Clinician's guide to ulcerative colitis (UC) management

Disease severity*

SYMPTOMS:

- Diarrhoea
- Urgency of defecation or loss of control
- Nocturnal bowel movements
- Rectal bleeding – assess
- Abdominal pain or discomfort

S1 Mild: ≤4 stools/day without blood

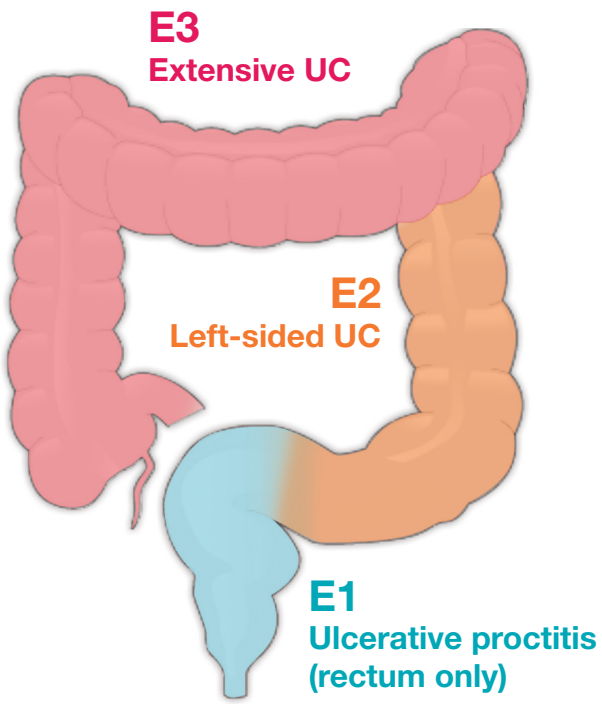
S2 Moderate: >4 stools/day, +/– blood but without systemic toxicity

S3 Severe: >6 bloody stools/day with any systemic feature

Red Flags: fever, anaemia, tachycardia, elevated erythrocyte sedimentation rate (ESR) or C-reactive protein (CRP), low albumin.

S3 of any extent, contact a gastroenterologist or admit to hospital.

Disease extent*



Investigations

RULE OUT INFECTION:

Stool microscopy and culture
(include *Clostridium difficile* toxin).

ASSESS CURRENT LEVEL OF INFLAMMATION:

- Blood tests: full blood count (FBC); liver function test (LFT); albumin; electrolytes, urea, creatinine (EUC); CRP; ESR.
- Faecal biomarker testing: calprotectin and/or lactoferrin.†

ADDITIONAL DIAGNOSTIC TESTS:

Colonoscopy and flexible sigmoidoscopy.

Management

Treatment should be based on disease extent and severity.

For active disease prescribe topical 5-aminosalicylic acid (5-ASA suppository, foam or enema) in addition to recommended induction doses of oral 5-ASA.

E1: 5-ASA rectal suppository (1 g/day)

E2 & E3: Oral 5-ASA (≥2.4g/day) + topical 5-ASA enema (≥1g/day)

- In active disease, combination oral and topical 5-ASA is more effective than either alone.

*Based on the Montreal classification of UC disease severity and extent. †Not currently covered by Medicare.

Maintenance

5-ASA MAINTENANCE THERAPY TO REDUCE THE RISK OF RELAPSE

Medication formulations should be given at ≥2 g/day. Check individual drug PI for more information (https://www.ebs.tga.gov.au).

- Lifelong therapy is recommended to reduce the risk of colon cancer. Refer to NHMRC guidelines on surveillance colonoscopy (https://wiki.cancer.org.au/australia/Guidelines).

OTHER CONSIDERATIONS:

- Psychological support (http://www.ibdclinic.org.au) and dietetic advice (https://www.monashfodmap.com) should be made available.
- When planning a pregnancy, patients should be referred to a gastroenterologist. Refer to ECCO guidelines on IBD in pregnancy (https://www.ecco-ibd.eu).
- IBD patients may be at increased risk of osteoporosis. Refer to BSG guidelines (https://gut.bmj.com/content/46/suppl_1/I1.long).
- Patients may benefit from participating in a patient support group, such as Crohn's & Colitis Australia (https://www.crohnsandcolitis.com.au).

Flares

INCREASE ORAL 5-ASA THERAPY TO INDUCTION DOSE AND CONSIDER ADDING RECTAL THERAPY DURING A FLARE

Medication formulations can be doubled (check individual drug PI for more information; they often recommend dosing up to 4.8 g/day, but most drugs can be safely increased to up to 6 g/day).

- Reassess symptomatic response in 1–2 weeks. If the patient does not respond to treatment, refer to a gastroenterologist.
- If symptoms persist despite 5-ASA, consider systemic corticosteroids. This should be done in consultation with a gastroenterologist, and a strategy for complete withdrawal should be developed.
- Patients who have steroid-dependent disease or have been using steroids more than once a year should be reviewed by a gastroenterologist. They may require azathioprine or 6-mercaptopurine.
- The most common cause of flares is non-adherence. Refer to MARS to assess patient adherence (http://pub.basecase.com/EvGWaXTPrR/).

Red Flags

REFER TO A GASTROENTEROLOGIST IF:

- severe (S3)
- family history of colon cancer
- pain
- unexplained weight loss
- symptoms persistent despite therapy

REFER TO HOSPITAL ADMISSION FOR TREATMENT IF:

- severe (S3) or extensive UC with any of the following signs of systemic toxicity:

  fever >37.8°C, anaemia (haemoglobin <10.5 g/dL), tachycardia (>90 bpm), elevated ESR >30 mm/h or CRP >30, low albumin.

Additional information

Gastroenterological Society of Australia (GESA):
http://www.gesa.org.au/resources/clinical-guidelines-and-updates/inflammatory-bowel-disease/

ECCO guidelines: https://www.ecco-ibd.eu

References: 1. Harbord M et al. J Crohns Colitis 2017;11(7):769–784. **2.** Mowat C, Cole A, Windsor A et al. Gut 2011;60:571–607. **3.** Satsangi J, Silverberg MS, Vermeire S et al. Gut 2006;55:749–53. **4.** Selinger C, Eaden J, Jones D et al. Inflammatory Bowel Diseases 2013;19(10):2199–2206.

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