Transcript Details
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/crohns-colitis-foundation-perspectives/reviewing-difficult-cases-in-ulcerative-colitis/11755/

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Reviewing Difficult Cases in Ulcerative Colitis

Announcer:
Welcome to Crohn's and Colitis Perspectives on ReachMD. The following program is produced in collaboration with the Crohn's & Colitis Foundation and the American Gastroenterological Association. Here's Dr. Britt Christensen, head of the Inflammatory Bowel Disease Center at Royal Melbourne Hospital in Melbourne, Australia, sharing some of her difficult cases in ulcerative colitis.

Dr. Christensen:
I actually find the milder cases more difficult. I think if someone's got really severe disease, in some ways it can be easier because you're gonna just throw everything at it at high doses. In ulcerative colitis, the hard patients are gonna be the ones that are very refractory to treatments. And patients who have had past histories of cancers or HIV or things like that makes it even more complicated.

I think the difficult cases are often the ones that have been on steroids for many years; they've been undertreated. If you treat people aggressively at the start, they do really well, but it's the patient who's been out in the community, undertreated, on steroids a long time underdosed on whatever medication they've been on, and by the time they get to you, you then start hitting them hard, they don't respond as well. So I think the big message to my colleagues is doing that sort of topdown approach, trying to get them into remission as quickly as possible.

So for ulcerative colitis, I've had patients with extraordinarily mildly raised LP and it's just a one-off bounce, and if I get the MRCP, often you end up finding that they've got it. If they've got persistently raised LFTs, obstructive LFTs, you've done a full liver screen, and you can't find any other cause for it and the MRCP is normal, then getting a biopsy, but I very rarely have to do that, so that's for small duct PSC.

In ulcerative colitis, and I think if you ever have a stricture anywhere in the colon with ulcerative colitis, alarm bells need to start ringing. You need to be concerned about cancer so you're gonna be looking at that stricture very closely, taking lots of biopsies. And the problem is that sometimes those biopsies can be negative and there can still be a cancer submucosally, so I would even be talking to my surgical colleagues and having a look if they do an endoanal ultrasound. If the patient is symptomatic, then you're gonna be pushing towards surgery because of the concern of cancer. If asymptomatic, it's a bit more difficult, but just talking to the surgeons, making sure you're getting good imaging and then surveying that really closely.

Announcer:
That was Dr. Britt Christensen from Royal Melbourne Hospital in Melbourne, Australia. This program was produced in collaboration with the Crohn's & Colitis Foundation and the American Gastroenterological Association. If you missed any part of this discussion, or to find others in this series, visit ReachMD.com/foundation, where you can be part of the knowledge.