The medical management of severe acute and chronic ulcerative colitis — Current recommendations from the Belgian Working group

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Case 1

A 50 y.o. male has an history of ulcerative colitis with a severe attack treated 5 years ago with steroids. He presents now with another severe attack (with fever and rectal bleeding) which do not responds to IV steroids.

Therapeutic options

- surgery (colonic resection, ileostomy, rectostomy) ;
- cyclosporin.

Case 2

A 50 y.o. male has a 10 years history of ulcerative colitis with pancolitis. He is in remission under mesalazine and azathioprine. A diagnosis of sclerosing cholangitis was made 5 years ago.

Options for the follow-up

- surgery (ileo-anal anastomosis) ;
- endoscopic follow-up.

1. All severe attacks of fulminant acute severe colitis should be managed by a joint medical and surgical team to avoid emergent complications, too early or too late or unnecessary surgery and ensure the patient is in good condition for surgery. The patient and patient's family should be kept well informed on the evolution of the clinical state.
2. Initial evaluation include Truelove's criteria with iterative evaluation of bowel movements, blood in stool, temperature, clinical state, heart rate, hemoglobin, albumin, CRP and plain abdominal X-ray. The combination of a toxic state of the patient and a colon diameter (on plian X-ray) greater than 5.5 cm or a progressive increase of diameter up to 8 to 10 cm are indicative of toxic megacolon with a risk of perforation.
   Stool cultures for bacteria, parasites and virus as well as virological determinations (such as CMV antigenemia) should be done initially and during the follow-up to diagnose initial or superinfected colitis. Proctoscopy with biopsies can be performed to confirm the diagnosis of ulcerative colitis and to exclude infective colitis.
   Barium enema and extensive colonoscopy with air insufflation should be avoided.
3. Supportive therapy includes intravenous fluids, electrolytes, and blood if the hemoglobin falls below 10 g/dl.
   Narcotic antidiarrheals should be avoided.
4. Corticosteroids (IV methylprednisolone, 20 to 30 mg every 12 hours according to body weight) should be started early on. IV cyclosporine (at a dose of 2 to 4 mg/kg/day as a continuous infusion) should be reserved for patients who failed to response after 5 to 10 days of steroids and the steroids are maintained at a tapering dose.
   Through levels (200 to 400 ng/ml) of cyclosporine should be monitored and drug interactions as well as potential infectious and non-infectious complication of this immunosuppressive regimen should be looked for. In patients at high risk (old age, heavy immunosuppression, malnutrition), prophylactic treatment against Pneumocystis carinii should be considered.
5. Response to intravenous cyclosporine is usually seen after 5 to 7 days.
   In case of failure, colectomy should be performed.
6. The use of antibiotics (metronidazole, ciprofloxacin) remains controversial. They may be indicated in case of transmural extension of the disease, risk of microperforation, systemic bacteremia and perioperative prophylaxis.
   The use of full doses of heparin is not recommended as controlled clinical trials are lacking.
7. The addition of 6 mercaptopurine/azathioprine (2-2.5 mg/kg/day) is recommended in all cyclosporine responders, for maintaining remission following response to medical therapy.
8. Failure of medical therapy is a good indication for surgery in diffuse chronic ulcerative colitis, but judging exactly when medical therapy has failed is not easy. Elective operation must be considered in case of intractable disease (persistent active disease, recurrent acute colitis, failure or complications of medical treatment and cancer prophylaxis (see #10).
9. Ileal pouch-anal and anastomosis is the optimal surgical procedure (three or two stage) which offers

cure of disease and good quality of life even if patients may suffer from the consequences of recurrent pouchitis or pouch failure.

10. Ulcerative colitis is associated with an increased risk of dysplasia and colorectal cancer. Disease duration (more than 10 years), extension (pancolitis) and concomitant primary sclerosing cholangitis are the major risk factors. In the presence of cancer or unequivocal high-grade dysplasia and/or dysplasia associated lesion or mass (DALM), protocolectomy is indicated. Regular surveillance colonoscopy is warranted in patients at risk. The pitfalls of surveillance colonoscopy and prophylactic colectomy should be discussed.
Patients with ulcerative colitis who develop an adenoma-like DALM that endoscopically and histologically resembles a sporadic adenoma may be treated with polypectomy and endoscopic surveillance.