



Ulcerative Proctitis

Ulcerative proctitis is a mild form of ulcerative colitis, a chronic inflammatory bowel disease (IBD) consisting of fine ulcerations in the inner mucosal lining of the large intestine that do not penetrate the bowel muscle wall. In this form of colitis, the inflammation begins at the rectum, and spreads no more than about 20 cm (~8") into the colon. About 25-30% of people diagnosed with ulcerative colitis actually have this form of the disease.

The cause of ulcerative proctitis is undetermined but there is considerable research evidence to suggest that interactions between environmental factors, intestinal flora, immune dysregulation, and genetic predisposition are responsible. It is unclear why the inflammation is limited to the rectum. There is a slightly increased risk for those who have a family member with the condition.

Although there is a range of treatments to help ease symptoms and induce remission, there is no cure. A diagnosis of ulcerative proctitis can occur at any point throughout life, with a high occurrence in young children and then again around 40-50 years of age. Progression of this disease to ulcerative colitis, extending farther up the bowel to involve the sigmoid colon, occurs in about 30-50% of patients with ulcerative proctitis.

Symptoms/Complications

The presenting symptoms of ulcerative proctitis all relate to the rectum. Blood in the stool occurs in almost all patients. Diarrhea is a common symptom although constipation can also develop, as the body struggles to maintain normal bowel function.

Inflammation of the rectum may cause a sense of urgency to have a bowel movement, discomfort after having a bowel movement, and a sensation of incomplete emptying of the bowels. Systemic symptoms such as fever, tiredness, nausea, and weight loss are rare.

Ulcerative proctitis has very few complications but with increased irritation to the anal and rectal area, hemorrhoids may occur. Only rarely do other complications occur, such as

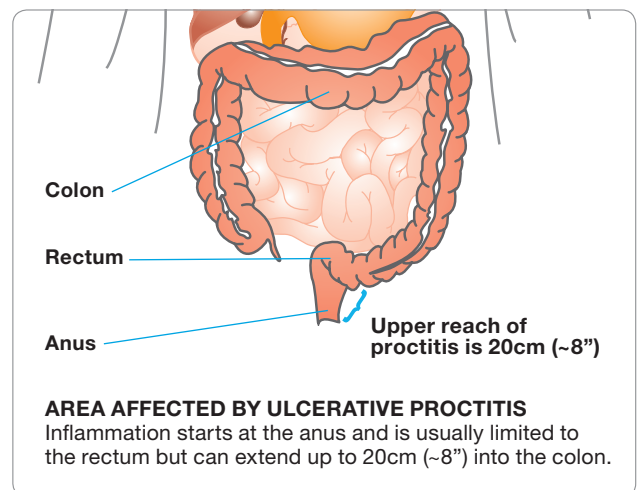
abscesses and extra-intestinal manifestations. Patients with ulcerative proctitis are not at any greater risk for developing colorectal cancer than those without the disease.

Diagnosis

Typically, the physician makes a diagnosis of ulcerative proctitis after taking the patient's history, doing a general examination, and performing a standard sigmoidoscopy. A sigmoidoscope is an instrument with a tiny light and camera, inserted via the anus, which allows the physician to view the bowel lining. Small biopsies taken during the sigmoidoscopy may help rule out other possible causes of rectal inflammation. Stool cultures may also aid in the diagnosis. X-rays are not generally required, although at times they may be necessary to assess the small intestine or other parts of the colon.

Management

The treatment of ulcerative proctitis is multi-faceted; it includes managing symptoms along with following therapies targeted to reduce the underlying inflammation.



Dietary and Lifestyle Modifications

As most nutrients are absorbed higher up in the digestive tract, persons with ulcerative proctitis generally do not have nutrient deficiencies; however, other factors may influence the patient's nutritional state. Disease symptoms may cause food avoidance, leading to food choices that might not provide a balanced diet. If bleeding is excessive, then modifications to the diet will be necessary to compensate for this.

Better overall nutrition provides the body with the means to heal itself. It is important to follow *Canada's Food Guide*, but some foods may irritate the rectum and increase symptoms, even though they do not affect the disease course. The customized recommendations of a registered dietitian can address the patient's sensitive digestive tract.

Symptomatic Medication Therapy

The symptoms are the most distressing components of ulcerative proctitis; therefore, direct treatment of bloody diarrhea and pain will improve quality of life for the patient. Dietary adjustment may be beneficial and anti-diarrheal medications have a major role to play. For painful symptoms not controlled by other drugs, analgesics can be helpful, with acetaminophen (Tylenol®) being the preferred choice.

There are two types of anti-diarrheal medications directed at preventing cramps and controlling defecation.

One group alters the muscle activity of the intestine, slowing down content transit. These include: nonnarcotic loperamide (Imodium®); narcotic agents diphenoxylate (Lomotil®), codeine, opium tincture and paregoric (camphor/opium); and anti-spasmodic agents hyoscyamine sulfate (Levsin®), dicyclomine (Bentylol®), propantheline (Pro-Banthine®), and hyoscine butylbromide (Buscopan®).

The other group adjusts stool looseness and frequency by soaking up (binding to) water, regulating stool consistency so it is of a form and consistency that is easy to pass. These work in different ways; some, such as Metamucil® or Prodiem®, come from plant fibres, whereas cholestyramine resin (Questran®) is a bile salt binder. Interestingly, plant fibres are also useful for constipation, due to their stool regulating effects.

Individuals with ulcerative proctitis may be anemic from chronic blood loss. Adding dietary supplements could help improve this condition, with heme iron polypeptide (Proferrin®) being the preferred choice, due to its quick-acting and low side-effect profiles.

Anti-inflammatory Medication Therapy

Since the inflammation of ulcerative proctitis is limited to a small area of the lower colon, and is relatively accessible, treatment is most successful when given rectally. Your physician may prescribe treatment for you in the typical manners described below, or use an approach designed specifically for your situation.

5-Aminosalicylic Acid (5-ASA)

These medications, taken orally, include mesalamine (Asacol®, Mesasal®, Mezavant®, Pentasa®, Salofalk®) and olsalazine sodium (Dipentum®). They are safe and well tolerated for long-term use. However, quicker results can occur when medication is used in a topical form, taken rectally. Salofalk® is available in 500 mg and 1 g suppositories. Salofalk® 1 g and Pentasa® 1 g suppositories are once-a-day therapies. In a more difficult case, you may receive 5-ASA enema therapy (Salofalk® 4 g & 2 g/60 mL and Pentasa® 1 g, 2 g, or 4 g/100 mL) for a short course, followed by suppositories, as the inflammation improves. Some patients may benefit from a combination of orally and rectally administered 5-ASA therapies in cases that do not respond to rectal therapy alone.

5-ASA helps to settle acute inflammation and, when taken on a long-term basis (maintenance), it tends to keep the inflammation inactive. It is important to keep up your medicine regimen even if your symptoms disappear and you feel well again. Maintenance therapy can be at the full initial dosage or at a reduced dosage and interval, depending on the disease response. Typically, a patient starts on one type of preparation and if there is inadequate response, then switches to another type. On some occasions, it may be necessary (and some patients prefer) to use an oral form of 5-ASA to keep the disease in remission.

Corticosteroids

Patients can also administer these rectally. They come in liquid preparation, thick foam, or suppository, including budesonide (Entocort®), hydrocortisone (Cortenema®, Cortifoam®, Proctofoam®), and bethamethsone, (Betnesol®). However, if the patient has significant diarrhea, then the rectal medications may be difficult to hold. Cortifoam® is a foam preparation of a smaller volume so the patient may retain the treatment in the rectum longer, thereby increasing the amount of time it has to work.

Patients use rectal medications nightly at first and, as the disease improves, treatments become less frequent. Sometimes your doctor will stop treatment and start it again if there is a flare up, and sometimes maintenance therapy two to three times a week may be required long-term.

Surgery

Although ulcerative proctitis can sometimes be very resistant to therapy, it is rare to have surgery to treat this condition.

Outlook

With an appropriate treatment regimen, most ulcerative proctitis patients manage their disease successfully. Further research is essential to uncover the cause, potential treatments, and possible prevention strategies for many digestive diseases and disorders. Historically, gastrointestinal research in Canada has been severely under-funded. Ongoing public support will help further scientific advances.

NOTES:

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