Ulcerative Colitis (UC)

Definition

Idiopathic chronic inflammatory disease of the colon that follows a course of relapse and remission. Occasionally UC is associated with extra-intestinal features. Disease always involves distal colon, but may extend proximally (without skip lesions) to the whole of the large bowel. Multiple small superficial ulcers, friable mucosa with contact bleeding, pseudopolyposis. Isolated colonic Crohn's disease may appear similar.

Epidemiology

Prevalence: 0.1% in the Western world.
Peak incidence: 10-40 yrs, but may affect any age

Aetiology

Unknown.
Probable response to env triggers (infection, drugs, or other agents) in genetically susceptible. 10-20% have family member with IBD. Ashkenazi Jews having a particularly high incidence. NSAIDs or infections may cause an exacerbation.

Presentation

Symptoms

- Bloody diarrhoea is cardinal symptom
- Also: colicky abdominal pain, bloating, urgency, or tenesmus.
- If only proctitis: may present with constipation and rectal bleeding.
- Systemic symptoms: malaise, fever, weight loss, and extraintestinal manifestations.

Signs

- Depending on disease severity, may be clearly unwell, ↑HR, pale, ↓BP, ↑T & dehydrated.
- Abdo exam may reveal tenderness, distension (?toxic megacolon) or palpable masses
- Clubbing

Severity

- Mild: <4 stools/day ± blood, no systemic disturbance, normal ESR/CRP
- Moderate: 4-6 stools/day ± blood, minimal systemic disturbance
- Severe: >6 bloody stools/day ± blood, systemic disturbance

Extraintestinal disease

- Anaemia (25%)
- Seronegative arthropathy affecting the wrists, hips, or knees (25%)
- Erythema nodosum or pyoderma gangrenosum (15%)
- Uveitis, iritis, or episcleritis (5%)
- Clubbing
- Aphthous ulcers
- Sacroiliitis, or ankylosing spondylitis
- Primary sclerosing cholangitis

Differential Diagnosis

- Crohn's disease
- Infective colitis
- Mild colitis may mimic irritable bowel syndrome

Investigations

Bloods: FBC, UEC, ESR (better than CRP), LFT
Stool: Culture, including ova, cysts and parasites and also Clostridium difficile toxin.
Imaging: AXR (exclude toxic dilatation and perforation) , sigmoidoscopy/colonoscopy and biopsy

Management

Resuscitation as needed

- Fluids
- If toxic megacolon suspected:
    - Urgent surgical review
    - Cease antidiarrhoeal agents, NSAID and opioid drugs.

Drugs

- Aminosalicylates – For relapses & maintenance: **mesalazine** (5ASA) [topical or oral, may ↓Ca.], **sulfasalazine** [sl.better for maint,but ↑SE], **olsalazine** [diarrhoea], **balsalazide**
- Corticosteroids for relapses. Topically (suppositories, liquid or foam enemas), **prednisolone** PO or **hydrocortisone** IV:
- **Azathioprine** or **mercaptopurine** for steroid-sparing or steroid-intolerance
- Immunosuppressants: in refractory cases – **cyclosporin**, **infliximab**, **tacrolimus**
- Stool bulking agents e.g. **ispaghula** if proximal constipation
- Antibiotics only if high suspicion of infection – e.g. **ampicillin** + **metronidazole**.

Treat any extraintestinal complications
Regular screening for colon Ca.
Surgery:

- If toxic megacolon >24hrs
- Severe disease unresponsive to 10 days corticosteroid therapy
- Chronic persisting colitis
- Dysplasia or cancer

Complications

- Colorectal cancer: ↑risk with ↑duration, ↑extent of disease & 1° sclerosing cholangitis
- Pouchitis: **Metronidazole** or **ciprofloxacin** x 2wks. **Mesalazine** or **steroids** if ineffective
- Osteoporosis: quite common.

Prognosis

- Generally good with optimal medical/surgical Mx.
- About 50% of patients with UC have a relapse in any year.
- 20-30% of patients with pancolitis require colectomy.
- Severe attack still a potentially life threatening.
- Toxic megacolon mort>30% if perfs.