Ulcerative colitis

Here we summarise the recent NICE guidance on the management of ulcerative colitis picking out the most pertinent bits for primary care. But first a reminder about presentation and when to suspect the diagnosis (BMJ 2013;346:f432).

What is ulcerative colitis and who gets it?

- Ulcerative colitis is the most common type of inflammatory bowel disease in the UK affecting 1 in 200 adults.
- It is most commonly diagnosed between age 15 and 25y but there may be a second peak between 55 and 65y.
- The cause is unknown.
- Superficial and continuous inflammation starting in the rectum and extending variably proximally through the bowel.
- Smoking protects against developing ulcerative colitis (but not Crohn’s disease).
- There is a genetic link with an 8x increased risk in individuals with an affected first degree relative.

Presentation and diagnosis

The most common presenting features are:

- Rectal bleeding and bloody diarrhoea.
- Abdominal pain.
- Faecal urgency and tenesmus.

Ulcerative colitis is also linked with other autoimmune diseases and these affect 30% of those diagnosed. Common associated conditions include:

- Liver: autoimmune liver disease and primary sclerosing cholangitis.
- Joints: seronegative arthropathy, ankylosing spondylitis and sacroilitis.
- Eye: scleritis, episcleritis and anterior uveitis.
- Skin: erythema nodosum and pyoderma gangrenosum.

Consider the diagnosis in any individual presenting with these symptoms – neither NICE nor the BMJ discuss primary care investigations – I suspect most of us would check FBC, ESR, CRP and stool cultures and refer for colonoscopy which is the gold standard for diagnosis!

Management of ulcerative colitis

NICE produced guidance on the management of ulcerative colitis in 2013 – unhelpfully for GPs, they did not consider diagnosis (NICE 2013; CG 166). Clearly much of this guidance is focused on secondary care but I have picked out the important bits for GPs – mainly so we understand why certain drugs are selected in certain situations and what monitoring is required. Note that the management does differ from Crohn’s disease which is discussed separately.

NICE on management of ulcerative colitis

How can we decide if a flair is mild, moderate or severe?

I thought these criteria were useful when we are assessing an ulcerative colitis patient in primary care – NICE recommends the Truelove and Witts’ severity index:

<table>
<thead>
<tr>
<th>Mild to moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of bowel movements per day</td>
<td>&lt;6 stools</td>
</tr>
</tbody>
</table>
Inducing remission:

**Step 1: mild to moderate ulcerative colitis**

These are individuals with mild to moderate symptoms or an exacerbation of proctitis or proctosigmoiditis:

- Offer topical aminosalicylates (e.g. mesalazine, olsalazine or sulfasalazine) as suppositories or enemas.
- **Add** an oral aminosalicylate if not responding.
- Oral aminosalicylates alone are not as effective as topical or combined treatment.

For individuals with more extensive left sided or pancolitis:

- Offer high dose oral aminosalicylates.
- Add topical aminosalicylates or oral beclomethasone dipropionate.

In both cases, if aminosalicylates are contraindicated (e.g. aspirin allergy) or not tolerated consider topical steroids or oral prednisolone. If no improvement is seen after 4w or if symptoms deteriorate despite treatment:

Consider adding oral prednisolone – no dose recommended – see details of BNF doses in Crohn’s section. **If there is no response to this after 2–4 weeks consider oral tacrolimus.**

*We may be involved in prescribing and shared care for these patients.*

**Step 2: Acute severe ulcerative colitis**

Clearly these patients require admission and hospital treatment.

- Consider IV corticosteroids.
- Consider adding IV cyclosporine or infliximab.
- Consider surgery if no improvement within 72h of starting IV steroids.

**Maintaining remission:**

- Once daily oral aminosalicylates are preferable for maintaining remission though may result in more side-effects than multiple doses.
- If remission is not maintained with oral aminosalicylates or if ≥2 exacerbations in 12m requiring steroids consider:
  - Oral azathioprine
  - Oral mercaptopurine.

*See drug dilemmas below for information about prescribing and monitoring.*

**Monitoring:**

<table>
<thead>
<tr>
<th>Blood in stools</th>
<th>Small amounts only</th>
<th>Visible blood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pyrexia (&gt;37.8 °C)</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Pulse &gt;90bpm</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Anaemia</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>ESR (mm/h)</td>
<td>≤30</td>
<td>&gt;30</td>
</tr>
</tbody>
</table>
Consider bone health in individuals with ulcerative colitis – they are at increased risk because of steroid use and systemic inflammation – see section on osteoporosis.

Monitor height, weight and pubertal status of children and young people receiving treatment.

Drug monitoring is discussed below.

**Cancer risk and surveillance**

There is a whole NICE Guideline on this topic (NICE 2011, CG118)! However, in brief, people with ulcerative colitis (other than just proctitis) or Crohn’s should be offered a colonoscopy and chromoscopy (dye sprayed during colonoscopy which increases detection of abnormal mucosa) 10y after diagnosis. Follow on colonoscopies are then scheduled according to the degree of abnormality seen. I’ve put a brief summary of this below, but the decision should be based on the colonoscopy findings. Our job is to ensure these colonoscopies occur at the appropriate time! In our practice we code the incoming colonoscopy result picking up the date for next scoping and then write to the endoscopy department when this date approaches.

**Diagram:**

- **Low risk**
  - Limited disease or extensive but quiescent
  - OR
  - Adenoma <10mm
  - Re-scope 5y

- **Intermediate risk**
  - Extensive disease but mild inflammation on biopsy
  - OR
  - First degree relative with colon cancer ≥50y
  - OR
  - Adenoma: several small adenomas or 1–2 larger adenomas
  - Re-scope 3y

- **High risk**
  - Extensive disease with moderate/severe inflammation on biopsy
  - OR
  - First degree relative with colon cancer <50y
  - OR
  - Stricture in last 5y
  - OR
  - 5+ small adenomas or ≥3 larger adenomas
  - Re-scope 1y
Ulcerative colitis

- Consider the diagnosis in young people presenting with bloody diarrhoea, abdominal pain and faecal urgency/tenesmus – refer for colonoscopy.
- Determine how severe a flair is using the Truelove and Witts’ index – >6 stools per day in a systemically unwell individual may require admission – others can be managed as outpatients.
- Oral and topical 5-ASAs are the mainstay of treatment both to induce and maintain remission.
- If these are ineffective, steroids, azathioprine/mercaptopurine or even surgery may be offered.
- Be aware of the dosing regimens and monitoring for these drugs and ensure you have robust systems to ensure patients attend and results are communicated.
- Colonoscopy and chromoscopy is required 10y after diagnosis and then at variable intervals after this for cancer surveillance.
- Remember bone health!

Do you have robust recall systems for toxic drug monitoring and colonoscopy referrals?

Crohn’s and Colitis UK: www.nacc.org.uk

We make every effort to ensure the information in these pages is accurate and correct at the date of publication, but it is of necessity of a brief and general nature, and this should not replace your own good clinical judgement, or be regarded as a substitute for taking professional advice in appropriate circumstances. In particular check drug doses, side effects and interactions with the British National Formulary. Save insofar as any such liability cannot be excluded at law, we do not accept any liability for loss of any type caused by reliance on the information in these pages.

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- Lead. Manage. Thrive! (location) ............................................................. (date).........................
- The Telephone Consultation Course (location) ............................................................. (date).........................
- The Effective Consultation Course (location) ............................................................. (date).........................
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