Fulminant acute and diffuse chronic ulcerative colitis — the argument for surgery

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Introduction

There is little evidence based information on which to justify medical as opposed to surgical treatment for severe acute colitis — there are no randomised trials and only a few comparative series. Indeed the cornerstone of treatment over the last 20 years has been joint medical and surgical management, bringing the mortality of a severe attack down to 2% or less. Gastroenterologists will persist with medical treatment because they hope they can induce a remission, perhaps have an unrealistic view of effectiveness of their therapy and see surgical referral as a professional failure. Patients also hope for a remission, have unreasonable expectations of medical therapy and are misinformed as to the benefits, risks and complications of surgery. Surgeons too are often blind to the tough challenge an operation presents to our patients and easily forget complications and are uncritical of functional outcomes from restorative surgery.

Fulminant acute severe colitis

All severe attacks should be managed by a joint medical and surgical team to avoid unnecessary or too early surgery and ensuring the patient is in good shape if the patient does come to surgery. In a recent study involving 51 episodes of colitis we showed that after 3 days of intensive treatment patients with frequent stools (> 8 per day) or raised CRP (> 45 mg/l) were most likely to require colectomy. After 7 days patients with > 3 stools/ day or visible blood had a 60% chance of continuing symptoms and a 40% chance of colectomy in the following months (1).

With the advent of cyclosporin therapy and the RCT showing an 82% response rate in refractory colitis (2) several reports have confirmed its short-term effectiveness. In our experience over 5 years, 39 patients treated with cyclosporin had an initial response rate of 59% but this fell to 44% with a quarter of responders relapsing and undergoing colectomy. In Chicago (3) 42 refractory patients had cyclosporin with 62% avoiding colectomy overall, 6 had immediate surgery and 10 initial responders came to surgery after a mean of 6 months. It may well buy time for an elective colectomy in patients otherwise having emergency surgery.

In those patients on cyclosporin who fail and come to surgery there does not appear to be an increased complication rate. 57% had complications including ileus, DVT, wound infection and rectal stump dehiscence (4). In our study comparing 19 treated with cyclosporin and 25 with steroids alone, major complications occurred in 16 and 24%, and medical problems were equivalent (5). We found no evidence for an increased complication rate provided cyclosporin treatment was for a defined period and surgery no unduly delayed.

Diffuse chronic ulcerative colitis

The indications for surgery in chronic ulcerative colitis are well known. Failure of medical therapy is usually included, but judging exactly when medical therapy has failed is not easy. Quality of life studies comparing medical and surgical outcomes are few.

Much will depend on the age, occupation and wishes of the patient, the gastroenterologists view on the chances of success of long term therapy and the experience of the surgeon. Steroid dependent, steroid refractory and non compliant patients, and those increasingly found with osteoporosis should be considered for surgery. The miserable effects on function of a small contracted rectum with urgency and incontinence and patients with pre-cancer changes will also be candidates.

Restorative proctocolectomy is no panacea, it does not restore normality, but it does avoid a stoma. An honest balancing of the risks of medical therapy versus surgical outcomes will help patients make good long term decisions for themselves.

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