Gastrointestinal Immune-Related Adverse Event Management Algorithm

Grading of diarrhoea	Action	Follow up
Grade 1 Increase of <4 stools per day Mild increase in ostomy output compared to baseline Clinically well with normal vital signs	**Investigations** • Baseline bloods: FBC, CRP, U&E, LFTs, full TFTs, cortisol • Faecal calprotectin • Stool culture including C.difficile **Management** • Continue ICI therapy • Low fibre diet, spasmolytic	**If remains stable / resolves:** • Early review within 1-2 weeks • Monitor closely and advise patient to report worsening symptoms immediately • Ensure patient is completing stool diary **If worsens / persists >15 days or deranged U+Es:** • Treat as G2 or 3/4
Grade 2 4-6 stools per day over baseline / moderate increase in ostomy output compared to baseline	**Investigations** • As per G1 • Stool chart, faecal elastase • Whole blood PCR CMV • Consider viral pathogen screen e.g. Norovirus • Flexible sigmoidoscopy [a] **Management** • Hold I-O therapy • Start oral prednisolone 1mg/kg/day (maximum 60mg OD) • PPI cover	**Review in 1 week.** **If improves to G1:** • Taper oral steroids over 8 weeks (see separate steroid-weaning document) • Resume I-O therapy **If worsens or persists more than 5-7 days with steroids:** • Treat as G3/4
Grade 3 – 4 7 or more stools per day over baseline / severe increase in ostomy output Severe or continuous abdominal pain Fever 37.8oC Tachycardia over 90bpm Dehydration Consider: Rising CRP or CRP over 30 if previously normal Falling Hb or Hb less than 105g/L if previously normal Falling albumin or low albumin if previously normal	**Investigations** • As per G2 • Pre-biologics screen • AXR • CTAP if persistent pain, peritonitic or febrile **Management** • Discontinue I-O therapy • Admit patient • 1mg/kg/day IV Methylprednisolone OD (+ PPI) • IV fluid replacement • Daily U&Es with fluid balance chart • Continue accurate stool chart • Refer to gastroenterology	**If symptoms resolving:** • Continue IV for at least 3-5 days then switch to PO prednisolone 1mg/kg OD (maximum 60mg OD) and taper as per standard regimen **If symptoms persist more than 3-5 days or recur after improvement:** • Refer to gastroenterology for ongoing guidance • Add infliximab (5mg/kg if no contraindication) workup on next page **If persists more than 3-5 days or worsens after infliximab:** • Consider switching to other biologics guided by gastroenterology [b] • Consider early transfer to gastroenterology ward 7F [c] • Refer to surgeons for consideration of colectomy

Additional information:

- Any patient with I-O colitis should NOT be commenced on Loperamide. This will mask the symptoms of colitis without addressing the underlying cause.
- [a] If biopsies from endoscopy show microscopic colitis, switch steroids to Budesonide 9mg OD for 6 weeks, then reduce to 6mg OD for one week, then to 3mg OD for another week then stop.
- [b] E.g. high dose infliximab, ustekinumab, tofacitinib, faecal microbiota transplantation, extracorporeal photopheresis.
- [c] Consider early transfer of IO colitis inpatients refractory to infliximab and/ or vedolizumab to the gastroenterology ward 7F if not improving in 48-72hrs after dose through consultant to consultant discussion. Once transferred, acute oncology service can consult at JRH.
- Infliximab Workup: to include- TB Quantiferon test, hepatitis screen, HIV, varicella zoster anti-bodies (IGG antibody), chest X-Ray (if chest CT not already performed)

Issue date:	08.01.2025
Version No:	2.0
Authors:	Anil Babar Alekhia Nippani Vincent Cheung