



CROHN'S & COLITIS
FOUNDATION OF AMERICA

Ulcerative Colitis: The A to Z of Treating UC

An informational program for patients, family members, and caregivers.



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Centocor Ortho Biotech Inc.

Featuring

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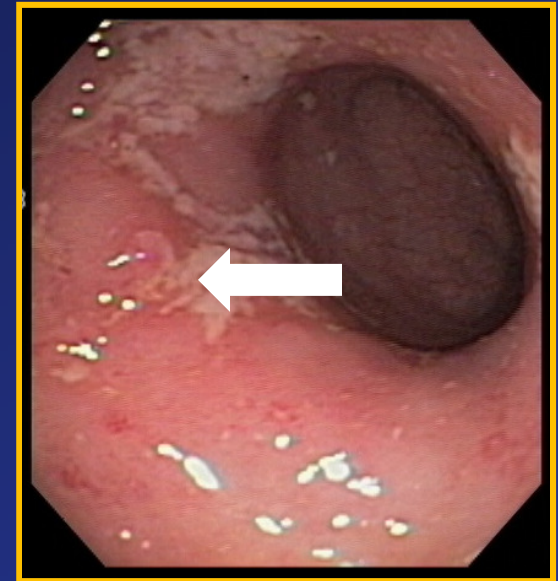
Ulcerative Colitis: The A to Z of Treating UC

Goals

- Provide an overview of UC
- Discuss treatment options
- Review the impact of UC on quality of life
- Identify questions to ask your doctor

An Overview of Ulcerative Colitis

- Type of inflammatory bowel disease (IBD)
- Chronic, relapsing disease of large intestine (colon) causing inflammation and ulceration in bowel lining
- About half of cases are mild
- Flares may be alternating with symptom-free periods
- Usually requires treatment to obtain remission
- Some similarities to Crohn's disease (CD)



Patients with UC have shallow open sores (ulcerations) in the colon.

Comparison of Ulcerative Colitis vs Crohn's Disease

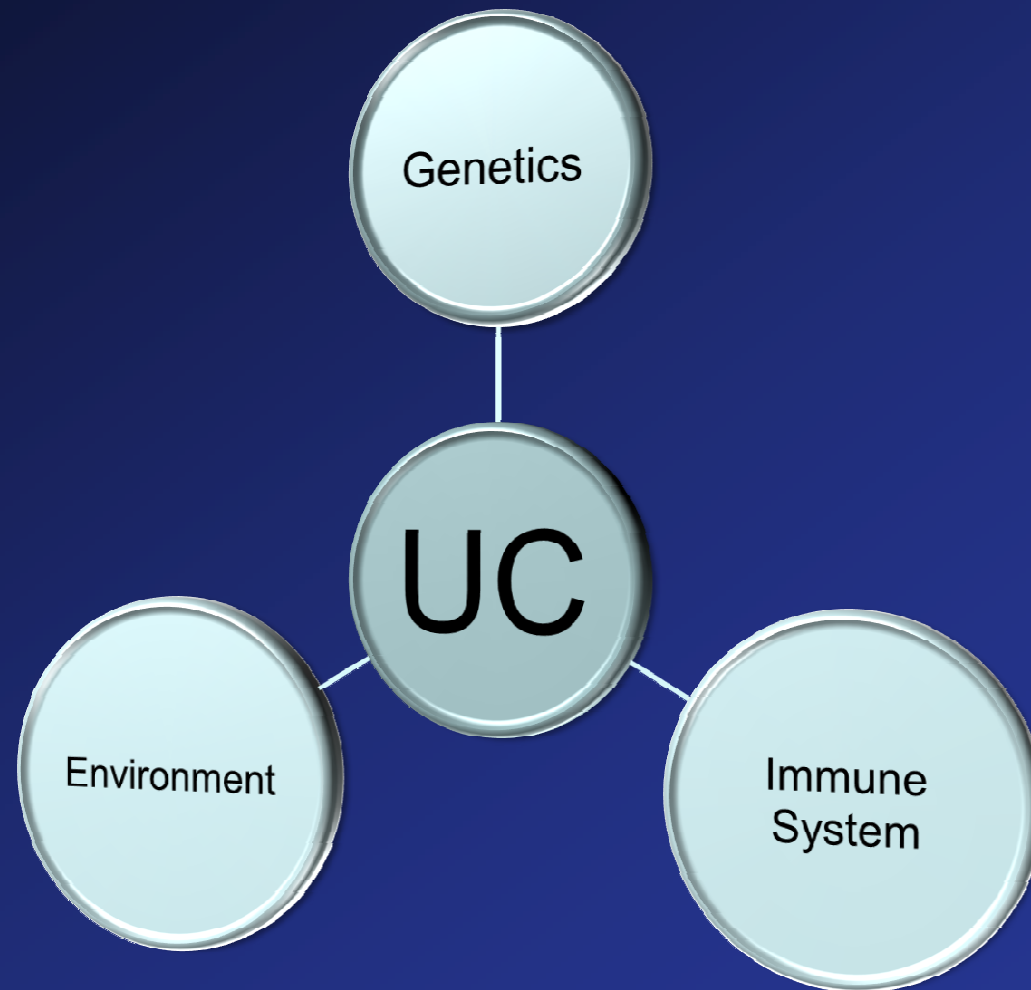
Comparison factor	UC	CD
Type of IBD	Yes	Yes
Prevalence	About equal	
Area affected	Colon	Colon + small intestine
Lesions	Shallow ulcerations	Deep ulcerations
Ulceration pattern	Continuous, snake-like	Patchy
Surgical option	25–40% will ultimately have surgery	66–75% will eventually undergo surgery
Colorectal cancer risk	Higher than CD	Lower than UC

Causes of Ulcerative Colitis

MYTH DISPELLED:

IBD is **NOT** caused or triggered by stress; however, stress may worsen symptoms

Causes of Ulcerative Colitis



Causes of Ulcerative Colitis

- Connection and combination of 3 factors: environment, auto-immune, genetics
 - **Environmental factors** (eg, infectious agents) may trigger inflammation
 - Immune system “over-responds” to environmental insult
 - **Immune cells** attack normal tissue causing inflammation and tissue injury
 - Inflammatory process can affect other parts of body (joints, skin, eyes, oral mucosa)
 - **Genetic mapping** has identified UC-associated genes
 - Genes may “turn on” inflammatory pathways, causing UC
 - Could enable new treatments targeting inflammatory pathways signaled by specific genes
 - May predict course of disease and therapy

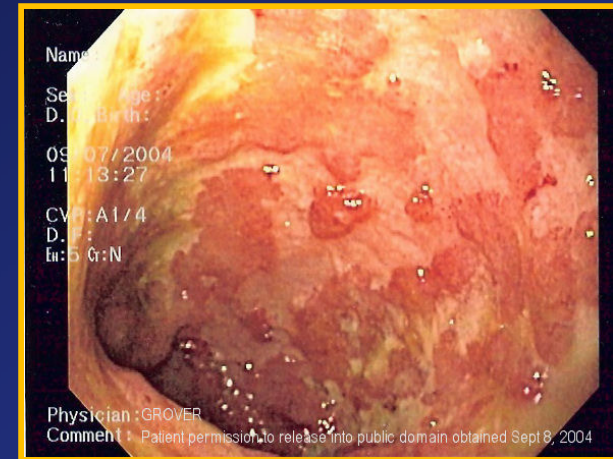
Symptoms

- Diarrhea, mixed with blood and mucous
- Abdominal pain and cramping
- Urgency to have a bowel movement
- Appetite loss, fatigue, weight loss
- May be intermittent with flare-ups
- Growth impairment in children
- Non-intestinal complications: joint pain, skin and oral ulceration, eye inflammation, bile duct inflammation, others



Disease Pattern

- Rectum almost always involved
- Classified by extent of area affected
- Patients usually report gradual onset
- Recurrent attacks couple with complete remission of symptoms in the interim



UC usually has continuous, superficial ulcerations.

Disease Pattern

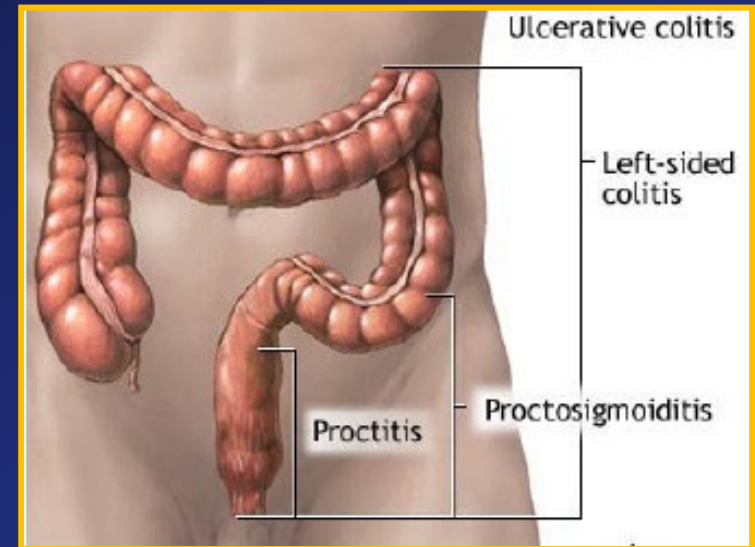
- Triggers include
 - Psychological stress
 - NSAIDs
 - Aspirin, ibuprofen, naproxen
 - Appendectomy
- Remission rate declines with disease severity
- Relapse rate higher in younger patients and can decrease with increasing age
- Primarily affects quality of life, not lifespan

Disease Severity

- **Mild:** up to 4 loose stools daily, may be bloody, mild abdominal pain
- **Moderate:** 4–6 stools daily, moderate abdominal pain, anemia
- **Severe:** more than 6 bloody stools daily, fever, anemia
- **Fulminant:** more than 10 stools daily, continuous bleeding, abdominal pain and distension; potentially fatal

Types of Ulcerative Colitis

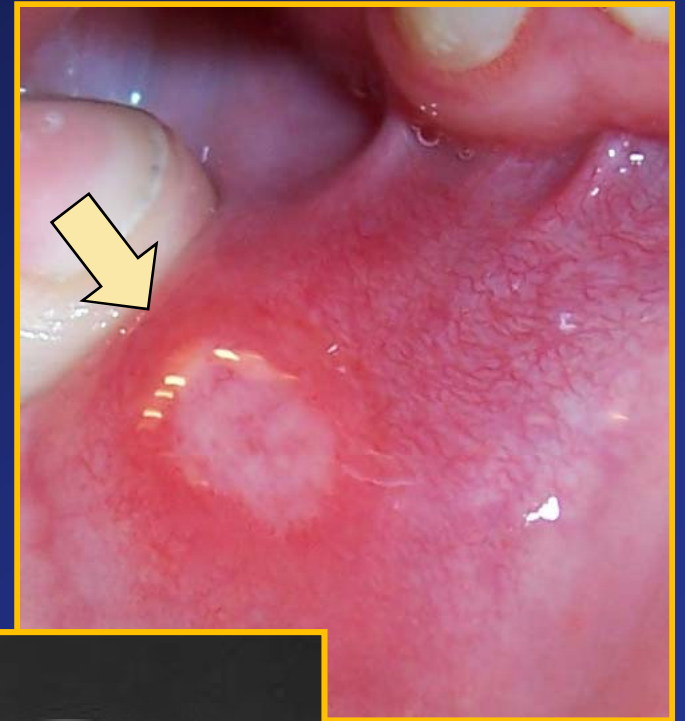
- **Proctitis:** involvement limited to rectum
- **Proctosigmoiditis:** involves rectum and sigmoid colon (lower segment)
- **Left-sided colitis:** extends from rectum and entire left colon
- **Extensive:** involves more than half the colon or the entire colon



UC usually affects one continuous section of the colon beginning with the rectum.

Extra-Intestinal Features

- Oral ulceration
- Eye inflammation
- Arthritis of hands and feet, lower spine
- Skin sores

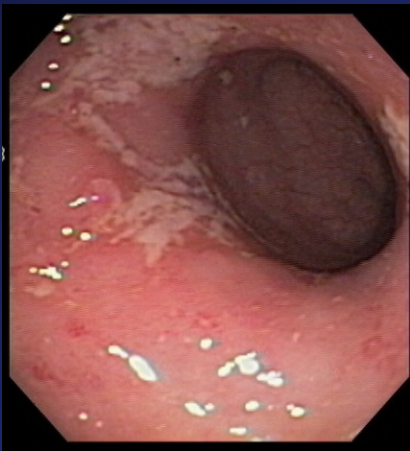


Risk Factors and Frequency

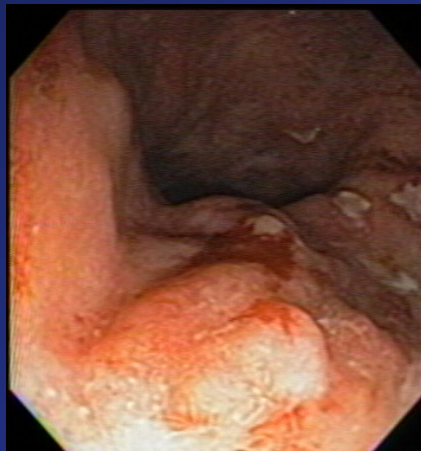
- Can occur at any age, often in the 30's, with a second peak in the 50's or 60's
- Affects all ethnic backgrounds; however, more common in Caucasians and Ashkenazi Jews
- More common in women than men
- Higher risk for patients with first-degree relative (parent, sibling, offspring) with UC
- Affects 35–100 people per 100,000; estimated 700,000 in US with UC

Colorectal Cancer Risk

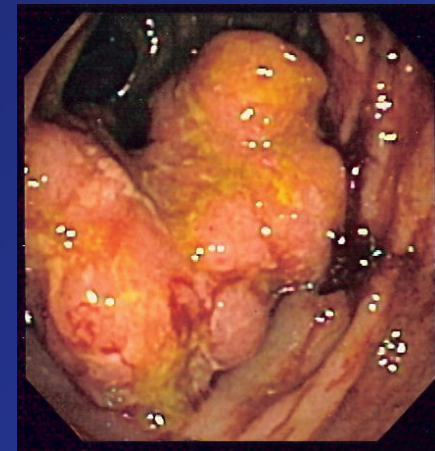
- UC a risk factor for colorectal cancer
- Increases after 8–10 years from UC onset
- More common as severity of UC increases
- Screening colonoscopies recommended for UC patients



Ulcerative colitis



Abnormal growth



Colon cancer

Common Tests to Diagnose and Maintain Ulcerative Colitis

- **Diagnostic testing**

- Fecal sample (presence of bacteria, parasites)
- Blood sample (infection, anemia, inflammatory markers)
- Biopsy of intestinal lining
- Liver and kidney function tests

- **Endoscopy**

- Gold standard for UC diagnosis
- Flexible scope inserted into rectum
- Sigmoidoscope examines lower third of colon
- Colonoscope examines entire colon

- **Visual examination**

- Radiograph (image shows constrictions)
- Barium enema (radio-opaque)
- CT scan provides more detail than x-rays

Treatment Options

Medications

- Anti-inflammatory drugs
 - Aminosalicylates (5-ASA)
 - Corticosteroids (prednisone, hydrocortisone)
- Immunosuppressants
 - Azathioprine/6-MP (6-mercaptopurine)
 - Cyclosporine
 - Methotrexate
- Biologic therapy: blocks inflammatory pathways
 - Infliximab
- Antibiotics to treat infections

Location, Location, Location

Rectum often responsible for most nagging symptoms

- Frequency
- Urgency
- Nighttime BMs
- “Tenesmus”

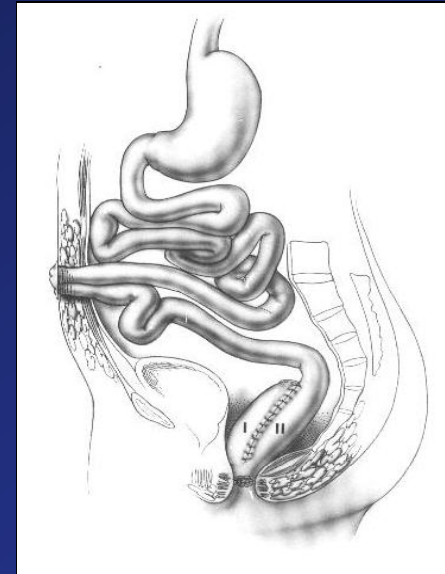
Rectal therapy can minimize these symptoms

- Enema
- Suppository
- Foam

Treatment Options

Surgery

- Option for UC patients who don't respond to medication (25–40% of cases)
- Considered a cure for UC
- Possible approaches:
 - Proctocolectomy
 - Removal of entire colon
 - Small intestine brought to abdominal wall
 - Patient wears an appliance to “catch” waste
 - Ileoanal anastomosis
 - Newer approach, preserves normal bowel function
 - Creates internal pouch from small intestine



J pouch with
diverting ileostomy

Treatment Strategies

- Primary goals of medical treatment:
 - Remission
 - Prevention of recurrence
 - Control impact of complications
 - Maximize quality of life



Treatment Strategies

- Monotherapy
 - Single medication treatment
- Combination therapy
 - Multiple medication treatment
- Choice of strategy dependent on
 - Disease severity
 - Patient's considerations

Treatment Strategies

- **Response to Medications**
 - Prolonged maintenance
 - Possible side effects

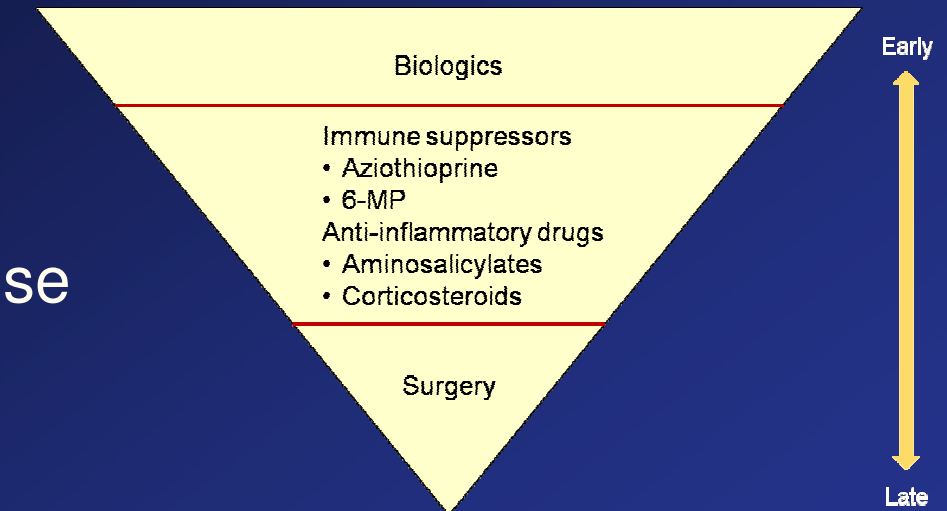
Common Question:

When should I see a response to this medication?

Treatment Strategies

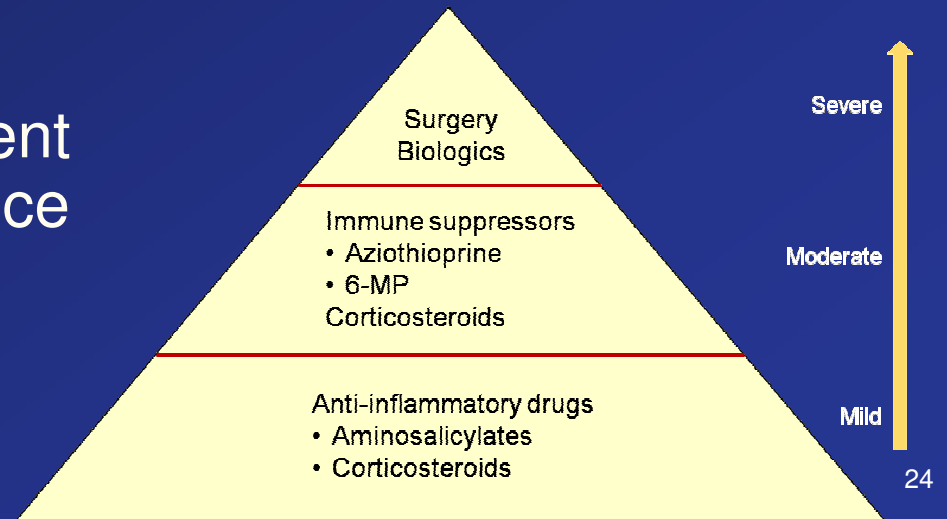
“Top-down” Strategy

- Early, aggressive use of infliximab as initial treatment
- Induces rapid clinical response
- May enhance quality of life



“Bottom-up” strategy

- Standard, sequential treatment for remission and maintenance
- Cost-effective
- Minimal side effects



UC Impact on Quality of Life

Practical Consequences of UC Flare-up

- Unpredictable episodes of diarrhea, bleeding, cramping
- Sudden urgency to use restroom
- Temptation to avoid travel or activity

Medication Adherence

- Decreased chance to flare
- Increased chance of obtaining remission
- Prospective study in patients with UC in remission and taking mesalamine found chance of remission was
 - 89% in adherent patients
 - 39% in non-adherent patients
- Colorectal cancer prevention (possibly 5-ASAs)

UC Impact on Quality of Life: Long-Term Medication

Prescription Medications	Potential Side Effects
Methotrexate	Liver cirrhosis, low white blood cell counts, inflammation of the lungs
Cyclosporine	High blood pressure, impairment of kidney function, tingling sensations in the extremities, anaphylactic shock and seizures
Steroid (Not for maintenance treatment; 3–4 months usual limit)	Weight gain, “moon face,” increased blood pressure, suppressed immune system, increased infection risk
Over-the-Counter Medications	Potential Side Effects
Anti-diarrheals	Increased risk of toxic megacolon
NSAIDs – aspirin, ibuprofen (Advil, Motrin, others) or naproxen (Aleve)	Likely to make symptoms worse (even short-term)

UC Impact on Quality of Life

Managing a Chronic Illness

- Advance planning
 - Medications
 - Personal supplies
 - Bathroom locations
- Overcoming fear of being in public
 - Ileostomy patients
- Maintaining social interaction to enhance self image

UC Impact on Quality of Life

Exercising With UC

- Helps maintain weight and wellbeing, reduce stress
- Things to emphasize
 - Consider low-impact activities
 - Yoga
 - Swimming
 - Golf
 - Bowling
 - Walk instead of run
 - Plan bathroom breaks
 - Listen to your body (ie, don't needlessly overdo)
 - Consult your physician
 - Exercise between flare-ups

UC Impact on Quality of Life

Role of Diet in Managing UC

- Link between diet and flare-ups not established
- Avoid foods that aggravate symptoms
 - Limit dairy products if lactose-intolerant
- Experiment with fiber
- Eat several smaller meals instead of 3 large ones
- Drink ample fluids
- Consider nutritional supplements
- Consider probiotics



UC Impact on Quality of Life

CCFA Coping Resources

- CCFA community website
www.ccfa.org
- CCFA helpful links
<http://www.ccfa.org/info/links?LMI=4.8>
- Information Resource Center (IRC)
1.888.MY.GUT.PAIN (1-888-694-8872)
- Local support groups
- Local CCFA chapters



Strengthen Communication with Your Doctor

Questions to Ask Your Doctor

- What parts of my bowel are affected?
- What treatment plan is suitable for me?
- Would you recommend probiotics?
- What side effects from medication may occur?
- How soon do symptoms subside?
- Should I change my diet or take supplements?
- Are there any restrictions on my activities?
- How often do I need a follow-up colonoscopy?

Question-and-Answer

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Thank you for your participation.

Help us to develop programs that will benefit you in the future.

Please complete the program evaluation by visiting

<http://www.aocic.net/treatinguc/ccfa1006webeval.html>