

Ulcerative Colitis

Ulcerative Colitis (UC) is a type of chronic inflammatory bowel disease (IBD) characterized by inflammation and ulceration of the inner lining (mucosa) of the large intestine (colon) and rectum. Unlike Crohn's disease, which can affect any part of the digestive tract, UC is confined to the colon and rectum.

What are the patterns of bowel involvement in Ulcerative Colitis?

Ulcerative Colitis is classified based on how much of the colon is affected. This helps us determine the most effective delivery method for medication (e.g., oral tablets vs. topical enemas/suppositories).

- Proctitis: Inflammation is limited to the rectum.
- Left-sided Colitis: Inflammation extends from the rectum up to the splenic flexure (the bend in the colon near the spleen).
- Extensive Colitis (Pancolitis): Inflammation affects the entire colon.

What are the common symptoms of Ulcerative Colitis?

Ulcerative Colitis symptoms typically follow a pattern of "flares" (when the disease is active) and "remission" (when the disease is quiet).

- Bloody diarrhoea: The most common symptom, often accompanied by mucus.
- Urgency: A sudden, often uncontrollable need to have a bowel movement.
- Tenesmus: The feeling of needing to pass stool even when the bowel is empty.
- Abdominal cramping: Often occurring immediately before a bowel movement.

How is Ulcerative Colitis treated?

The goal of treatment is to induce and then, maintain steroid-free remission.

1. Medical Therapy

- 5-ASAs (Pentasa): The cornerstone of UC treatment. These can be taken as tablets or delivered directly to the site of inflammation via suppositories or enemas.
- Corticosteroids: Used briefly to "bridge" the gap until long-term medications take effect. These can be taken as tablets, or occasionally delivered directly to site of inflammation as enemas.
- Immunomodulators: Medications such as Azathioprine that work by dampening the overactive immune system response. These are often used as "maintenance" therapy to keep the disease in remission over the long term.
- Biologic therapy and small molecules: These are advanced, targeted treatments (given via injection or infusion, or as tablets) that block specific proteins in the immune system responsible for inflammation. These are typically reserved for moderate-to-severe disease that has not responded to traditional therapies.

2. Cancer Surveillance

Patients with extensive UC for more than 8 years have a slightly increased risk of colon cancer. We manage this risk through regular surveillance colonoscopies to detect and treat any precancerous changes early.

Patients with co-existing primary sclerosing cholangitis (PSC) have higher risk of developing colorectal cancer and are recommended to undergo annual colonoscopy from the time of diagnosis.

3. Surgery

If medication is no longer effective or if precancerous changes are found, surgery may be recommended. Because UC is limited to the colon, a total colectomy (removal of the colon) is considered curative. Many patients are candidates for an Ileal Pouch-Anal Anastomosis (J-pouch), which creates an internal reservoir from the small intestine, allowing for normal bowel movements without a permanent stoma bag.

Where can I find further support?

For many patients, connecting with others who understand the journey of living with IBD is an invaluable part of management. We highly recommend joining Crohn's and Colitis New Zealand (CCNZ), a nationwide charitable trust dedicated to supporting IBD patients and their whānau.

- Resources: Access to patient-led support groups, educational resources, and events, and the "I Can't Wait" toilet card.
- Advocacy: CCNZ works at a national level to improve access to medications and specialist care for all New Zealanders.
- How to Join: Visit www.crohnsandcolitis.org.nz to access local Christchurch support networks.

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