This guideline is currently under review. In the interim, the guideline remains valid; if GPs have any specific concerns or questions, they should seek advice from the specialist with whom they have agreed to share care.

North and East Devon Healthcare Community Shared Care Guidelines

Sulfasalazine Enteric Coated for Inflammatory Bowel Disease

Key changes to updated guideline (ratified 2011)

1. Background to revisions

This guideline has been revised as part of the new process for shared care guidelines. The sections on specialist, GP and patient responsibilities and monitoring requirements are consistent with the updated shared care guideline for sulfasalazine for rheumatological conditions.

2. Specialist responsibilities

- New statement: ascertain patient's immune status by enquiring about history of chickenpox.

3. GP responsibilities

- New statement: brand prescribing recommended.

4. Monitoring

4.1 Baseline monitoring

Conducted by gastroenterology team

- Folate and vitamin B12 added to tests.

4.2 Monitoring during treatment

Conducted by primary care

4.2.1 New tests

U&Es and creatinine added to monitoring at same frequency as FBCs and LFTs.

4.2.2 Change to frequency of monitoring

- Monitoring of FBC and LFTs has changed from monthly for three months then three monthly thereafter to every two weeks for three months then three monthly thereafter (for consistency with rheumatology guideline).
- New advice on monitoring following dose increase

4.2.3 Action to be taken by GP including changes to criteria for stopping treatment and referral to specialist

- Neutrophil count added to FBC tests to check
- New advice for FBC tests in response to GP questions. If concerned, about sequential drops in FBC indices (possibly still within normal range) consider early retest
- New advice to refer if rise in MCV and no cause identified
- LFTs: threshold for action changed. Early next test if >2 x ULN, stop treatment and refer if > 3 x ULN.
- New advice if deterioration in renal function.
- Clarification of advice: patients reporting specific signs or symptoms should be seen within 24 hours for FBC and LFTs.

- Abnormal bruising, severe sore throat, severe oral ulceration and unexplained illness including severe nausea, vomiting or diarrhoea added to criteria for stopping treatment and referral.
- New advice for rash. Stop treatment and urgent referral to dermatology recommended for unexplained acute widespread rash.

4.3 Other statements

- New advice on what to do if patient requires surgery
- New advice on action to be taken if patient, who is not immune to chickenpox, comes into contact with chickenpox or shingles

Clinical Effectiveness Team, Public Health, NHS Devon
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