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.

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**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.

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**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 (2–4 g/day) + topical 5-ASA enema, foam and/or suppository

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

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*Based on the Montreal classification of UC disease severity and extent. *Not currently covered by Medicare.
5-ASA MAINTENANCE THERAPY TO REDUCE THE RISK OF RELAPSE

Medication formulations should be given at ≥1.5 g/day. Check individual drug PI for more information (www.tga.gov.au/hp/information-medicines-pi.htm).

- Lifelong therapy is recommended to reduce the risk of colon cancer. Refer to NHMRC guidelines on surveillance colonoscopy (https://www.nhmrc.gov.au/guidelines/publications/ext0008).

OTHER CONSIDERATIONS:

- Psychological support (http://www.ibdclinic.org.au) and dietetic support (http://www.med.monash.edu/cecs/gastro/fodmap) should be made available.


- IBD patients may be at increased risk of osteoporosis. Refer to BSG guidelines (http://www.bsg.org.uk/images/stories/clinical/ost_coe_ibd.pdf).

- Patients may benefit from participating in a patient support group, such as Crohn’s & Colitis Australia (http://www.crohnsandcolitis.com.au).

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

Medication formulations can be doubled to ~3 g/day (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/).

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


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