Ulcerative Colitis Guidelines Favor Combo Rx

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BERLIN — Combined therapy with a systemic drug and a topical drug is the cornerstone of treatment for most patients with ulcerative colitis, according to new consensus guidelines developed by the European Crohn's and Colitis Organization.

"It used to be that either a topical or systemic drug was used alone, but new results show that both together [are] superior to either alone," Dr. Eduard Stange said at the annual meeting of the 14th United European Gastroenterology Week. It would be a positive change if the new guidelines persuaded physicians to use combination regimens, Dr. Stange said in an interview.

The guidelines, drafted during a 2-day conference immediately before the annual meeting, will be published in 2007.

For treatment of ulcerative colitis that's confined to proctitis and is mild to moderately active, the new guidelines recommend topical mesalamine as the preferred initial treatment and identify a combination of topical mesalamine and either oral mesalamine or a topical steroid as the next step when neither agent works on its own.

Extensive mild colitis can be treated initially with a topical aminosalicylate plus oral mesalamine.

DR. STANGE

In both left-sided and extensive colitis, mild to moderately active disease is treated initially with a topical aminosalicylate plus oral mesalamine. This is the major, new recommendation of the guidelines, said Dr. Stange, chairman of the guidelines-writing group and chief of internal medicine at Robert Bosch Hospital in Stuttgart, Germany.

A French study recently showed that this combination is more effective than either drug alone. If the combination does not quickly show effectiveness, then treatment with an oral steroid can be initiated.

Management of severely active colitis requires hospitalization and intensive systemic therapy, especially in patients with signs of systemic toxicity, said Dr. Simon Travis, a collaborator on the guidelines and clinical director of gastroenterology and endoscopy at John Radcliffe Hospital in Oxford, England.

A typical steroid regimen is an infusion of methylprednisolone at 60 mg/day. For patients intolerant of IV steroids, an alternative is IV cyclosporine. Both tacrolimus and infliximab are third-line therapies.

When there is no improvement after 4-7 days of all treatment, colectomy is usually recommended.

Relapses during steroid treatment can be treated with azathioprine and 6-mercaptopurine.

Virtually all patients require maintenance therapy, and the goal is a maintenance regimen that does not include a steroid. The mainstay of maintenance therapy is topical aminosalicylate, combined with an oral salicylate if the topical alone is inadequate, said Dr. Marc Lemann, another collaborator on the guidelines and chief of the gastroenterology service at Hospital Saint-Louis in Paris.

Patients who achieve remission with cyclosporine or tacrolimus are usually maintained on azathioprine and 6-mercaptopurine, and those who reached remission on infliximab usually are maintained in infliximab.

For patients who don't respond to medical therapy, including treatment with at least 20 mg of prednisolone daily for 6 weeks, a staged proctocolectomy with rectum preservation is recommended, said Dr. Tom Öresland, coauthor of the guidelines and a surgeon at Sahlgrenska University in Göteborg, Sweden.

The new guidelines also address cancer surveillance. Patients with ulcerative colitis have a 20-year risk for colorectal cancer of about 5%, and a 30-year risk that may be as high as 18%. The evidence is equivocal as to whether surveillance colonoscopy improves survival rates.

All patients with a history of ulcerative colitis should consider taking mesalamine for preventing colorectal cancer. Results suggest the drug halves the cancer rate in colitis patients, Dr. Stange said at the meeting, sponsored by the United European Gastroenterology Federation. Colonoscopy surveillance should continue during mesalamine prophylaxis. ■