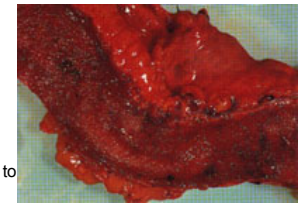
Ulcerative Colitis

Colonoscopy
Bowel Cancer
Cancer Follow up
Crohn's Disease
Haemorrhoids
Polyps
Ulcerative Colitis
Diverticular Disease
Anal Fissure
Anal Abscess / Anal Fistula
Pruritis Ani
Irritable Bowel Syndrome
Proctitis
Rectal Prolapse
Constipation
Faecal Incontinence
Clinical Guidelines



What is ulcerative colitis?
Ulcerative colitis is a rare disease affecting about 5 per 100,000 of population. Males and females are equally affected and may present at any age, particularly between the second and fourth decades.

What is the cause of ulcerative colitis?

The cause is unknown, but many theories exist. It does not appear to be contagious or hereditary, but rarely more than one family member can have the condition. It is not caused by any dietary factors. It may follow an acute diarrhoeal illness.

How is the bowel affected by ulcerative colitis?

Only the large bowel is involved, with the inflammation starting in the rectum and extending for a variable distance towards the beginning of the large bowel (caecum). If the caecum is involved it is called pancolitis, whereas if the rectum alone is involved it is called proctitis. Ulcerative colitis is comparable to a "bum" of the inner lining of the bowel (mucosa) resulting in inflammation and shallow ulceration which causes diarrhoea, bleeding and mucus. With time the patient may become anaemic, protein and salt depleted.

Can other problems occur with ulcerative colitis?

Occasionally liver disease can occur (sclerosing cholangitis), as can eye inflammation (iritis), arthritis and skin lesions (pyoderma gangrenosum). Ulcerative colitis is also a premalignant disease and the incidence of colon cancer progressively increases with the duration of the disease.

What are the symptoms?

Episodic or continuous diarrhoea with blood and mucus are the main symptoms. There may be urgency to defaecate, with crampy lower abdominal pains. The symptoms can be very mild or so severe that up to 30 bowel actions a day occur. Patients can feel completely normal or become very ill with a life threatening episode.The illness may run a continuous or relapsing course. Occasionally it can "burn out" after a number of years.

How is it diagnosed?

Diagnosis is based on the clinical picture and the appearance of the large bowel mucosa at colonoscopy. Biopsies are taken. In the earliest stages of the disease it is sometimes confused with other conditions. There are no diagnostic blood tests.

What treatment is available?

Medication consisting of salazopyrine or related drugs such as mesalazine is very effective. Sometimes anti-inflammatory drugs such as prednisone (cortisone) are necessary either in the form of local rectal preparations or tablets. Sometimes immune suppressants such as azothiaprine are needed. Iron tablets, antidian-hoeals and good nutrition all help. Unfortunately there is no known cure for ulcerative colitis other than surgical removal of the large bowel and this may be necessary. Biopsies looking for potential malignant change (dysplasia) are usually undertaken at appropriate intervals in patients who have longstanding disease.

When is surgery needed?

Surgery is indicated when medical treatment can no longer control the symptoms that prevent a patient from leading a reasonable lifestyle. Surgery may be indicated in the presence of, or to prevent such complications as haemorrhage, acute toxic colitis and cancer.

What operation might I have?

The aim is to remove all of the large bowel and this can be done in one or more stages. There are two options following total colectomy. The first is to have a permanent ileostomy (bag at the end of the small bowel) and the second is to preserve the anal sphincter muscles to maintain continence, and construct a "new rectum" using small bowel and connecting it to the anus. This removes the need for a permanent ileostomy. This operation, which is called "pouch" surgery or ileoanal reservoir is not suitable for all patients and is more complex surgery than a permanent ileostomy. It results in a variable number of loose but well-controlled bowel actions in a 24 hour period. If cancer has complicated ulcerative colitis the surgical treatment may be modified.

Who should do my surgery?

The decision to operate is always made by the patient's physician and surgeon in consultation, but it is very important that the surgeon is familiar with all aspects of ulcerative colitis and is skilled in the full range of available surgical techniques. Members of the colorectal surgical society of australia have these skills, and they are trained in the long term support and follow-up of patients who have had surgery for colitis.

What can I expect after surgery?

Removal of the diseased bowel implies cure without the need for drugs, and removes the risk of cancer. Life expectancy should be normal. With an ileostomy usual occupations and most sports can be resumed. A normal sex life and pregnancy should be possible. Pouch surgery allows defaecation through the anus, however functional results are variable.

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