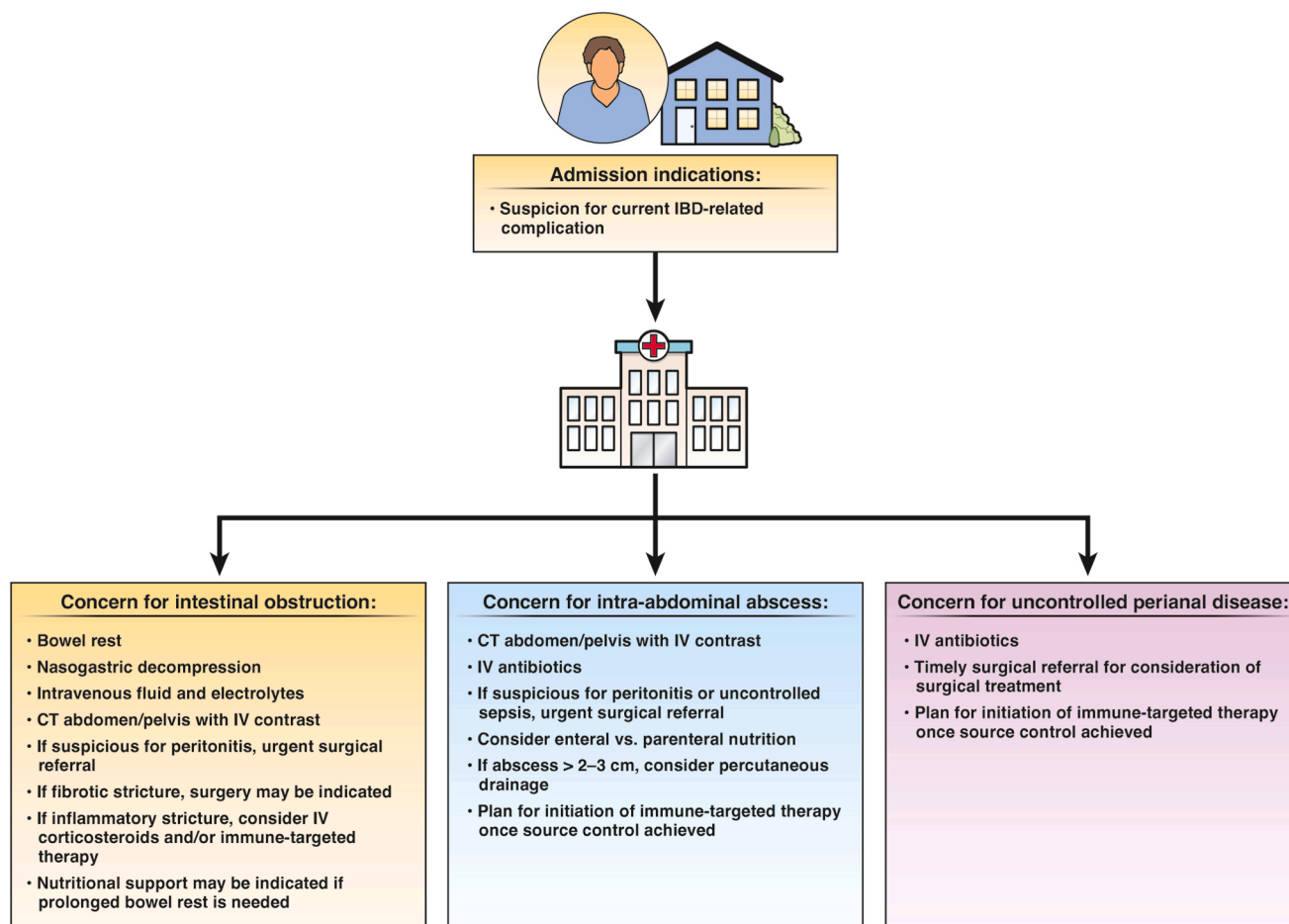


Figure 2. Flow diagram of the inpatient evaluation and management of CD-related complications.

bowel dilation proximal to a stricture may have the strongest association with need for surgery in the near-term.^{61,62} An endoscopic balloon-assisted dilation could also be considered for short-segment (<5 cm) noninflammatory strictures after resolution of the acute intestinal obstruction.⁶³ Nutritional support may be indicated if prolonged bowel rest is needed (ie, more than 7 days) or if there is pre-existing malnutrition or high risk of developing malnutrition.

Best Practice Advice 11: In hospitalized adult patients with CD and an intra-abdominal abscess, treatment should include infection control with abscess drainage (depending on size and location) and systemic antibiotics, as well as decision making regarding further medical or surgical management.

Patients with CD and intra-abdominal abscesses often present with abdominal pain and systemic signs of infection, such as fever, chills, or tachycardia. Intra-abdominal abscesses may result from uncontrolled transmural inflammation or strictures, and their characteristics (including size and location) can be delineated on either CT or MR imaging with intravenous contrast. Once an abscess is identified, a timely multidisciplinary discussion with colorectal surgery, interventional radiology, and gastroenterology is required to coordinate a treatment plan

(Figure 2). Initial medical treatment requires intravenous antibiotics with gastrointestinal flora coverage (eg, ciprofloxacin and metronidazole). Patients who present with peritonitis or uncontrolled sepsis require urgent surgical management.⁶⁴ In patients without clinically significant stricturing disease, an oral diet can be resumed. Exclusive enteral nutrition has been found to improve outcomes, including reduced rates of abscess recurrence, need for surgery, and need for stoma creation in select patients with percutaneously undrainable abscesses.⁶⁵ However, in the presence of a symptomatic stricture, malnutrition, or inability to tolerate an enteral diet, parenteral nutrition may be necessary.¹⁸ In these complex situations, patients should be comanaged with a dietitian.¹⁸

If an intra-abdominal abscess is >2–3 cm, percutaneous drainage should be pursued along with antibiotic treatment and nutritional optimization.^{24,58,66} In cases of large (>2–3 cm) percutaneously undrainable abscesses, treatment can be trialed with intravenous antibiotics and subsequent surgical management pursued if there is a lack of clinical response or clinical deterioration. Although infection control is critical, management of uncontrolled transmural inflammation is also important to prevent further complications. Therefore, treatment with steroid-sparing immune therapies is acceptable once source control is achieved

using antibiotics and/or drainage.²³ Definitive intestinal resection may be required, especially in the presence of a clinically significant intestinal stricture with proximal dilation or recurrent abscess formation. However, similar rates of abscess recurrence have been reported in patients with CD and abscess resolution who receive anti-tumor necrosis factor (TNF) therapy, regardless of whether they underwent intestinal resection.⁶⁶

Best Practice Advice 12: Hospitalized adult patients with CD and active perianal symptoms should have a multidisciplinary treatment approach involving both medical and surgical care.

Patients with CD and perianal disease, including fistulas or abscesses, often present with perianal pain or drainage. These patients are best served using a combined medical and surgical approach (Figure 2). Examination under anesthesia with incision and drainage of abscesses followed by seton placement are important immediate steps. Contrast-enhanced cross-sectional imaging (CT or MR) may further delineate complex fistula tracts or perianal abscesses.²³ The combination of surgical therapy, antibiotics, and anti-TNF therapy is considered the optimal approach for managing perianal fistulas and abscesses.⁶⁷ The efficacy of steroid-sparing immune therapies beyond anti-TNFs is less well established. Several outpatient interventions could also be considered, including but not limited to, fistulotomy for superficial fistulas, advancement flap in the absence of rectal inflammation, and ligation of the intersphincteric fistula tract. For patients with severe refractory disease, diverting colostomy or ileostomy can be a temporizing measure, recognizing that not all patients will undergo successful ostomy closure (due to patient preference or recurrence after re-establishment of intestinal continuity).

Best Practice Advice 13: Stability of treatment response should be achieved before discharge, and a clear discharge transition plan established.

IBD-related hospital readmissions are common and can lead to increased morbidity and cost for patients and health systems. Therefore, discharge planning is critical to successful inpatient IBD care. Hospital discharge is appropriate after resolution or stabilization of the acute admission indication and does not necessarily require normalization of inflammatory biomarkers (eg, CRP) or imaging findings. Inpatient monitoring is not required for hospitalized patients transitioning from intravenous to oral systemic corticosteroids, but may be indicated in select patients who are at high risk of failing oral corticosteroid treatment (eg, readmitted patients). A clear transition plan should be developed for patients as they transition to an outpatient medical or post-surgical regimen. This plan should include identification and communication with responsible outpatient clinicians and patient education on the treatment transition plan (eg, corticosteroid tapering plan and outpatient infusion scheduling), as well as indications for communicating with the medical team. Finally, any social determinants or barriers that may negatively impact discharge should be identified early and addressed, including prior authorizations for new medication

prescriptions, copay affordability, and transportation challenges to future appointments.

Future Directions

This Expert Review is intended to provide advice for inpatient IBD care, including indications for admission, initial evaluation, and treatment algorithms for managing uncontrolled inflammation or IBD-related complication (Supplementary Material). There are several ways in which inpatient IBD care has recently evolved. First, patients are more likely to be hospitalized for failing outpatient medical management than an acute fulminant presentation, creating a need for refining admission criteria. Second, because many risk factors for VTE in IBD are not limited to the inpatient setting, there are growing questions as to the benefit of continuing prophylactic anticoagulation on hospital discharge. Third, there is a growing interest in JAK inhibitors as an initial (potentially corticosteroid sparing) inpatient treatment option for ASUC, although optimal inpatient dosing and effectiveness in ASUC are yet to be demonstrated. Finally, intestinal ultrasound is used increasingly as a diagnostic tool for assessing intestinal inflammation and complications, and monitoring treatment response, but its role in inpatient IBD care needs to be further elucidated.

Supplementary Material

Note: To access the supplementary material accompanying this article, visit the online version of *Gastroenterology* at www.gastrojournal.org, and at <http://doi.org/10.1053/j.gastro.2025.08.039>.

Video

To view an accompanying video interview with the author, please visit the online version of the article at <https://doi.org/10.1053/j.gastro.2025.08.039>.

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Author Contributions

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Conflicts of interest

These authors disclose the following: Jana G. Hashash has served on the advisory board for Bristol Myers Squibb. Edward V. Loftus Jr has consulted for AbbVie, Abivax, Astellas, Avalo, Biocon, Bristol Myers Squibb, Celltrion, Eli Lilly, Fresenius Kabi, Genentech, Gilead, Iota Biosciences, Iterative Health, Janssen, Morphic, Ono Pharma, Takeda, and TR1X Bio; has received research support from AbbVie, Genentech, Gilead, Janssen, Merck, and Takeda; and is a shareholder of Exact Sciences and Moderna. David T. Rubin has served as a consultant for AbbVie, Abivax SA, Altrubio, Avalo Therapeutics, Bausch Health, Bristol Myers Squibb, Buhlmann Diagnostics Corp, Celltrion, ClostraBio, Connect BioPharma, Eli Lilly & Co, Foresee, Genentech (Roche) Inc, Image Analysis Group, InDex Pharmaceuticals, Iterative Health, Janssen Pharmaceuticals, Pfizer, Sanofi, Takeda Pharmaceuticals, and Vedanta; and has served on the Board of Trustees for the Crohn's & Colitis Foundation and on the Board of Directors for Cornerstone Health. The remaining author discloses no conflicts.