



The Association of Coloproctology of Great Britain and Ireland (ACPGBI) is a group of 1000+ surgeons, nurses, and allied health professionals who advance the knowledge and treatment of bowel diseases in Britain and Ireland.

Registered office:
Royal College of Surgeons of England
35-43 Lincoln's Inn Fields
London, WC2A 3PE

+44 (0)20 7973 0307
+44 (0)20 7973 0373
info@acpgbi.org.uk
www.acpgbi.org.uk



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of Great Britain and Ireland**

Ulcerative colitis

Patient information

Ulcerative colitis is a form of inflammatory bowel disease that affects the lining of the large bowel (colon) and back passage (rectum).

The inflammation may be limited to the rectum (proctitis) but it may gradually move upwards and very occasionally may affect the whole of the large bowel.

What are the symptoms?

The disease can give trouble on and off throughout life. Most of the time sufferers feel well with no symptoms – this means the disease is inactive (in remission). The disease flares up from time to time and becomes active (relapse). The main symptoms are:

- Frequent and urgent need to pass blood and mucous (slime from your back passage)
- Diarrhoea
- Abdominal pain
- A general feeling of tiredness

Occasionally, other symptoms occur and these may include reddening of the eyes, joint pain, skin lesions, loss of appetite, irritability and depression.

How is the diagnosis made?

To make a diagnosis of ulcerative colitis it is essential to examine the back passage and colon with a flexible telescope (flexible sigmoidoscope or colonoscope) which allows direct examination of the lining of the bowel.

Often a tiny portion of tissue (biopsy) is taken from the lining of the bowel for laboratory examination.

How can it be treated?

Ulcerative colitis can be cured by surgical

removal of the large bowel. However, for most patients the disease can be controlled by drugs.

- Steroids such as prednisolone are often prescribed for moderate to severe attacks of ulcerative colitis to damp down the inflammation. Steroids may be given as tablets by mouth, enemas, rectal foams or suppositories via the back passage. Severe attacks will be treated in hospital with steroids given via a vein into the blood stream. Another drug, cyclosporin, is sometimes given with intravenous steroids.
- Sulphasalazine, mesalazine or olsalazine are often given during an attack and for long-term use to keep the disease in remission. These drugs may be given as tablets, enemas or suppositories.
- Azathioprine is used for a few patients with long term active disease who would otherwise need repeated courses of steroids.
- Anti-TNF drugs are another group of drugs that can be given to patients with ulcerative colitis to try and prevent inflammation. These drugs are only used in a few patients with severe disease and are given by a Gastroenterologist.
- If only the rectum is inflamed, treatment may just be with enemas, rectal foams or suppositories.

When is surgery necessary?

Most people never need an operation. The colon may have to be removed if:

A very severe attack of ulcerative colitis fails to respond to intensive medical treatment
Repeated attacks cause ill-health

Pre-cancerous changes are found in the colon

What operations are available for ulcerative colitis?

There are several operations available for the surgical treatment of ulcerative colitis. All of these operations involve the removal of the large bowel.

For some patients a proctocolectomy with an ileal pouch is suitable. This involves removal of the entire large bowel and the formation of a pouch to replace the rectum. The pouch is made from a segment of the small bowel and joined to the anus. The operation is often done in stages via a single large incision (open surgery) or with multiple small incisions (laparoscopic or 'key-hole' surgery). Part of the remaining small bowel (ileum) is brought through the abdominal wall onto the tummy as a spout (ileostomy), which drains into a small plastic bag (stoma). When the pouch has healed the bowel is then reconnected such that the spout is put back into the abdomen.

For some patients including those who do not have a good working muscle around the back passage, the most suitable operation is proctocolectomy. This is where the whole colon and rectum are removed and an ileostomy is formed which is permanent. Specialist nurses train the patient in how to care for the ileostomy.

No operation is perfect. Each has advantages and disadvantages. In each case, the choice of operation has to be made on an individual basis by the patient and surgeon.

Do I need a special diet?

In general people with inflammatory bowel disease can eat what they like but it is important to maintain weight. In a few people, milk can make symptoms worse, but the majority of sufferers can take milk products without harm

Can ulcerative colitis lead to cancer?

Yes, but the circumstances under which this occurs are well understood. The risks are only substantial in patients with ulcerative colitis if their disease affects most of, or the whole, colon and has been present for many years. It is sometimes possible to detect warning changes (dysplasia) in the bowel before cancer develops. Some doctors advise patients at risk to have regular annual colonoscopic examinations to detect such changes. If they are found, the person is advised to have the colon removed. The cancer risk can be one factor to be taken into account when deciding whether an operation should be advised for long standing colitis.

Further information

<https://www.crohnsandcolitis.org.uk>