**Assess for the presence of risk factors:**

Autoimmune in origin exact etiology unknown
IBD has a familial tendency
Ulcerative colitis tends to occur in people in their mid-30s, although the disease can occur at any age.
Crohn's disease may occur in people of all ages, but it is primarily a disease of adolescents and young adults, affecting mainly those between 15 and 35.
Ulcerative colitis can tend to run in families
Males and females appear to be affected equally.
The prevalence rates among Hispanics and Asians are lower than those for whites and African Americans.
Crohn's is more common in urban than in rural areas, and in northern than in southern climates

Source: [http://www.ccfa.org/info/about/crohns](http://www.ccfa.org/info/about/crohns), [http://www.ccfa.org/info/about/ucp](http://www.ccfa.org/info/about/ucp)

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**Monitor for s/s of IBD:**
- Fatigue, anemia, weight loss, fever, GI distress, associated Arthralgia
  - Ulcerative colitis
    - Bloody diarrhea.
    - Pain is uncommon but may occur.
    - Toxic megacolon
    - Colorectal cancer
  - Crohn disease
    - Abdominal pain and diarrhea.
    - Strictures and obstructions
    - Fistulae and perianal disease
    - Small intestine malignancy

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**Are positive findings present?**

**YES**
- Follow plan of care for an exacerbation of IBD
  - See plan of care for GI bleeding
  - See plan of care for bowel obstruction
  - See plan if care for colorectal cancer

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**NO**
- Are Risk Factors Present?
  - Yes
  - Initiate client education for Health Seeking Behaviors to identify:
    - Teach client about signs and symptoms of inflammatory bowel disease especially if there is a family history
    - Don’t smoke
  - No
  - Follow plan of care for Risk for ineffective therapeutic regimen management: PUD meds, procedures and lifestyle modifications
    - Discuss disease process and characteristics of exacerbation and remission and life long increased risk for malignancy
    - Review procedures/testing; colonoscopy
    - Eat a low residue diet when experiencing exacerbations
    - Drink plenty of fluids when having diarrhea
    - Avoid milk products if lactose sensitive
    - Use NSAIDS and ASA sparingly until its link to intestinal inflammation is clarified
    - Avoid smoking to reduce flares of IBD
    - Take vitamins and B12 as prescribed
    - Take immunosuppressive therapy as prescribed and report adverse effect
    - Discuss surgical interventions; intestinal diversions
    - Teach s/s of Potential complications:
      - Fistulas, Obstruction, Bleeding, malnutrition, malignancy
    - Review diagnostic testing and Periodic assessment
    - Seek consultation if experiencing an exacerbation of disease
Collaborative Problem

**Potential Complication: IBD Flare**

**ASSESS s/s of the IBD Flare**

**Fatigue, anemia, weight loss, fever, GI distress, associated Arthralgia**
- **Ulcerative colitis**
  - Bloody diarrhea.
  - Pain is uncommon but may occur.
  - Toxic megacolon
  - Colorectal cancer
- **Crohn disease**
  - Abdominal pain and diarrhea.
  - Strictures and obstructions
  - Fistulae and perianal disease
  - Small intestine malignancy

Assess for contributing factors:
- Physical or psychological stressors, smoking, possible aspirin or NSAID use, nonadherence or ineffective anti-inflammatory therapy

**Monitor for presence of an IBD Flare**

- Monitor bowel pattern, frequency, quality and characteristics
- Monitor results stool specimens cultures to rule out infectious origin.
- Monitor results of inflammatory bowel disease serology if performed (ANCA, ASCA)
- Monitor for elevations in ESR indicating inflammation
- Monitor reports from colonoscopy performed during periods of remission
- Monitor BMP to evaluate for electrolyte depletion and dehydration
- Monitor I/O
- Monitor FOBT testing results
- Monitor baseline weight and weekly assessments during acute flare

Additional assessment includes monitoring from presence of complications of an IBD Flare

- Monitor H&H to evaluate blood loss and iron, folic acid and B12 to evaluate nutritional deficiencies
- Monitor urine for fecal matter
- Monitor abdomen for peritoneal signs and abdominal x-rays for s/s of obstruction
- Monitor results from small bowel series to evaluate degree of inflammation and stricture

**DO**

Perform nursing actions that correct IBD Flare
- Keep NPO
- Insert Salem Sump nasogastric tube and connect to continuous low suction (maintain patency according to MD order and hospital protocol)
- Establish IV access and administer IV crystalloids with electrolytes as prescribed
- Administer anti-inflammatory medications and monitor effectiveness
- Administer antidiarrheals and antispasmodics for diarrhea and cramping
- Obtain nutritional consult
- Administer parenteral nutrition if indicated
- Administer vitamins and minerals as prescribed
- Prepare client for surgical intervention; proctocolectomy with ileostomy and total colectomy with ileoanal anastomosis. And surgical resection in Crohn’s
- Treat complications:
  - Prepare to transfuse client with PRBCs to maintain hemoglobin between 8-10
  - Withhold any prescribed agents that promote inflammation such as NSAIDS

**CALL**

- Prepare client for surgical intervention if toxic megacolon is present refractory to anti-inflammatory medication in UC
- Monitor for declining Hemoglobin and Hematocrit, s/s of perforation and peritonitis, fistula formation, obstruction in IBD
  - If present, Initiate more frequent hemodynamic monitoring
  - Perform shock management & call ready response team and MD

**OUTCOMES/BENCHMARKS:**

- No diarrhea or abdominal pain, increased fever, fatigue
- Hgb and Hct WNL, no frank blood in stool
- No abdominal distention or abrupt decline on # of BMs
- No unintentional weight loss
- No enterocutaneous or enterovesical fistulas noted