

Ulcerative Colitis:

A Case Study



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Abstract

A 28-year-old male presented to our office for a consultation about his bloody bowel movements. Colonoscopy revealed moderately active left-sided ulcerative colitis extending from the anal verge up to the mid-descending colon. He was prescribed both oral and rectal 5-ASAs for induction therapy, and is in remission. Appropriate patient education has helped him realize that the best chance of staying in remission is to continue on his medical therapy.

Key words: *ulcerative colitis, 5-aminosalicylate, medication adherence, dysplasia surveillance, rectal inflammation*

A 28-year-old male (R.B.) presented to our office for an initial consultation about his significant bowel issues. During the previous 4 months, he had noticed a change in his bowel routine, often having up to five bloody bowel movements in a 24-hour period (usually one of which occurred during the night). These bowel movements were preceded by significant abdominal cramps. R.B. had not lost any weight and had not experienced fever or chills, but he felt his energy had been less since his bowel routine had changed. R.B.'s symptoms were not preceded by any significant infectious exposures or antibiotic use.

Clearly high up on our list of possible diagnoses was ulcerative

colitis (UC); the test of choice to confirm this diagnosis was colonoscopy. To ensure that alternative processes were not contributing to R.B.'s presentation, we collected stool samples to test for infectious causes since the typical findings of *Clostridium difficile* colitis are not usually present on endoscopic assessment in presence of UC.

The colonoscopy revealed moderately active left-sided UC extending from the anal verge up to the mid-descending colon. Biopsies were taken at 40 cm from the anal verge, in the distal sigmoid colon and rectum. It is important to determine *before* treatment begins if there is rectal inflammation. In order to know whether a patient with left-



Key Point

Stool samples should be tested for infectious causes of bloody diarrhea.

sided disease will require dysplasia surveillance, you have to determine whether there is microscopic inflammation proximal to 35 cm from the anal verge. Therefore, if on endoscopy the inflammation appears to stop before this level, it is critical to take biopsies prior to beginning therapy. This allows you to better counsel patients on their long-term cancer risk.

Discussion and Case Update

Treatment options for moderately active left-sided UC include oral/rectal 5-aminosalicylates (5-ASAs) and steroids. If possible, the goal for treating patients with UC includes avoiding steroid exposure as this medication carries the most risk compared with any standard medical therapy indicated for treatment of UC. For treatment, R.B. was prescribed both oral (3.0 g) 5-ASA and rectal (4 g enemas) 5-ASA for induction therapy. The choice of which oral or rectal 5-ASA is likely of little relevance as there is no convincing evidence that any particular brand is more effective than others. Once-daily dosing of the oral 5-ASA appears to be the best way to use this class of medication regardless of the brand.

This treatment regimen is the optimal approach for induction of remission; however, this plan must involve appropriate education. R.B. had to learn how to properly administer an enema (Figure 1). This method of drug delivery can be challenging for many patients, so you have to clearly explain to them why this component of their treatment plan is important.

R.B. was seen two months later. This follow-up visit served two purposes. The first goal was to ensure that R.B. was in remission.

THIS TREATMENT REGIMEN IS THE OPTIMAL APPROACH FOR INDUCTION OF REMISSION; HOWEVER, THIS PLAN MUST INVOLVE APPROPRIATE EDUCATION.

Clinical remission is an acceptable outcome; it is controversial whether endoscopic remission should also be achieved. Obtaining endoscopic remission has been shown to be an important predictor of reducing the risk of subsequent flares and even colectomy.^{1,2} The second goal of this visit focused around the importance of using medical therapy to maintain remission. R.B. has to understand why we do what we do when it comes to the treatment of UC. He needs to realize that although we have effective and safe medication for treating UC, we cannot cure this disease—this means that the best chance of staying in remission is to continue on his medical therapy.

R.B. continues to take his oral 5-ASA when he is in remission, but he struggles with issues around medication adherence. Sometimes, because he is feeling well, he wonders if taking the medications is truly necessary. On the other hand, he knows that this medication is doing exactly what it is suppose to do—keep him in remission. Because of the time spent educating him about



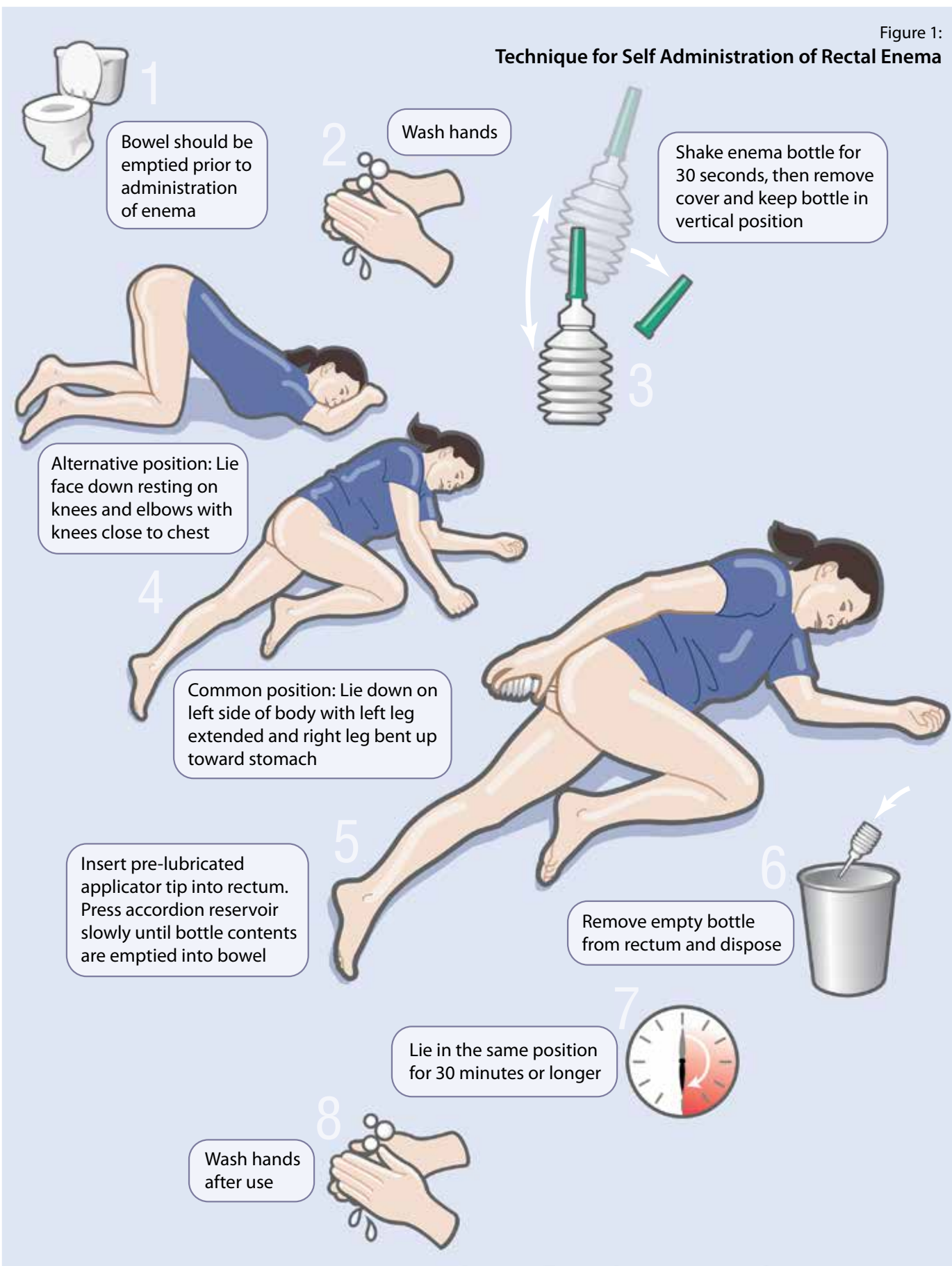
Key Points

Treatment with steroids should be avoided, if possible, as this medication carries the most risk.

In most cases, clinical remission is an acceptable outcome.

Figure 1:

Technique for Self Administration of Rectal Enema





Key Points

Stool samples should be tested for infectious causes of bloody diarrhea.

Treatment with steroids should be avoided, if possible, as this medication carries the most risk.

In most cases, clinical remission is an acceptable outcome.

In patients newly diagnosed with left-sided ulcerative colitis, if macroscopic evidence of inflammation stops before 35 cm from the anal verge, it is critical to take biopsies in the proximal left colon in normal-appearing mucosa to determine whether a patient with left-sided disease will require dysplasia surveillance.

UC and the rationale of maintenance therapy, R.B. continues to adhere to the treatment plan laid out at his follow-up visit. Assessing a patient's adherence and the possible barriers to it are important issues to cover at each follow-up visit.

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References

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Clinical Pearls

Patient education at each follow-up visit helps to ensure medication adherence.

We need to help patients understand that UC can be managed with medication, but not cured.