Management of acute severe ulcerative colitis

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Abstract

The management strategy of acute severe ulcerative colitis has evolved over the past decade from being entirely restricted to twin choices of intravenous steroids or colectomy to include colon rescue therapies like cyclosporin as well as infliximab. However it still remains a medical emergency requiring hospitalization and requires care from a multidisciplinary team comprising of a gastroenterologist and a colorectal surgeon. The frame shift in management has been the emphasis on time bound decision making with an attempt to curtail the mortality rate to below 1%. Intravenous corticosteroids are the mainstay of therapy. Response to steroids should be assessed at day 3 of admission and partial/non-responders should be considered for alternative medical therapy/surgery. Medical rescue therapies include intravenous cyclosporin and infliximab. Cyclosporin is administered in a dose of 2 mg/kg per day and infliximab is administered as a single dose intravenous infusion of 5 mg/kg. Approximately 75% patients have short term and 50% patients have long term response to cyclosporin. Long term response to cyclosporin is improved in patients who are thiopurine naïve and are started on thiopurines on day 7. Infliximab also has a response rate of approximately 70% in short term and 50% in long term. Both cyclosporin and infliximab are equally efficacious medical rescue therapies as demonstrated in a recent randomized control trial. Patients not responding to infliximab or cyclosporin should be considered for colectomy.

INTRODUCTION

Acute severe ulcerative colitis (UC) is a medical emergency characterized by presence of more than 6 bloody stools/d along with any of the following: tachycardia > 90 bpm, fever > 37.8 °C, Hb < 10.5 gm/dL, and/or ESR > 30 mm/h (Truelove and Witt's criteria). Other indices for defining severity include modified Mayo's classification, which is a combination of clinical and endoscopic findings, and Montreal classification, which is primarily based on Truelove and Witt's criteria.
However, Truelove and Witt’s criteria is the most widely accepted disease severity index in clinical practice. The term acute severe colitis is preferred over fulminant colitis because the term fulminant is not well defined. It was coined in 1950 when it meant that single attack of UC could lead to mortality within 1 year,[1] which is no longer relevant today. Approximately 20% UC patients with initial disease flares have severe UC,[4], and about 15% patients have a severe attack at some stage of their disease.[5] Megacolon refers to presence of dilated colon (> 5.5 cm) on a plain abdominal X-ray film. Toxic megacolon is presence of megacolon with signs of systemic toxicity (fever, tachycardia, hypotension, leukocytosis). The overall lifetime incidence of toxic megacolon in patients with UC is 1%-2.5%.[6] Prior to introduction of corticosteroid therapy, mortality with acute severe UC was reported to be up to 22%-75% within first year of diagnosis.[7] First clinical trial of steroids for severe UC was performed in the 1950s and this trial reported a mortality of 7% in patients treated with steroids compared with 24% in the placebo group.[8] The mortality with severe UC has reduced to < 1% in specialist centers.

**APPRAOCH TO MANAGEMENT**

**Investigations required at admission**

In addition to monitoring patient’s clinical feature and vital signs, all patients should have their full blood counts, liver and kidney function tests, electrolytes including serum magnesium and inflammatory markers [C-reactive protein (CRP) and erythrocyte sedimentation rate (ESR)]. At least 3 stool samples for *Clostridium difficile* (*C. difficile*) toxin should be obtained to rule out superimposed pseudo-membranous colitis.[9] A plain abdominal X-ray should be done to exclude megacolon. Plain radiograph can also provide information about the extent of disease and can also predict response to treatment. The distal distribution of fecal residue can provide a rough estimate of disease extent as it correlates with the proximal extent of disease.[10] The predictors of poor response to treatment on a plain abdominal radiograph are presence of mucosal islands which are small, circular opacities that represent residual mucosa isolated by surrounding ulceration, or presence of more than two gas-filled loops of small bowel.[11] Flexible unprepared sigmoidoscopy with minimal air insufflation should be performed to confirm the diagnosis and exclude superimposed infection, especially cytomegalovirus (CMV) colitis.[12]. Endoscopic markers of severe disease activity include hemorrhagic mucosa with deep ulceration, mucosal detachment on the edge of these ulcerations, and well like ulcerations.[13].

**Treatment**

**General management**: In addition to specific therapy these supportive measures are very important in the management of patients with acute severe UC. These include: (1) Monitoring and replacement of intravenous fluid and electrolytes to correct and prevent dehydration or electrolyte imbalance as hypokalaemia/hypomagnesaemia can precipitate toxic dilatation[14]; (2) Anticholinergic, antidiarrheal, non-steroidal anti-inflammatory drugs and opioid drugs should be promptly withdrawn as these may precipitate colonic dilatation; (3) Malnourished patients should receive adequate nutritional support. Enteral nutrition is most appropriate and is preferred over parenteral nutrition as it is associated with significantly fewer complications than parenteral nutrition in acute colitis.[14] There is no evidence that bowel rest with parenteral nutrition alters the outcome[15]; (4) Flexible unprepared sigmoidoscopy and biopsy should be done to confirm the diagnosis of acute severe UC and exclude infections such as CMV. Presence of active CMV infection is indicated by presence of cytomegalovirus inclusion bodies on colonic biopsies. However inclusion bodies are not very frequent even in patients with active disease with a sensitivity as low as 37.5%.[17] Special immunohistochemical staining against immediate early antigens of CMV increases the diagnostic sensitivity of histologic examination for CMV. In addition positive plasma real time PCR assays for CMV DNA at levels > 20 copies/100 μL is also an indicator of active CMV disease.[18]. Presence of active CMV disease requires treatment with ganciclovir, especially if the patient is slow to respond to conventional therapy; (5) Stool analysis (in atleast 3 stool samples) to exclude co-existing *C. difficile* toxin is required especially in patients with history of prolonged hospitalization.[19] *C. difficile* infection co-existing with acute severe UC has been associated with increased morbidity and mortality, and requires appropriate antibiotic therapy (oral vancomycin or metronidazole).[20] (6) There is increased risk of thromboembolic phenomena, in patients with active IBD compared to controls, especially during disease flares.[21] Therefore prophylaxis with subcutaneous low molecular weight heparin is indicated to reduce the risk of thromboembolism; (7) Topical corticosteroids or mesalazine may be administered if patient can tolerate and is able to retain them, although there have been no systematic studies in acute severe colitis; (8) Antibiotics are indicated only if infection is suspected or immediately prior to surgery. Controlled trials of antibiotics such as oral or intravenous metronidazole or ciprofloxacin in acute colitis have not shown any significant benefit in addition to conventional therapy[22,23]; and (9) Blood transfusion is indicated in patients with hemoglobin < 10 gm/dL[24]. In addition to these measures daily assessment
of patients’ clinical status should be done in following manner: (1) Physical examination is required daily to evaluate abdominal and rebound tenderness. Joint collaboration between medical and surgical team is required for appropriate management of such patients; (2) Vital signs should be recorded four times daily and more often if deterioration is noted; (3) A stool chart which records the number and character of bowel movements, including the presence or absence of blood and liquid versus solid stool should be properly maintained; (4) Measurement of blood count, CRP, serum electrolytes, serum albumin, liver function tests, and glucose should be done every 24 h; and (5) Abdominal radiographs should be done every 24 h; and (5) Abdominal radiographs should be done every 24 h; and (5) Abdominal radiographs should be done every 24 h; and (5) Abdominal radiographs should be done every 24 h; and (5) Abdominal radiographs should be done every 24 h; and (5) Abdominal radiographs should be done every 24 h; and (5) Abdominal radiographs should be done every 24 h; and (5) Abdominal radiographs should be done every 24 h.

**CORTICOSTEROIDS**

Corticosteroids are the mainstay of therapy for acute severe UC. Steroids are given intravenously with methylprednisolone given in a dose of 60 mg/d or hydrocortisone 100 mg every 6 h. Treatment duration is usually limited to 7 to 10 d; continuing corticosteroid treatment beyond that period carries no additional benefit. True-love and Jewell published the first clinical trial of intravenous corticosteroids for acute severe UC in 1974. Of 49 patients treated with intravenous steroids, 36 (73%) achieved complete remission by day 5. In a recently published systematic review of 1991 patients from 1974 to 2000, patients with significantly longer duration of preoperative medical therapy (> 8 d) were more likely to have major post-operative complications.

**Predictors of response to steroids**

Response to steroids is indicated by improvement in patients’ symptoms (decreased stool frequency, urgency and rectal bleeding, improved stool consistency, reduction in abdominal pain, and improvement in general well being) and improved laboratory parameters (reduced CRP and ESR and improvement in hemoglobin and albumin).

At day 3 of admission, response to steroids should be measured by assessing stool frequency and CRP levels (Figure 1). In the landmark study by Travis et al, which included patients with 51 episodes of severe UC, presence of more than 8 stools/d or 3-8 stools/d plus a CRP > 45 mg/L at day 3 predicted a colectomy rate of 85%. In another prospective study by Lindgren et al, which included 97 episodes of severe UC, the following mathematical model was devised to predict colectomy: number of stools/d + 0.14 × CRP (mg/L) ≥ 8 predicted a colectomy rate of 72%.

Therefore regular assessment of response to steroids is of paramount importance in treating patients with acute severe UC. In a group of 80 patients who underwent emergency colectomy for severe UC between 1994 and 2000 in Oxford, patients with significantly longer duration of preoperative medical therapy (> 8 d) were more likely to have major post-operative complications.

Therefore at day 3 of admission, in cases of non response to steroids according to above mentioned criteria (stool frequency > 8/d or stool frequency 3-8/d and CRP > 45 mg/L) other treatment options or surgery should be considered. In cases of partial response, therapy should be continued till day 5-7, and if the patient still does not respond, other therapies/surgery should be considered (Table 2). In patients who respond to steroids, oral steroids should be started after 5-7 d of
intensive therapy.

There are several other studies which have predicted response to steroids in acute severe UC. Ho et al\[29\], in a retrospective study found that, number of stools/day (score 1-4); hypoalbuminaemia < 3 mg/dL. (score 1) and colonic dilatation > 5.5 cm (score 4) were useful in predicting colectomy as 85% of patients with a score ≥ 4 required colectomy. In another study by Ananthakrishnan et al\[30\], anemia, malnutrition, need for blood transfusion and total parenteral nutrition would independently predict colectomy. Radiological markers which can predict colectomy include the presence of mucosal islands on a plain abdominal radiograph which is associated with a 75% colectomy rate\[31\], and presence of an ileus (indicated by 3 or more small bowel loops of gas) which is associated with 73% colectomy rate\[32\]. In a study, presence of deep ulcers on endoscopy after gentle air insufflation identified 42/49 patients who required colectomy\[33\].

**Cyclosporin**

Two controlled clinical trials established the efficacy of intravenous cyclosporin (fungal calcineurin inhibitor) as medical rescue therapy for acute severe UC not responding to intravenous corticosteroids. In the first landmark trial by Lichtiger et al\[34\] 9 out 11 patients in the cyclosporin (4 mg/kg per day) group had a response vs none of 9 placebo treated patients. The trial was terminated early for ethical reasons because of marked response to cyclosporin. Of nine placebo treated patients 5 patients were crossed over to cyclosporin and all five responded. In another study 73 patients were randomized to 4 mg/kg vs 2 mg/kg of intravenous cyclosporin\[35\]. Response rates at 8 d were similar in both groups (83% and 82% respectively), with 9% and 13% colectomy rate in 2 and 4 mg/kg group respectively. Therefore, cyclosporin dose of 2 mg/kg per day has become the standard in clinical practice. Another European study compared intravenous cyclosporin (4 mg/kg) with intravenous steroids and found similar response rates between the two groups (64% vs 53%)\[36\]. Therefore cyclosporin monotherapy may be preferred over steroids in patients who have high chances of side-effects with steroids including patients with osteoporosis, poorly controlled diabetes and those who are susceptible to steroid-psychois. Overall, pooled results from controlled and non-controlled trials show response rates with intravenous cyclosporin to vary from 76% to 85%, with median time to response being 4 d\[37\].

However, one of the major limitations associated with cyclosporin use is its side effect profile. The short-term side effects are a cause of concern because cyclosporin is generally used as bridge to immunomodulators. These include minor side effects, which occur in 31%-51% patients, including tremors, paresthesias, malaise, headache, abnormal liver function tests, gingival hyperplasia and hirsutism. Major complications are reported in 0%-17% including hypertension, renal impairment, infections and neurotoxicity\[38\]. Cyclosporin therapy in UC is associated with a mortality rate of approximately 1.8%-3.5%\[39\]. Therefore, following points should be considered before starting cyclosporin therapy.

Cyclosporin should not be used if cholesterol < 115 mg/dL or magnesium < 1.4 mEq/L. It should also be avoided in presence of hypertension, renal impairment, epilepsy, sepsis, age > 80 years. Magnesium, cholesterol, and creatinine should be measured at baseline and within 48 h of starting cyclosporin.

Cyclosporin should be administered in a dose of 2 mg/kg per day intravenously aiming for levels 150-250 ng/mL\[35\].

Oral microemulsion 4 mg/kg twice daily can be alternatively considered.

Blood Pressure and renal function should be monitored and cyclosporin should be stopped if serum creatinine rises > 25%.

Cyclosporin should be stopped if there is no improvement in 7 d.

In responders intravenous cyclosporin (Figure 2) should be switched to oral cyclosporin 4 mg/kg per day twice daily. Monitoring of trough levels (150-250 mg/mL) should be regularly done. Azathioprine should be started along with oral cyclosporin. Cyclosporin should be stopped after 3 mo.

Infective complications with cyclosporin can be avoided by minimizing concomitant immunosuppressants and by using prophylactic antibiotics when indicated.

Regarding long term efficacy of cyclosporin (Table 3) several cohorts have been evaluated long term colectomy in patients treated with cyclosporin. In the retrospective cohort from Oxford, 42% patients could avoid colectomy after 7 years\[40\]. Overall, approximately 50% patients will avoid colectomy over a period of 2-3 years\[40,41\]. Immuno modulators when used with cyclosporin can decrease the colectomy rate, thus improving the long term efficacy of cyclosporin. In a study by Cohen et al\[41\] probability of avoiding colectomy at long-term follow-up (5.5 years) was 66% in patients receiving cyclosporin and azathioprine/mercaptopurine compared with 40% in those who received cyclosporin alone. Further studies in this regard

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**Table 2** Ten year follow up of patients of Oxford cohort categorized at day 7 of intensive therapy

| Parameter                      | Complete responders | Incomplete responders |
|-------------------------------|---------------------|-----------------------|
| Colectomy rate at 1 yr        | 5%                  | 54%                   |
| Number requiring colectomy    | 6/19 (32%)          | 10/13 (76.9%)         |
| Maximum steroid free remission| 3.5 yr              | < 1 yr                |

**Table 3** Long term response rates to cyclosporin\[38\]

| Initial response | 74% |
|------------------|-----|
| 1 yr             | 65% relapsed |
| 3 yr             | 90% relapsed |
| 7 yr             | 58% colectomy rates |
have shown that in patients already on immunomodulators at the time of admission with acute severe UC, the likelihood of needing a colectomy following treatment with cyclosporin is higher than among those in whom immunomodulators are started after admission[40]. Therefore, cyclosporin is more beneficial in patients with acute severe UC who are thiopurine naïve at the time of admission. In patients who are already on thiopurine at the time of admission, the outcome with cyclosporin would be less favourable and other medical options or surgery needs to be considered.

INFLIXIMAB

Infliximab the chimeric monoclonal antibody against tumor necrosis factor (TNF) alpha has been found to have a favorable response in patients with steroid refractory acute severe UC. In an open label study of 6 steroid refractory severe UC patients[42], single infusion of infliximab in a dose of 5 mg/kg showed marked clinical improvement at day 7 in all patients. Four out of these 6 patients were in long term remission at median follow up of 5.5 mo. Later a randomized placebo controlled trial of 45 patients (24 infliximab and 21 placebo) showed that a colectomy rate at 3 mo was significantly lower in infliximab group as compared to placebo group (29% vs 67%, P = 0.017)[43]. The maximum benefit of infliximab was seen in patients with moderately severe disease than in those with most severe disease. Prior exposure to thiopurines does not seem to affect the outcome of patients treated with infliximab[43]. Other factors which may adversely affect outcome with infliximab include increased baseline CRP (> 20 mg/L), concomitant steroid use, disease duration ≤ 3 years and baseline Mayo score ≥ 10[44]. Screening for infections and immunization history should be obtained prior to initiating infliximab therapy. Screening tests which need to be done include hepatitis B serology, HIV serology, chest radiograph and tuberculin skin test or Interferon gamma release assays for latent tuberculosis.

Long term follow up data up to 3 years in infliximab treated severe UC patients are available. Two studies with follow up data of 1 year show colectomy rates of approximately 25% at 1 year in infliximab treated patients[43,44]. In another Swedish study, colectomy rate at 3 years in infliximab treated patients was 50% as compared to placebo (76%)[47].

There are no exclusive trials of other anti TNF agents for acute severe UC. However, there are few trials of adalimumab in moderate to severe active UC which showed efficacy of adalimumab over placebo. Reinsch et al[50] showed that adalimumab induced remission in 18.5% patients as compared to 9.2% patients in placebo group (P = 0.031). In another study Sandborn et al[49], in a similar group of patients showed efficacy of adalimumab over placebo (16.5% vs 9.3%, P = 0.019) in inducing remission.

CYCLOSPORIN VS INFLIXIMAB

Before the landmark randomized trial CYSIF (Cyclosporin With Infliximab in Steroid-refractory Severe Attacks of Ulcerative Colitis) between cyclosporin and infliximab there was limited evidence to suggest any difference in efficacy of cyclosporin and infliximab. In a retrospective review of two cohorts (43 treated with cyclosporin and 49 treated with infliximab) there was lower short term colectomy rate in the cyclosporin group[48]. The CYSIF trial[51] randomized 111 thiopurine naïve patients with severe UC after 5 d of IV steroids to cyclosporin (2 mg/kg per day for 8 d followed by 4 mg/kg per day orally) and infliximab (5 mg/kg iv infusion at 0, 2 and 6 wk). Patients who responded at day 7 received oral azathioprine and tapered steroids from day 8. The response to treatment at day 7 was seen in approximately 85% patients in both groups. Colectomy rates at day 98 were also similar be-

![Algorithm for medical rescue therapy after failure of response to intravenous steroids.](image)
between cyclosporin and infliximab (18% vs 21%, \( P = 0.66 \)). Treatment failure at day 98 was also similar, seen in 60% patients in the cyclosporin group \( vs \) 54% in the infliximab group. There was no clear evidence of superiority of any one therapy over other.

Therefore choosing between cyclosporin and infliximab depends upon physician and patient preferences as both appear to be equally efficacious in the setting of acute severe colitis.

### Switching Between Infliximab and Cyclosporin

In cases of non-response to infliximab or cyclosporin, switching to either therapy is associated with significant morbidity and mortality and is not recommended. In the largest study of 86 patients on this aspect, 65 patients were administered infliximab after cyclosporin and 21 patients had cyclosporin after infliximab. Thirty-three percent patients underwent colectomy within 3 mo and 1/3rd of the patients had adverse effects in form of infections\(^5\,^6\).

### Tacrolimus

Tacrolimus is also a calcineurin inhibitor with mechanism of action similar to that of cyclosporin. A randomized trial of tacrolimus included 27/60 patients with severe UC\(^5\,^9\). In this trial partial response was seen in 67% patients, although complete remission was not seen on any patient. However, further case series have shown results similar to that of cyclosporin\(^6\,^9\).

### Toxic Megacolon and Other Complications of Severe UC

Toxic megacolon may be defined as colonic dilatation of more than 5.5 cm along with signs of systemic toxicity. Lifetime incidence of toxic megacolon in patients with UC varies from 1%-2.5% and approximately 5% severe UC patients who are hospitalized may develop toxic megacolon\(^6\). Risk factors include dyselectrolytemia, full bowel preparation and medications (antidiarrheal, anticholinergic, and opioids)\(^6\). Earlier identification of this condition, prompt institution of medical therapy (nil per oral, intravenous broad spectrum antibiotics, fluid and electrolyte management, and intensive therapy) and low threshold of surgery in cases of non-response to medical therapy within 48 h will decrease the morbidity and mortality of this condition.

Other complications include perforation which is the most serious complication of severe UC. Risk factors include inappropriate total colonoscopy and delaying treatment of toxic megacolon. Diagnosis of perforation can often be delayed as abdominal signs can be masked when patient is on steroids. Therefore, patients with severe UC should be monitored closely for abdominal signs and on the slightest suspicion abdominal radiographs should be obtained. Other complication includes severe hemorrhage.

### Surgery

Surgery is the final option for patients with severe UC not responding to medical therapy. Other indications for surgery include toxic megacolon, perforation and severe haemorrhage. The decision for surgery should not be delayed as this increases the morbidity and mortality of surgery. In a study performed at our center, the mortality of emergency surgery was very high if the intervention was delayed beyond 5 d following non-response to intravenous steroid therapy (Table 4)\(^5\). In another study from Oxford, higher surgical complication was noted if surgery was delayed beyond 8 d of medical therapy\(^2\). Therefore management of severe UC requires close collaboration between surgeon and gastroenterologist so that appropriate decisions can be taken without delay.

Most centers advocate a 3 step surgery in emergency setting. The surgical procedure of choice in acute setting is subtotal colectomy and ileostomy, with the rectum left in situ. The whole of rectum and inferior mesenteric artery should be preserved, which facilitates further surgery. The bowel can either be closed in subcutaneous fat or brought forward as mucous fistula, depending upon the surgeon’s decision. Subtotal colectomy is a safe procedure even in critically ill patients\(^8\,^9\) and will relieve the patient from burden of severe colitis, thus allowing the patient to normalise health and nutrition. Reconstructive surgery is best performed approximately 6 mo after primary surgery\(^9\). The second step consists of ileal pouch formation and defunctioning temporary ileostomy. In the final step ileal pouch anal anastomosis (IPAA) is done restoring normal continuty.

There appears to be a strong association of prolonged use of immunosuppression and poor wound healing after surgery which may manifest as wound dehiscence, infection following intestinal leak or a pelvic abscess following anastomotic leak. Long-term preoperative steroid use has been found to be a significant risk factor for anastomotic leak. Immunosuppressive agents (azathioprine and 6-mercaptopurine) have not been associated with increased postoperative complications. When used alone, cyclosporin has not been associated with increased postoperative complications. The use of infliximab (IFX) and its impact on postoperative course is debatable and is a subject of intense interest. Two studies have identified a relationship between IFX and postoperative complica-

### Table 4 Mortality according to day of surgery after intensive steroid therapy

| Timing of surgery | Number of patients | Mortality |
|-------------------|--------------------|-----------|
| Overall           | 51                 | 8         |
| \( \leq 5 \) d     | 17                 | 0/17      |
| \( > 5 \) d        | 34                 | 8/34      |

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tions in IPAA patients. The first report came from Mayo Clinic, which included a retrospective survey of 47 patients who received preoperative IFX and 254 who did not. In the multivariate analysis, IFX was independently associated with increased risk of pouch-related and infectious complications. The authors concluded that IFX was a surrogate for critical patients who were at a higher risk for postoperative complications. The second study by Mor et al. had a case control design. It suggested that patients who had preoperative IFX were 3.5 times more likely to experience an early postoperative complication as compared to control patients. IFX-exposed patients were nearly 14 times more likely to suffer infectious complications. Other studies, which have not been in agreement with the conclusion of above-mentioned studies, include a large retrospective review of 413 patients with UC and CD over a 14-year period. This study did not find any association between IFX and postoperative complications. The study faced certain criticisms, which included a heterogeneous population with > 50% of patients having CD and only 26 patients with UC who had a preoperative exposure to IFX. Another study, evaluating surgical outcomes in 141 UC patients over a 10-year period, found no association of IFX exposure with postoperative complications. In the same study, steroid use was related to increased infectious complications. The limitation of this study was that only 22 patients had IFX exposure prior to surgery. A recent meta-analysis concluded that infliximab use is not associated with increased risk of post-operative complications. At present, no firm conclusions can be drawn. All these studies suffer from a retrospective design. Moreover, it is possible that patients who require IFX represent a patient population, which is at a higher risk for postoperative complications. At the same time, evidence exists that IFX may have a causal role in impairing wound healing and causing anastomotic failure and pelvic sepsis. The definite conclusion which can be drawn is that in patients who have received IFX, a three-stage procedure for IPAA should be considered rather than a two-stage procedure.

Mortality rates associated with emergency colectomy are higher as compared to elective colectomy. In a study from England which included more than 20000 patients with IBD, mortality rates for patients with UC 3 years after colectomy was significantly lower with elective as compared to emergency colectomy (3.7% vs 13.2%) Surgery is not the preferred modality of therapy in young females as ileal pouch anal anastomosis has been associated with lower fertility and fecundity rates. In patients with severe malnutrition, surgery may have to be deferred as the risk of post operative complications is significantly increased in this setting.

CONCLUSION

Acute severe ulcerative colitis as defined by Truelove Witt’s criteria is a medical emergency that requires immediate hospitalization. Fluid and electrolyte balance, withdrawal of drugs promoting colonic dilatation and adequate nutritional support are important adjuncts in the management of severe UC. Intravenous corticosteroids are the first line therapy for severe UC, and approximately two thirds of patients respond. Response to steroids should be assessed at day 3, and in non-responders/partial responders, medical rescue therapy or surgery should be considered. Efficacy of both cyclosporin and infliximab in this setting is comparable as shown in a recent randomized trial. A close coordination between gastroenterologist and surgeon is required for optimal management of severe UC. Surgery is always an option after failure of IV steroids, and all patients should be given an option of surgery. A time bound strategy is required to manage such patients and surgery should not be delayed beyond 5 d of intensive therapy, as a delay increases surgical morbidity and mortality.

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