

IBDIQ

Spotlight on Ulcerative Colitis

MANAGING THE DISEASE



PART OF THE IBD PROJECT

Understanding ulcerative colitis

Ulcerative colitis (UC) is a chronic, immune-mediated inflammatory bowel disease, mainly affecting the colonic mucosa.¹⁻⁵

In UC, inflammation can occur from the rectum and extend proximally to involve additional areas of the colon.¹

Evidence suggests that UC may be progressive and is complicated by damage beyond the mucosal layer, with associated abnormalities.⁶⁻⁸

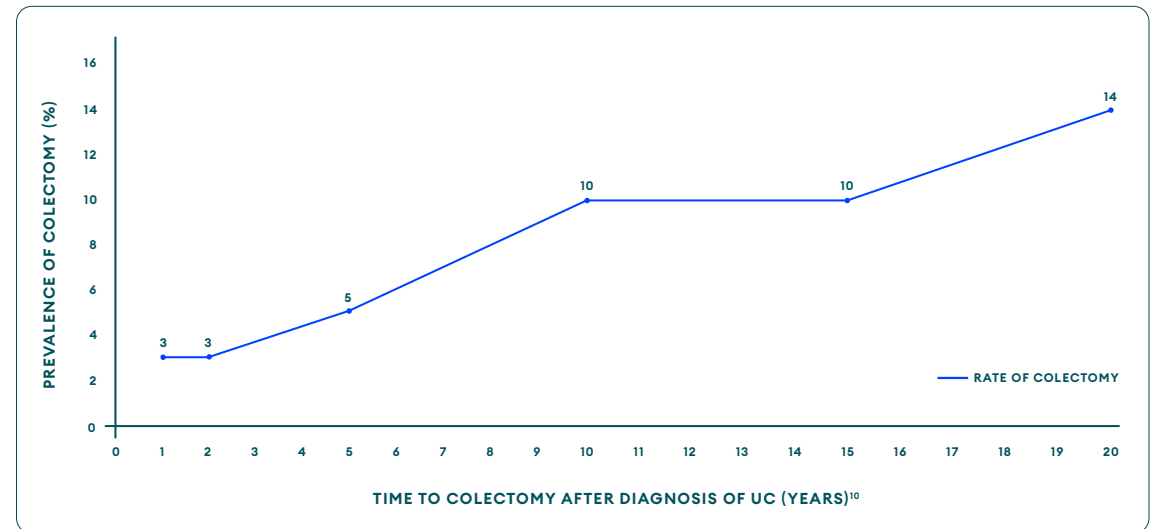
Structural abnormalities⁶⁻⁸

- Fibrosis
- Strictures
- Pseudopolyps
- Neoplasia

Functional abnormalities⁶⁻⁸

- Increased colonic permeability
- Decreased contractility
- Changes in rectal motility and compliance

Studies have shown an increase in colectomy over time, with about 10% of patients requiring colectomy at 10 years after UC diagnosis.^{9,10}



A 2023 systematic review and meta-analysis examined the prevalence of colectomy in patients with UC by analyzing 31 population-based and cohort studies published between 1985 and 2021. The risk of colectomy was assessed at various time intervals following a UC diagnosis: 1 year (67,102 patients), 2 years (7,492 patients), 5 years (68,618 patients), 10 years (149,126 patients), 15 years (7,229 patients), and 20 years (12,497 patients).¹⁰

OVER TIME, PATIENTS WITH UC MAY EXPERIENCE STRUCTURAL AND FUNCTIONAL DAMAGE AND INCREASED PREVALENCE OF COLECTOMY.^{6-8,10}

Assessing disease severity

Assess an individual patient's disease location and severity using available tools and resources to guide disease management decisions.¹¹⁻¹³

Assessing UC disease severity according to the proposed American College of Gastroenterology (ACG) UC Activity Index¹

PROPOSED ACG UC ACTIVITY INDEX									
	Stools (number per day)	Blood in stools	Urgency	Hemoglobin	ESR	CRP (mg/L)	FC (mcg/g)	Endoscopy (Mayo subscore)	UCEIS
Remission	Formed stool	None	None	Normal	<30	Normal	<150-200	0-1	0-1
Mild	<4	Intermittent	Mild, occasional	Normal	<30	Elevated	>150-200	1	2-4
Moderate-severe	>6	Frequent	Often	<75% of normal	>30	Elevated	>150-200	2-3	5-8
Fulminant	>10	Continuous	Continuous	Transfusion required	>30	Elevated	>150-200	3	7-8

These factors are general guides for disease activity. Outside of remission, a patient does not need to have all of these factors to be considered in a specific category.¹

CRP=C-reactive protein; ESR=erythrocyte sedimentation rate; FC=fecal calprotectin; UCEIS=Ulcerative Colitis Endoscopic Index of Severity.

“THERAPEUTIC MANAGEMENT IN UC SHOULD BE GUIDED BY THE SPECIFIC DIAGNOSIS (ie, MONTREAL CLASSIFICATION), AN ASSESSMENT OF DISEASE ACTIVITY (ie, MILD, MODERATE, OR SEVERE), AND DISEASE PROGNOSIS.”

American College of Gastroenterology 2019 Clinical Guidelines for UC in Adults¹

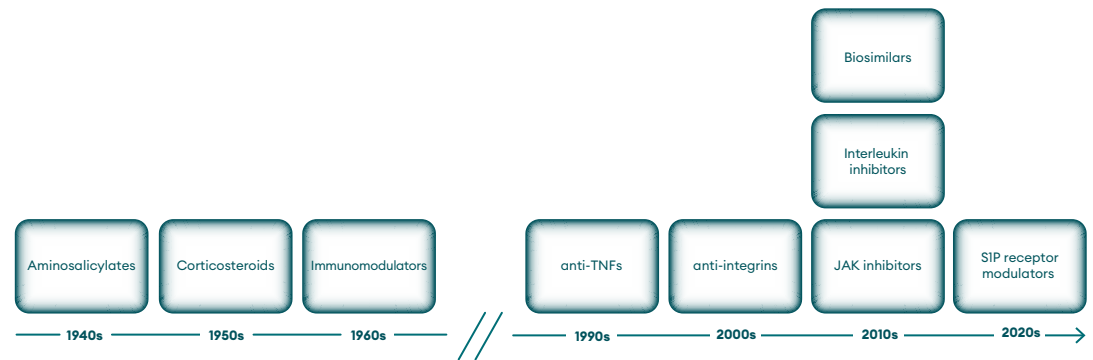
Exploring disease management options

Discuss with patients their desired disease management goals, as well as the benefits and the risks of available management options.¹⁴

Enable shared decision-making to determine disease management goals and select an appropriate management plan that is consistent with patients' best interests.¹⁴

The IBD treatment landscape has evolved^{1,25-26}

Various IBD therapeutic options are available and should be selected based on the location, extent, phenotype, severity of disease, and benefits and risks of therapeutic options.^{14,18}



Please note: This overview is intended to be used in combination with your clinical assessment and latest guidelines to facilitate decisions regarding disease management plans.

JAK=Janus kinase; SIP=sphingosine-1-phosphate; TNF=tumor necrosis factor.



Management of UC may also include the incorporation of non-pharmacological strategies to possibly alleviate symptoms and potentially reduce disease complications^{1,27,28}:



Diet modification

In patients with UC, diet modification, including personalized nutrition and established diets (eg, fiber supplements, low FODMAP), may help reduce symptoms and inflammation markers.^{27,28}



Physical activity and exercise

Improvement in disease activity may be possible by incorporating physical activity, which has the potential to improve quality of life and cardiovascular and bone health.²⁷



Psychotherapy

Negative psychosocial outcomes can be common in patients with UC.²⁷ Psychotherapy may have a positive impact on quality of life, coping skills, and certain mental health symptoms.²⁹



Intestinal surgery

When disease has progressed significantly (eg, patient has acute severe UC, is non-responsive to medical treatment, has dysplasia or carcinoma), surgery/colectomy may be an appropriate approach to disease management.¹



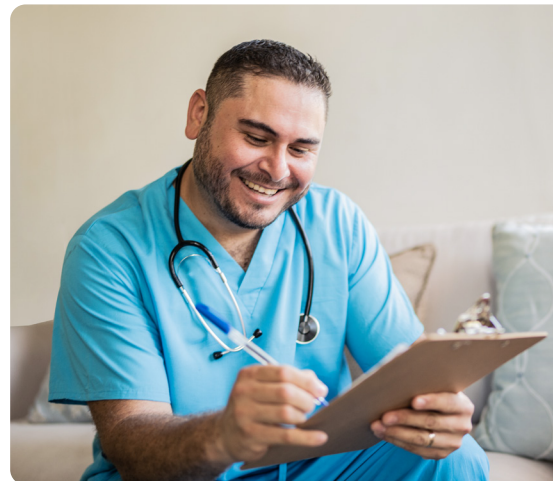
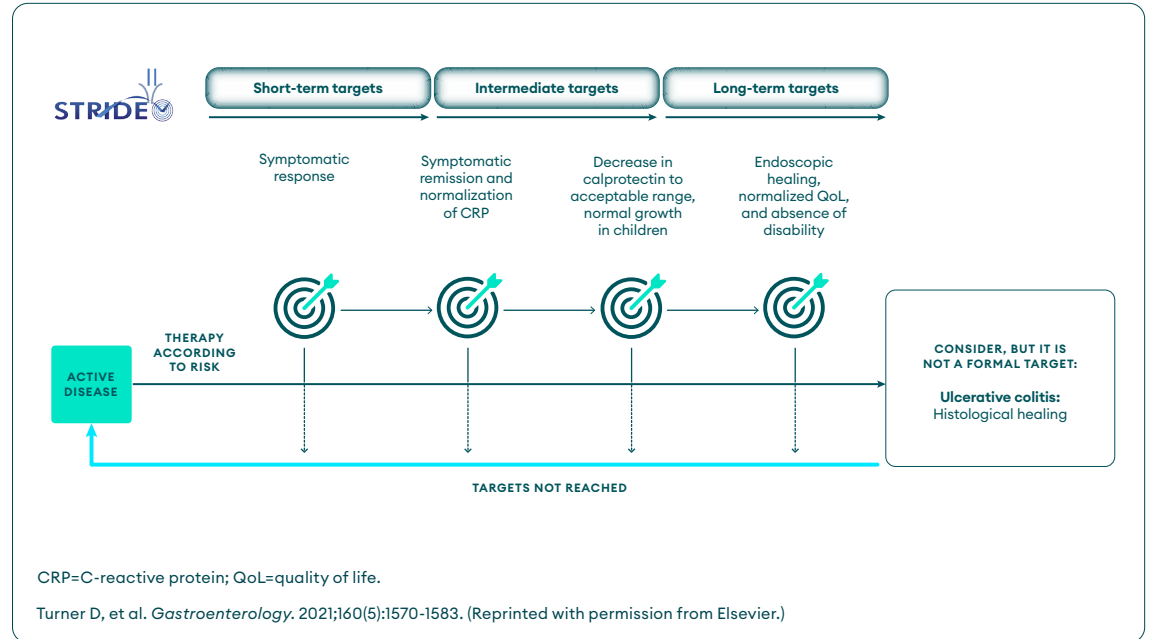
CANCER SCREENING AND SUBSEQUENT SURVEILLANCE IS RECOMMENDED IN CERTAIN PATIENTS WITH UC BASED ON THE ACG GUIDELINES, AS INFLAMMATION MAY BE A PRIMARY DRIVER OF CANCER RISK IN UC.¹

ACG=American College of Gastroenterology; FODMAP=fermentable oligosaccharides, disaccharides, monosaccharides, and polyols.

Establishing treatment targets

A treat-to-target approach is recommended by STRIDE-II with the goal of improving long-term outcomes for patients with IBD.^{30,31}

The Selecting Therapeutic Targets in IBD (STRIDE) recommendations were developed and first published by the International Organization for the Study of IBD (IOIBD) in 2015.³¹ They were updated in 2021 (becoming known as STRIDE II). The STRIDE recommendations use evidence-based expert consensus with the aim of determining treatment targets for IBD to be used for a “treat-to-target” clinical management strategy.



Monitoring treatment targets

Effective monitoring strategies support the appropriate timely management of IBD.³⁰

There are a variety of monitoring tools available to support IBD disease management, such as these outlined by STRIDE II.^{30,31}



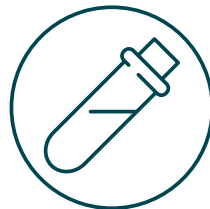
Clinical response and remission (Scoring system)

- PRO2
- Partial Mayo Score
- SCCAI
- Full Mayo Score



Endoscopic and histological assessment

- Mayo endoscopic subscore
- UCEIS
- Sigmoidoscopy or colonoscopy



Biomarkers

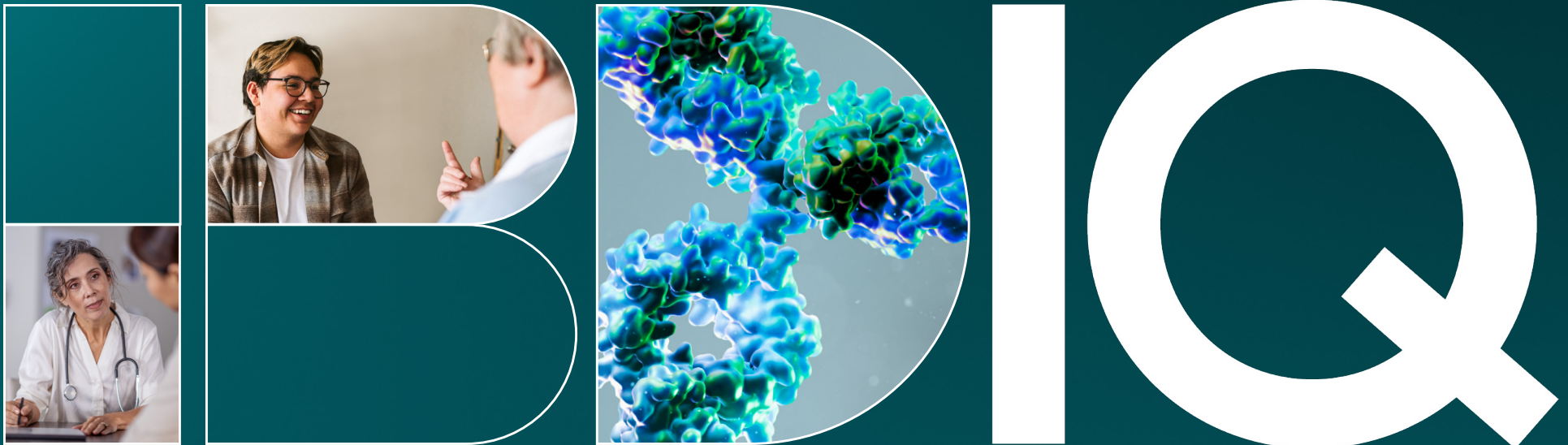
- CRP
- Fecal calprotectin
- ESR

CRP=C-reactive protein; ESR=erythrocyte sedimentation rate; PRO2=patient-reported outcome 2-item; SCCAI=Simple Clinical Colitis Activity Index; UCEIS=Ulcerative Colitis Endoscopic Index of Severity

Learn more about ulcerative colitis at IBDIQ.com today.



SCAN THE QR CODE
TO LEARN MORE



References: 1. Rubin DT, Ananthakrishnan AN, Siegel CA, Sauer BG, Long MD. *Am J Gastroenterol.* 2019;114(3):384-413. 2. Tatiya-Aphiradee N, Chatuphonprasert W, Jarukamjorn K. *J Basic Clin Physiol Pharmacol.* 2018;30 (1):1-10. 3. Reimund JM, Wittersheim C, Dumont S, et al. *J Clin Immunol.* 1996;16 (3):144-150. 4. Nalleweg N, Chiriac MT, Podstawa E, et al. *Gut.* 2015;64 (5):743-755. 5. Ghazi HF. *J Fac Med Baghdad.* 2010;52(3):306-310. 6. Torres J, Billioud V, Sachar DB, Peyrin-Biroulet L, Colombel J-F. *Inflamm Bowel Dis.* 2012;18(7):1356-1363. 7. Le Berre C, Ananthakrishnan AN, Danese S, Singh S, Peyrin-Biroulet L. *Clin Gastroenterol Hepatol.* 2020;18(1):14-23. 8. Cleveland NK, Torres J, Rubin DT. *Gastroenterology.* 2022;162(5):1396-1408. 9. Frolkis A, Dykeman J, Negrón ME, et al. *Gastroenterology.* 2013;145(5):996-1006. 10. Dai N, Haidar O, Askari A, Segal JP. *Dig Liver Dis.* 2023;55(1):13-20. 11. Dassopoulos T, Cohen RD, Scherl EJ, Schwartz RM, Kosinski L, Regueiro MD. *Gastroenterology.* 2015;149(1):238-245. 12. Kim AH, Girgis A, Karimi N, et al. *JMIR Res Protoc.* 2020;9(7):e15994. 13. Dulai PS, Wong ECL, Reinisch W, Colombel J-F, Marshall JK, Narula N. *Inflamm Bowel Dis.* 2022;28(10):1555-1564. 14. Song K, Wu D. *World J Gastroenterol.* 2022;28(26):3092-3100. 15. Murray A, Nguyen TM, Parker CE, Feagan BG, MacDonald JK. *Cochrane Database Syst Rev.* 2020;8(8):CD000544. 16. Dorrington AM, Selinger CP, Parkes GC, Smith M, Pollok RC, Raine T. *J Crohns Colitis.* 2020;14(9):1316-1329. 17. de Boer NKH, Peyrin-Biroulet L, Jharap B, et al. *J Crohns Colitis.* 2018;12(5):610-620. 18. Lichtenstein GR, Loftus EV, Jr, Isaacs KL, Regueiro MD, Gerson LB, Sands BE. *Am J Gastroenterol.* 2018;113(4):481-517. 19. Actis GC, Pellicano R, Fagoonee S, Ribaldone DG. *J Clin Med.* 2019;8(11):1970. 20. Santiago P, Braga-Neto MB, Loftus EV Jr. *Gastroenterol Hepatol (N Y).* 2022;18(8):453-465. 21. Pérez-Jeldres T, Tyler CJ, Boyer JD, et al. *Front Pharmacol.* 2019;10:212. 22. News & Events for Human Drugs. U.S. Food & Drug Administration Website. Published May 18, 2023. <https://www.fda.gov/drugs/news-events-human-drugs/fda-approves-first-oral-treatment-moderately-severely-active-crohns-disease>. Accessed October 7, 2024. 23. Moschen AR, Tilg H, Raine T. *Nat Rev Gastroenterol Hepatol.* 2019;16(3):185-196. 24. Choden T, Cohen NA, Rubin DT. *Gastroenterol Hepatol (N Y).* 2022;18(5):265-271. 25. Press Releases. Pfizer Website. Published October 13, 2023. <https://www.pfizer.com/news/press-release/press-release-detail/us-fda-approves-pfizers-velsipytytm-adults-moderately>. Accessed October 7, 2024. 26. Najeab H, Yasmin F, Surani S. *World J Clin Cases.* 2022;10(14):4327-4333. 27. Duff W, Haskey N, Potter G, Alcorn J, Hunter P, Fowler S. *World J Gastroenterol.* 2018;24(28):3055-3070. 28. Hsieh M-S, Hsu W-H, Wang J-W, et al. *J Formos Med Assoc.* 2020;119(12):1742-1749. 29. Taft TH, Ballou S, Bedell A, Lincenberg D. *Gastroenterol Clin North Am.* 2017;46(4):847-858. 30. Plevris N, Lees CW. *Gastroenterology.* 2022;162(5):1456-1475. 31. Turner D, Ricciuto A, Lewis A, et al; International Organization for the Study of IBD. *Gastroenterology.* 2021;160(5):1570-1583.