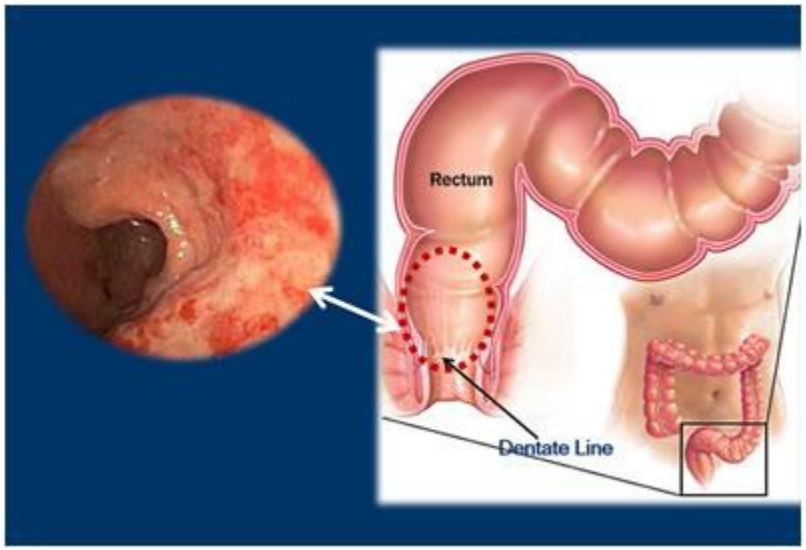
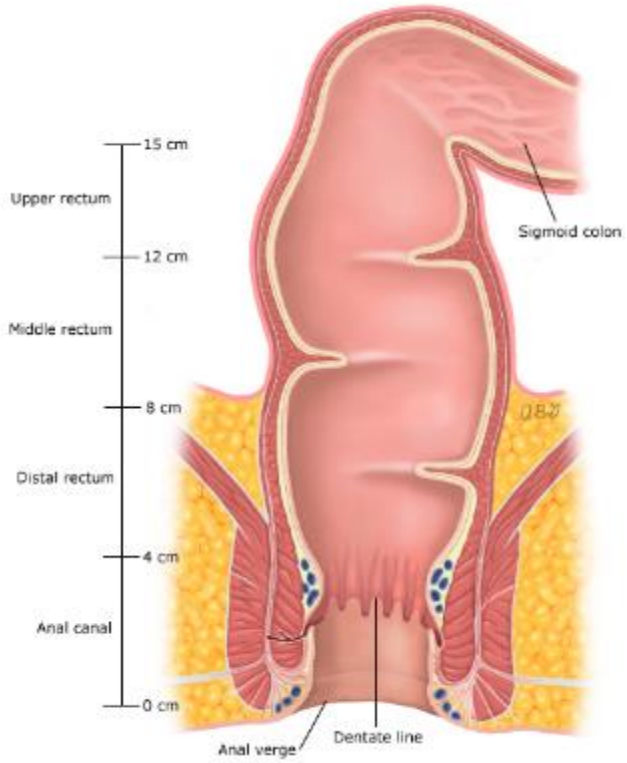
Ulcerative Proctitis

Dr. Nada Alshalabi

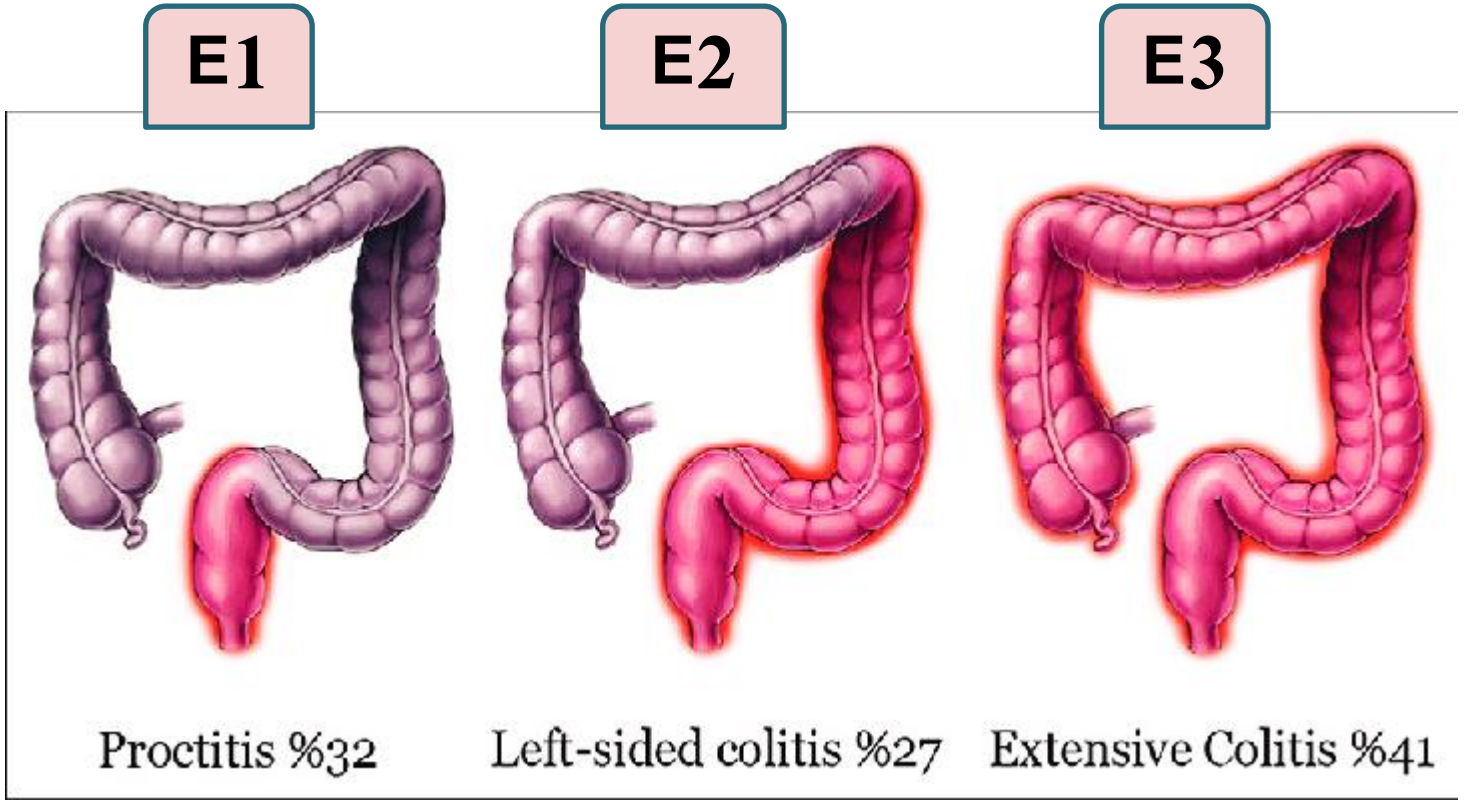


Proctitis is inflammation of the rectal mucosa, distal to the rectosigmoid junction, within 15-18 cm of the anal verge



> three relapses/y or need for systemic steroid or immunosuppressants

25–40% (5–10y)



Montreal classification (E, S, A)

Feeling of rectal fullness

Anal and rectal pain

Pain in the lower left abdomen

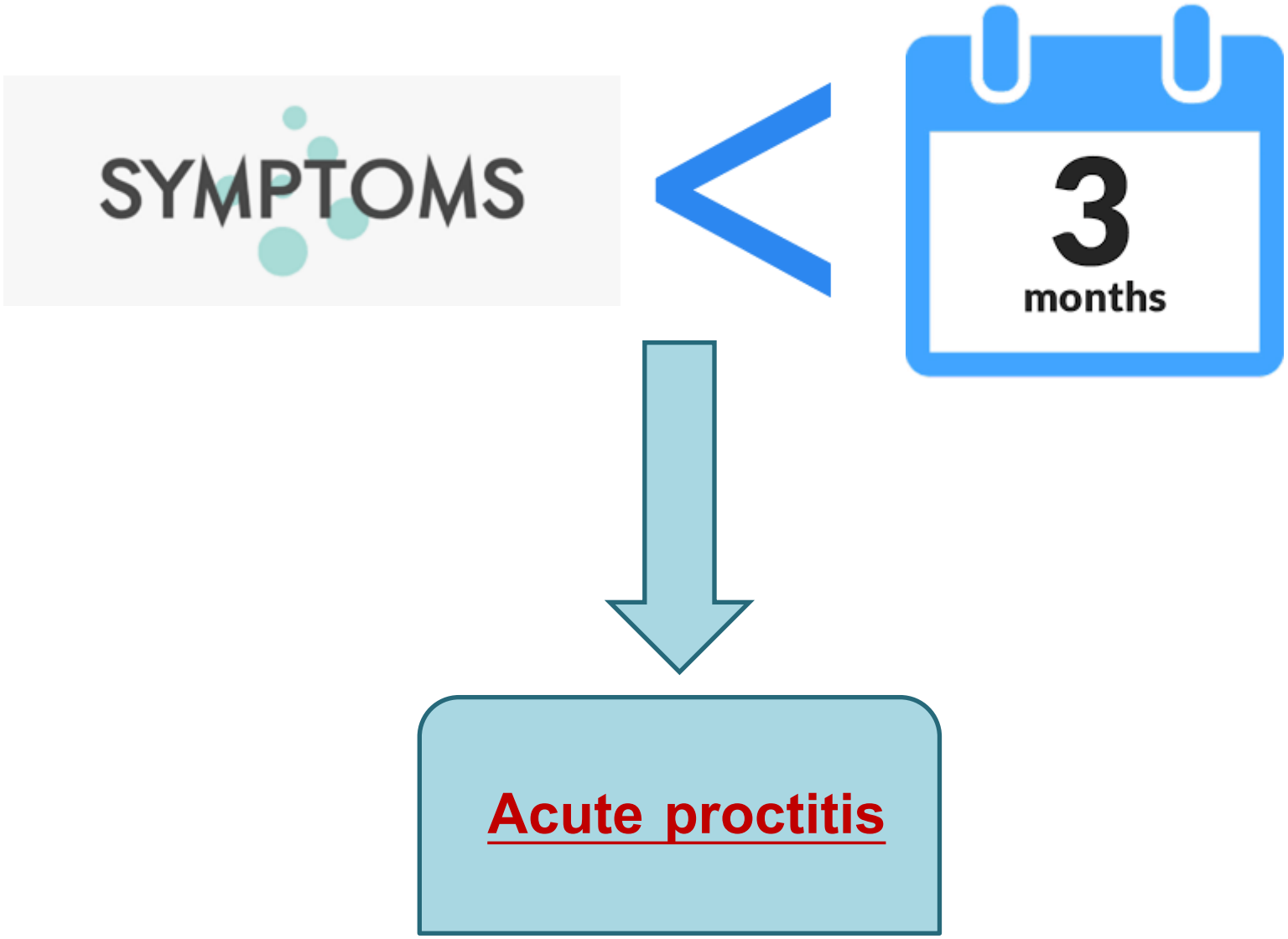
Systemic symptoms are uncommon

Frequent or continuous urge to have a bowel movement

Diarrhea, usually frequent, small amounts

Passing mucus through the rectum

Rectal bleeding


SYMPTOMS
<
3
months
Acute proctitis

Infectious proctitis

STDs

Neisseria gonorrhoeae
Chlamydia trachomatis
HSV types 1 and 2
syphilis

Foodborne infections

Salmonella
Shigella
Campylobacter
Amebiasis

Clostridium difficile

opportunistic infections

CMV

Radiation proctitis

Acute VS Chronic

- ✓ Acute = during or within six weeks of radiation therapy
- ✓ Risk factors

– Dose of radiation : > 45 Gy

– Area of exposure and Method of delivery : External beam radiation or brachytherapy

– Other potential risk factors : inflammatory bowel disease and HIV/AIDS

- **Drug-induced proctitis** : NSAIDS
- **ischemic proctitis** : rare / surgery involving the abdominal aorta

Patients with a prior diagnosis of inflammatory bowel disease who sustain a worsening of symptoms may have an additional etiology superimposed on their underlying disease

WORKUP

- ✓ Inflammatory bowel disease
- ✓ Pelvic irradiation
- ✓ Sexual history
- ✓ Medications (eg, NSAIDs or antibiotics)
- ✓ HIV status / immunocompromised

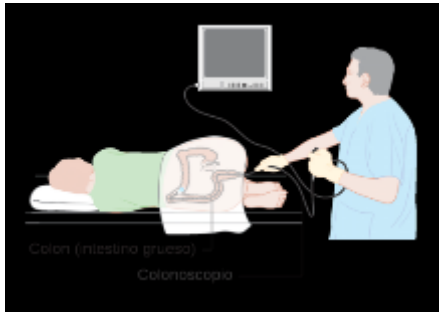
- ❑ A family history of IBD or other gastrointestinal (GI) diseases is extremely important.

WORKUP

- Rule out infectious etiologies

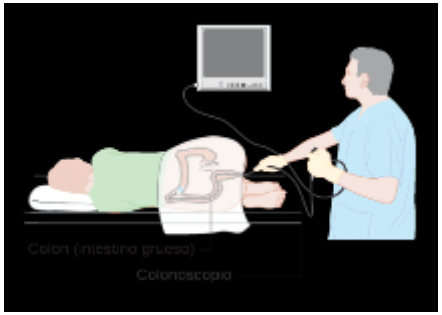
- ✓ Stool culture
- ✓ NAAT for gonorrhea and chlamydia
- ✓ Venereal Disease Research Laboratory (VDRL)/rapid plasma reagin (RPR) tests
- ✓ CMV PCR
- ✓ C difficile toxin titers
- ✓ Microscopic identification of cysts and trophozoites in the stool / E. histolytica antigens in stool /Enzyme immunoassay (EIA) kits for Entomoeba histolytica antibody detection

WORKUP

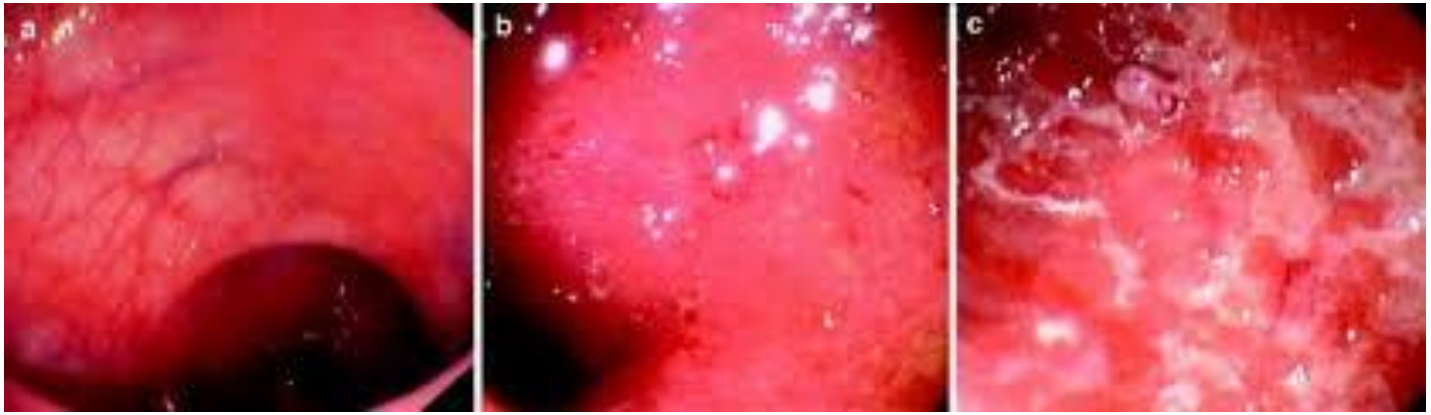


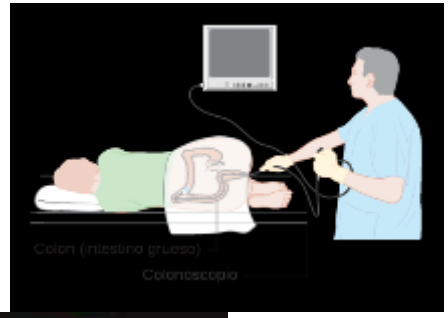
- ✓ A full colonoscopy is recommended for patients with proctitis.
- ✓ To exclude other causes
- ✓ To establish the diagnosis
- ✓ To determine the extent and severity of disease

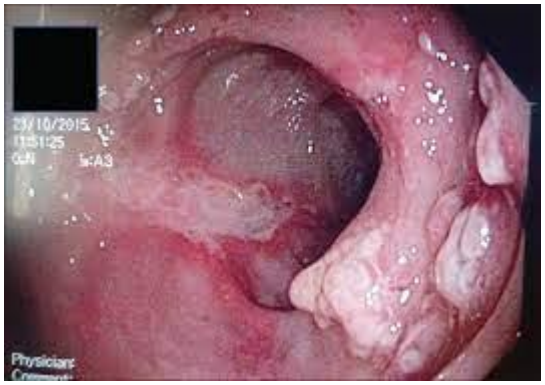
WORKUP



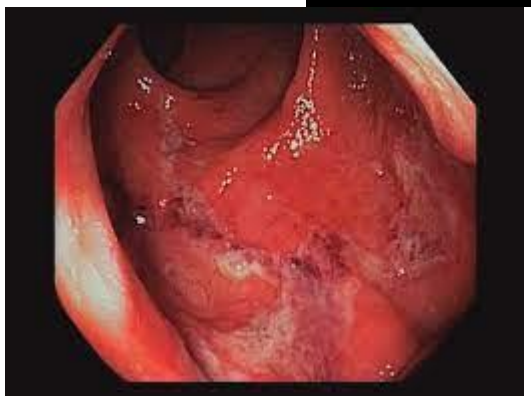
- continuous, circumferential involvement of the rectal mucosa that extends proximally
- Mucosal abnormalities include erythema, loss of vascular pattern, friability, ulcerations, and granularity
- Often a sharp demarcation between inflammation and normal mucosa



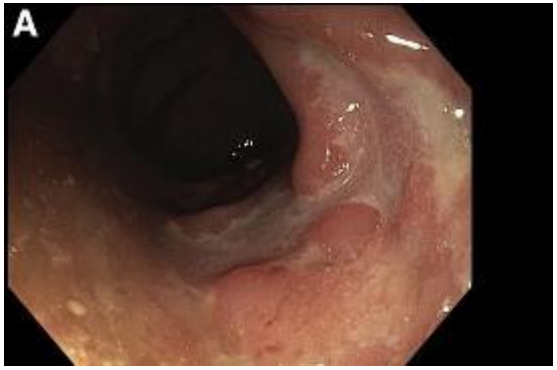




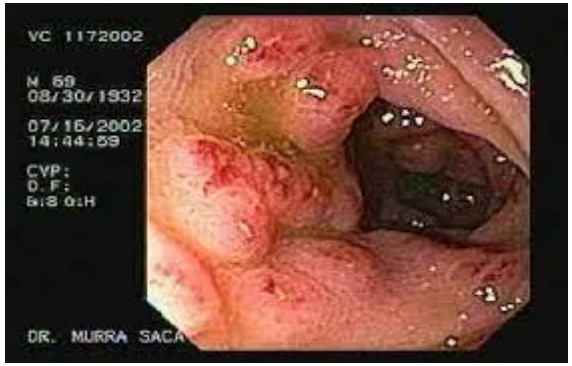
Chlamydia–proctitis



N.Gonorrhoeae proctitis



HIV-proctitis



Amebic colitis

- ✓ Rectal biopsies are useful for differentiating IBD from infectious colitis.
- ✓ Crypt distortion with forked glands, crypt atrophy, and a villiform surface appearance support the diagnosis of IBD and are not usually seen with infectious colitis.
- ✓ A mixed inflammatory infiltrate in the lamina propria is also associated with IBD.
- ✓ Changes in crypt architecture occur early in the course of the disease, being seen as soon as seven days after the onset of symptoms in patients with acute onset IBD

mesalamine suppository, (1) gram once daily/at night

Improvement within 2 weeks ?

YES

NO!

Maintenance with mesalamine supp/once daily

Increase dose to twice daily
Improvement within 2 weeks ?

NO!

YES

Add hydrocortisone supp,(25)mg/once daily
Reduce mesalamine supp to once daily
Improvement within 2–4 weeks ?

Maintenance with mesalamine supp/once daily

YES

NO!

Discontinue hydrocortisone
Maintenance with mesalamine supp/once daily

Add oral 5-ASA agent (>3g)
Continue topical 5-ASA+glucocorticoid regimen
Improvement within 2-4 weeks ?

Add budesonide
OR
Oral systemic glucocorticoid

Maintenance with oral 5-ASA
Discontinue topical therapy

Maintenance therapy

- For patients with ulcerative proctitis who responded to topical mesalamine for induction of remission and who have >1 flare per year, we use a maintenance regimen of one mesalamine suppository (1 gram) every night.

- For patients who are unwilling to use daily topical therapy for long-term maintenance, we reduce the dosing frequency (suppository given every other day or twice weekly)

- For patients who required an oral 5-ASA agent to achieve remission, we continue oral 5-ASA therapy to maintain remission.

- We assess patients clinically and with colonoscopy in 6 to 12 months after achieving clinical remission

FAILURE TO RESPOND

- Compliance

- Refractory disease = no symptomatic improvement with systemic glucocorticoids (prednisone 40 mg per day) within one to two weeks of initiating therapy are regarded as having glucocorticoid–refractory disease.

- Treatment options include a biologic agent (eg, anti–tumor necrosis factor agent) or a small molecule (tofacitinib).


Thank
you