



Complete Summary

GUIDELINE TITLE

Management of ulcerative colitis.

BIBLIOGRAPHIC SOURCE(S)

Society of Surgery of the Alimentary Tract, Inc. (SSAT). Management of ulcerative colitis. Manchester (MA): Society for Surgery of the Alimentary Tract, Inc. (SSAT); 2001. [5 references]

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SCOPE

DISEASE/CONDITION(S)

Ulcerative colitis

GUIDELINE CATEGORY

- Diagnosis
- Evaluation
- Management
- Risk Assessment
- Treatment

CLINICAL SPECIALTY

- Family Practice
- Gastroenterology
- Internal Medicine
- Surgery

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To guide primary care physicians to the appropriate utilization of surgical procedures on the alimentary tract or related organs

TARGET POPULATION

Adult patients with ulcerative colitis

INTERVENTIONS AND PRACTICES CONSIDERED

Medical Treatment

1. 5-Aminosalicylic acid (5-ASA) compounds (e.g., Asacol®, Pentasa®, Dipentum®, Azulfidine®, etc.)
2. Corticosteroids and/or cyclosporine
3. Immunosuppressants, such as azathioprine and 6-mercaptopurine (6-MP)
4. Hospitalization with bowel rest and intravenous corticosteroids

Surgical Treatment

1. Total proctocolectomy and ileostomy
2. Total proctocolectomy with continent ileostomy (Koch pouch)
3. Total proctocolectomy with ileal pouch-anal anastomosis
4. Colectomy with ileorectal anastomosis

MAJOR OUTCOMES CONSIDERED

- Perioperative and postoperative complications (mortality, major hemorrhage and abdominal infections, small bowel obstruction, clinical dehydration, and pouchitis)
- Long-term functioning of pouches after ileal pouch-anal anastomosis
- Quality of life
- Patient satisfaction

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The Society for Surgery of the Alimentary Tract (SSAT) guidelines are based on statements and recommendations that were overwhelmingly supported by clinical evidence. Each represents a consensus of opinion and is considered a reasonable plan for a specific clinical condition.

(See companion document Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. J Gastrointest Surg 1998;2:483-484.)

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The guidelines were reviewed by several committee members and then by the entire committee on several occasions. Each guideline was then sent back to the

original author for final comment and reviewed again by the committee. Each guideline was approved by the Board of Trustees of the Society for Surgery of the Alimentary Tract and final comments were reviewed by the committee.

(See companion document Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. *J Gastrointest Surg* 1998;2:483-484.)

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Medical Treatment

The goal of the medical treatment of ulcerative colitis is to induce clinical remission while avoiding toxic medications. Medications such as 5-aminosalicylic acid (5-ASA) products (e.g., Asacol®, Pentasa®, Dipentum®, Azulfidine®, etc.) are often used to maintain remission. Whereas, the 5-ASA medications are safe, chronic corticosteroids and cyclosporine are not. Therefore, when clinical remissions are induced with corticosteroids and/or cyclosporine, additional medications must be added to facilitate weaning of these drugs. 5-ASA compounds or immunosuppressants such as azathioprine and 6-mercaptopurine (6-MP) are recommended. It is probably wise to attempt weaning off azathioprine or 6-mercaptopurine after 1 to 2 years of remission.

The medical treatment should be tailored to the severity of symptoms and extent of disease. Patients with proctitis and proctosigmoiditis are best treated with topical treatment such as 5-ASA enemas or suppositories. As the disease extends proximally to the left colon, oral or systemic treatment becomes necessary. The first line of treatment should be 5-ASA products. In patients with severe colitis or moderate colitis that is not responding to maximal doses of 5-ASA, corticosteroids are initiated. Most patients with severe colitis (more than six stools/day, blood in stool, fever, tachycardia, and anemia) require hospitalization with bowel rest, intravenous corticosteroids, and parenteral nutrition. Approximately 50% of patients admitted to the hospital for treatment of severe or fulminant disease will respond to bowel rest and corticosteroids and will not require urgent operation. The addition of intravenous cyclosporine results in improvement in another 20-30% of patients. Thus, about 50-80% of patients can be discharged home without urgent surgery. Despite this, the majority of patients requiring hospitalization for treatment of severe ulcerative colitis undergo colectomy within one year.

Indications for Surgery

It is difficult to predict which patients with ulcerative colitis will require surgery. Approximately 85% of patients with severe or fulminant disease will undergo colectomy within one year. However, this subgroup represents only 10-20% of patients.

The majority of patients with mild or moderate disease have an unpredictable course. The cumulative likelihood of requiring colectomy by 25 years is about 32%. The most common indications for elective colectomy are inability to wean

off steroids over 6 to 9 months and/or a poor quality of life (e.g., fatigue, high stool frequency [>6 day], anemia). The development of dysplasia or cancer is an absolute indication for colectomy.

Patients with ulcerative proctitis or proctosigmoiditis have a risk of developing colon cancer similar to that of the normal population. On the other hand, patients with ulcerative colitis proximal to the splenic flexure have an increased risk for the development of colon cancer and warrant surveillance. Subsets of patients have different degrees of risk. The well-accepted colon cancer risk factors in patients with ulcerative colitis are extent of disease and duration of disease. The increased risk for cancer in patients with pancolitis begins 8 years after onset of disease, with an incidence of about 0.5-1.0 %/year thereafter. The optimal strategies for surveillance, diagnosis, and treatment of cancer in patients with ulcerative colitis are controversial and were recently addressed by a Consensus Panel of experts in gastrointestinal disease. This Panel posed several questions, some of which are summarized below:

1. Is there a risk of developing colon cancer in patients with ulcerative colitis? Yes. The patients at highest risk are those with pancolitis and duration of disease greater than eight years. The subset of patients who also have primary sclerosing cholangitis or who have a family history of colon cancer have additional risk. Early age at onset of disease likely is an additive risk factor. In one study, 50% of patients with onset before the age of 15 years developed cancer by the age of 50 years.
2. Is dysplasia a reliable and valid histologic marker in the identification of patients at risk for developing colon cancer in the face of ulcerative colitis? Yes and no. Patients with low-grade dysplasia, high-grade dysplasia, and especially dysplasia associated with a visible lesion or a mass (DALM) have a cancer risk that mandates elective colectomy. The problem with using dysplasia as a diagnostic test is its poor negative predictive value. That is, at least 20% of colectomy specimens from patients with ulcerative colitis who have developed cancer have no detectable dysplasia.
3. Is colonoscopic surveillance of benefit in reducing cancer in patients with ulcerative colitis? There have been no prospective randomized trials that could answer this question. Retrospective studies indicate that mortality is reduced when patients are in surveillance programs. Colonoscopy should probably be performed every 1 to 2 years starting 8 years after onset of disease and then yearly 15 years after onset of disease. Multiple biopsies (>25) should be taken randomly and of any macroscopic lesions.
4. Is there a role for prophylactic colectomy in patients with ulcerative colitis? Dysplasia associated with a visible lesion or a mass (DALM), low-grade or high-grade dysplasia, if confirmed by a second experienced pathologist, is usually an indication for elective colectomy. Some experts continue to recommend colectomy at 10 years after diagnosis of pancolitis. After 20 years, especially in patients with primary sclerosing cholangitis, a family history of colon cancer and/or in patients with young age of onset, the case becomes strong for true "prophylactic" colectomy.

Surgical Treatment

There are four surgical options in patients with ulcerative colitis: 1) total proctocolectomy and ileostomy; 2) total proctocolectomy with continent ileostomy

(Koch pouch); 3) total proctocolectomy with ileal pouch-anal anastomosis (IPAA); 4) colectomy with ileorectal anastomosis. With the refinement of the IPAA procedure, it has become the operation of choice in virtually all patients. The Koch pouch is typically reserved for patients with previous total proctocolectomies who are very unhappy with their ileostomies. Elderly patients, advanced rectal cancer, and previous anal sphincter damage are relative contraindications for the IPAA procedure. The IPAA is not indicated in patients with Crohn's disease.

The technical aspects of the IPAA continue to evolve. Although the use of protecting ileostomies at the time of IPAA was routine for years, many centers are now performing selective one-stage ileal pouch-anal anastomosis with excellent long-term results in patients who are well nourished and not taking corticosteroids. Similarly, the traditional procedure includes rectal mucosectomy followed by hand-sewn IPAA. Many surgeons now perform a "double-staple" technique without mucosectomy. In experienced hands, excellent results have been reported with either surgical technique.

Qualifications for Performing Surgery for Ulcerative Colitis

The qualifications of a surgeon to perform any operative procedure should be based on training (education), experience, and outcomes. At a minimum, surgeons who are certified or eligible for certification by the American Board of Surgery, the Royal College of Physicians and Surgeons of Canada, or their equivalent should perform emergency colectomy in patients with ulcerative colitis. It is desirable that surgeons who perform IPAA (or Koch Pouch) have specific training or significant experience with the procedure.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate management of ulcerative colitis, which may result in:

- Improved quality of life by reducing symptoms
- Decreased risk for colon cancer

Subgroups Most Likely to Benefit:

Patients at highest risk for colon cancer, including:

- Patients with ulcerative colitis proximal to the splenic flexure
- Patients with the well-accepted colon cancer risk factors of pancolitis and duration of disease greater than 8 years
- Patients with primary sclerosing cholangitis or a family history of colon cancer

POTENTIAL HARMS

Immunosuppressant medications

- Whereas the 5-aminosalicylic acid (5-ASA) medications are safe, chronic corticosteroids and cyclosporine are not. Therefore, when clinical remissions are induced with corticosteroids and/or cyclosporine, additional medications must be added to facilitate weaning of these drugs.

Surgical treatment

- Mortality rates for patients undergoing elective operation for ulcerative colitis are less than 1%. Technical problems such as major hemorrhage and abdominal infections are infrequent.
- The most common long-term problem after ileal pouch-anal anastomosis (IPAA) is acute and/or chronic inflammation of the ileal pouch, or pouchitis. Symptoms include increased stool frequency, urgency, soilage, bleeding and malaise. With long-term follow-up, about 50% of patients will report at least one episode of pouchitis. The cause of pouchitis is likely multifactorial; one factor may be bacterial overgrowth of the ileal pouch. While most patients respond quickly to a short course of antibiotics (e.g., metronidazole or ciprofloxacin), some patients develop a chronic syndrome. Newer treatments with probiotics have shown promise in treating pouchitis. Other therapies for pouchitis such as topical anti-inflammatory agents, volatile fatty acids or systemic corticosteroids are not consistently efficacious.
- Other causes of bad outcome after ileal pouch-anal anastomosis are technical failures and Crohn's disease.
- Other problems to be aware of after ileal pouch-anal anastomosis are small bowel obstruction, which occurs in about 28% of patients, and clinical dehydration, seen in about 14% of patients

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- These patient care guidelines were written for the primary care physician on a variety of digestive diseases to assist on when to refer the patient for surgical consultation.
- The goal of these guidelines is to guide PRIMARY CARE physicians to the appropriate utilization of surgical procedures on the alimentary tract or related organs and they are based on critical review of the literature and expert opinion. Both of the latter sources of information result in a consensus that is recorded in the form of these Guidelines. The consensus addresses the range of acceptable clinical practice and should not be construed as a standard of care.

- These guidelines require periodic revision to ensure that clinicians utilize procedures appropriately but the reader must realize that clinical judgment may justify a course of action outside of the recommendations contained herein.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Safety

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Society of Surgery of the Alimentary Tract, Inc. (SSAT). Management of ulcerative colitis. Manchester (MA): Society for Surgery of the Alimentary Tract, Inc. (SSAT); 2001. [5 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2000 (revised 2001)

GUIDELINE DEVELOPER(S)

Society for Surgery of the Alimentary Tract, Inc - Medical Specialty Society

SOURCE(S) OF FUNDING

Society of Surgery of the Alimentary Tract, Inc.

GUIDELINE COMMITTEE

Patient Care Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Committee Members: Gerald M. Fried, M.D. (Chairman); Arthur M. Carlin, M.D.; John W. Kilkenny, M.D.; Marco G. Patti, M.D.; Lelan F. Sillin, III, M.D.; Gregory V. Stiegmann, M.D.; Steven M. Strasberg, M.D.; Lee L. Swanstrom, M.D.; J. Nicholas Vauthey, M.D.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates the previously issued version.

An update is scheduled every two years.

GUIDELINE AVAILABILITY

Electronic copies: Available from the [Society for Surgery of the Alimentary Tract, Inc. \(SSAT\) Web site](#).

Print copies: Available from the Society for Surgery of the Alimentary Tract, Inc., 900 Cummings Center, Suite 221-0, Beverly, MA 01915; Telephone: (978) 927-8330; Fax: (978) 524-8890.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Gadacz TR, Traverso LW, Fried GM, Stabile B, Levine BA. Practice guidelines for patients with gastrointestinal surgical diseases. *J Gastrointest Surg* 1998;2:483-484.

Electronic copies: Not available at this time.

Print copies: Available from the Society for Surgery of the Alimentary Tract, Inc., 900 Cummings Center, Suite 221-0, Beverly, MA 01915; Telephone: (978) 927-8330; Fax: (978) 524-8890.

PATIENT RESOURCES

None available

NGC STATUS

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Date Modified: 11/15/2004

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