Refractory Ulcerative Colitis Management (Proctitis)

Panelists

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1404.1.28

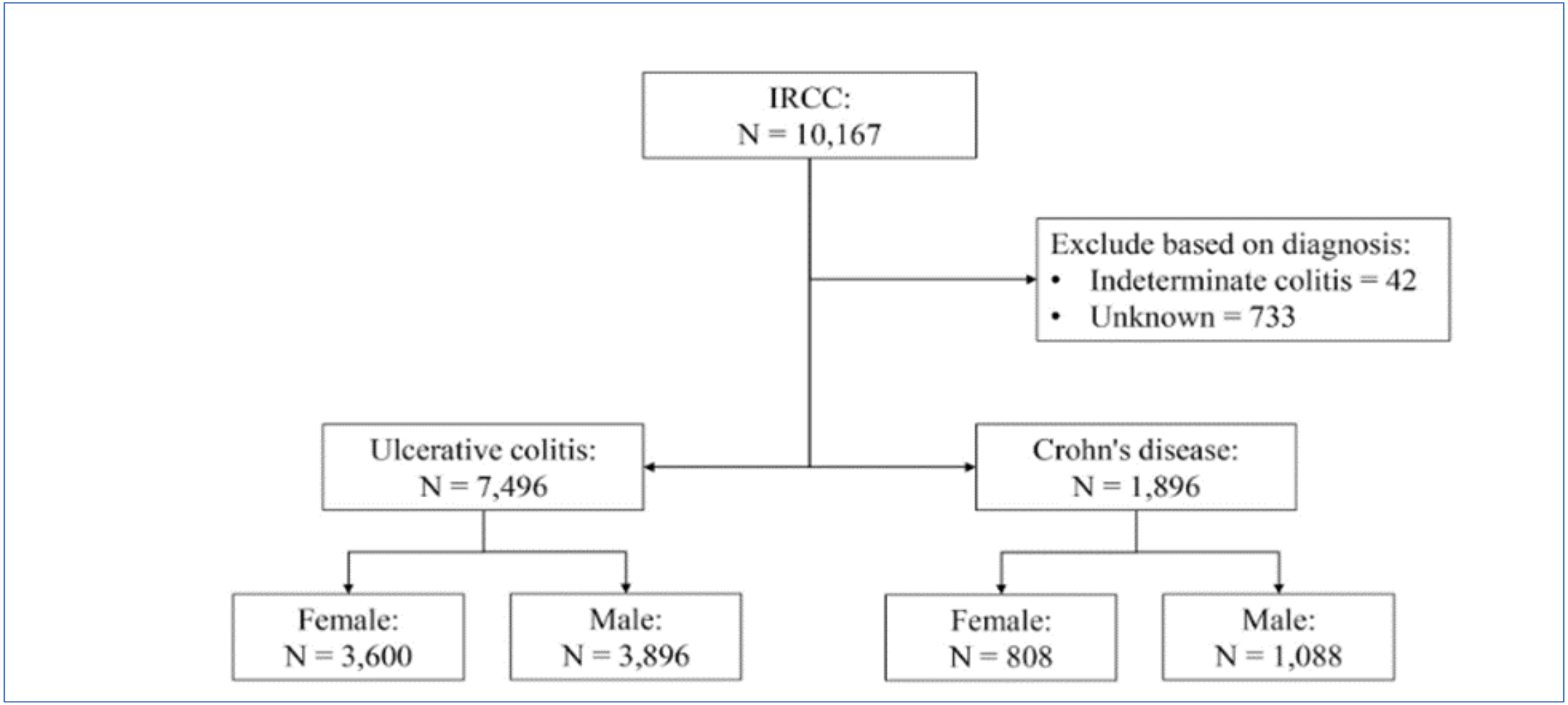
Ulcerative Proctitis

- UP is often under treated and under considered according to its extremely limited extension
- Up to 25-30% of the whole UC patients
- The incidence rate for UP varies from 0.5 to 24.5 per 100,000 person years worldwide
- Approximately 10% to 20% of UP patients *(Refractory)* require an advanced therapy
- Refractory UP;
  - -a neglected entity,
  - -with a dearth of prospective clinical trials

April 2018, Pages 49-57 research clinical gastroenterology

Gastroenterology & Hepatology February 2025 - Volume 21, Issue 2

EXPERT OPINION ON BIOLOGICAL THERAPY 2024, VOL. 24, NO. 6, 443–453


IRCC:
N = 10,167
Exclude based on diagnosis:
• Indeterminate colitis = 42
• Unknown = 733
Ulcerative colitis:
N = 7,496
Crohn's disease:
N = 1,896
Female:
N = 3,600
Male:
N = 3,896
Female:
N = 808
Male:
N = 1,088

Ulcerative Colitis Extension			
	Male	Female	Total
Proctitis	390 (19%)	422 (19%)	812 (19%)
Left sided colitis	759 (36%)	713 (32%)	1472 (34%)
Pan-ulcerative colitis	946 (45%)	1105 (49%)	2051 (47%)

PLOS ONE July 11, 2024 1 / 15

- Proximal extension of UP may occur in;
  - -up to 28% of patients after 5 years follow-up
  - -with progression to extensive colitis in 4–10% of cases

- In a recent population-based study;
  - -25% of UC pediatric patients had UP at diagnosis
  - -49% of them presented colonic extension at maximal follow up

- With respect to cancer risk;
  - -UC disease extent and disease duration
  - -Guidelines exclude UP patients for regular endoscopic surveillance

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Clinical Definitions of Ulcerative Proctitis

- Disease limited to the rectum (within 18 cm of the anal verge, distal to the rectosigmoid junction), but it can also involve other regions of the colon

- Some of providers think that UP and UC are different conditions

- UP and UC; they have the same pathogenetic mechanism and the same immunologic

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- **Therapeutic modalities for the induction and maintenance of remission in refractory proctitis included:**
  - **(i) immunomodulators,**
  - **(ii) monoclonal antibodies,**
  - **(iii) topical calcineurin inhibitors, or other topical therapies**
  - **(v) appendicectomy (10% not responding, or having inadequate response to biologics)**

- **Clinical remission rates for systemic therapies ranged;**
  - **-20–26% for azathioprine (maintenance)**
  - **-50–69% Anti-TNF therapies**

- **Topically tacrolimus in refractory UP;**
  - **-clinical remission rates of 42–46%,**
  - **-with a favorable safety profile**

Journal of Gastroenterology and Hepatology 38 (2023) 496–509

Key Components of Successful Treatment

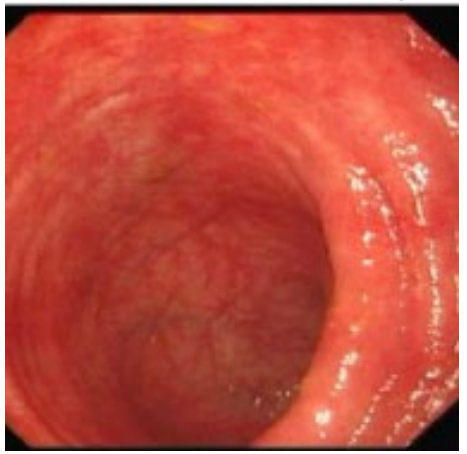
- Engaging patients
- Assessing risk factors
- Setting appropriate treatment targets
- Treating in a timely manner
- Regular and consistent monitoring of objective parameters
- Optimizing treatment, as appropriate, to reach target

Timely treatment and tight control of inflammation could potentially reduce progression of bowel damage and disability and could have a positive impact on the lives of patients with IBD

- 28 year-old female who works as a teacher and is the mother of a toddler
- Over a 3-month period, she experienced symptoms of rectal bleeding, abdominal pain, and 2 to 3 loose stools per day with some blood present, which led her to visit her local emergency department
- The patient was told that, she had hemorrhoidal bleeding and was referred to a gastroenterologist for follow-up care

Colonoscopy; Mild isolated Ulcerative Proctitis, other parts of colonic mucosa up to cecum were normal

Rectal Biopsy; CCDC



- She used topical 5-ASA enemas, but switched to oral 5-ASA
- After taking oral 5-ASA therapy for 6 months, she returned to her gastroenterologist reporting;

    -increased stool frequency (3-4 stools/d), with intermittent blood present

    -and accompanied by fecal urgency, tenesmus, and mild abdominal pain

- These symptoms caused her to;

    -miss several days of work and have negatively impacted her QoL and sleep

- She reports no EIMs, no fevers, nausea/vomiting, or weight loss

- She restarted 5-ASA enemas nightly, and oral prednisolone but her symptoms persist

- Age: 28 y
- Sex: female
- BMI: 26.3
- Diagnosed with isolated UP approximately 6 months ago
- Family history: No family history of IBD or CRC
- Drinks alcohol twice during the week
- Current medication history for UP:
  - 5-ASA (topical and oral)
- Depression:
  - SSRI

Q; 1

In addition to increase stool frequency

Which of the following signs/symptoms reported, is commonly used to assess changes in disease activity of UC/isolated UP?

1-Anxiety

2-Lack of sleep

3-Rectal bleeding

4-Abdominal pain

Score	Stool Frequency (0-3)	Rectal Bleeding (0-3)	Endoscopy (0-3)	PGA (0-3)	Score Range
Mayo Score	Yes	Yes	Yes	Yes	0-12
Modified Mayo Score	Yes	Yes	Yes	No	0-9
PRO2	Yes	Yes	No	No	0-6

- Common symptoms used to assess disease activity and PROs when evaluating patients with UC/UP include;

  -the frequency of loose stools

  -and the presence of rectal bleeding

- Rare symptoms;

  -abdominal pain, nausea, and vomiting are symptoms,

- The recent increase in stool frequency and rectal bleeding reported, indicates;

  -that her disease has worsened

  -and that a change in her treatment plan may be needed

Q; 2

Do you think the patient,s management and treatment is logical?

What kind of management and treatment did you have?

Q; 3

What is the definition of Refractory Ulcerative Proctitis?

- Refractory UP could be defined as;
  - -patients with endoscopically documented active proctitis,
  - -who fail oral CS combined with oral and rectal 5-ASA therapy

- The gold standard treatment for UP is the use of topical 5-ASA

- In a meta-analysis of 11 trials in 778 patients demonstrated that;
  - -topical enema or suppositories of 5-ASA induced clinical remission in active UP

- Cochrane systematic review of 38 clinical trials investigating treatment of distal colitis confirmed the superiority of topical 5-ASA

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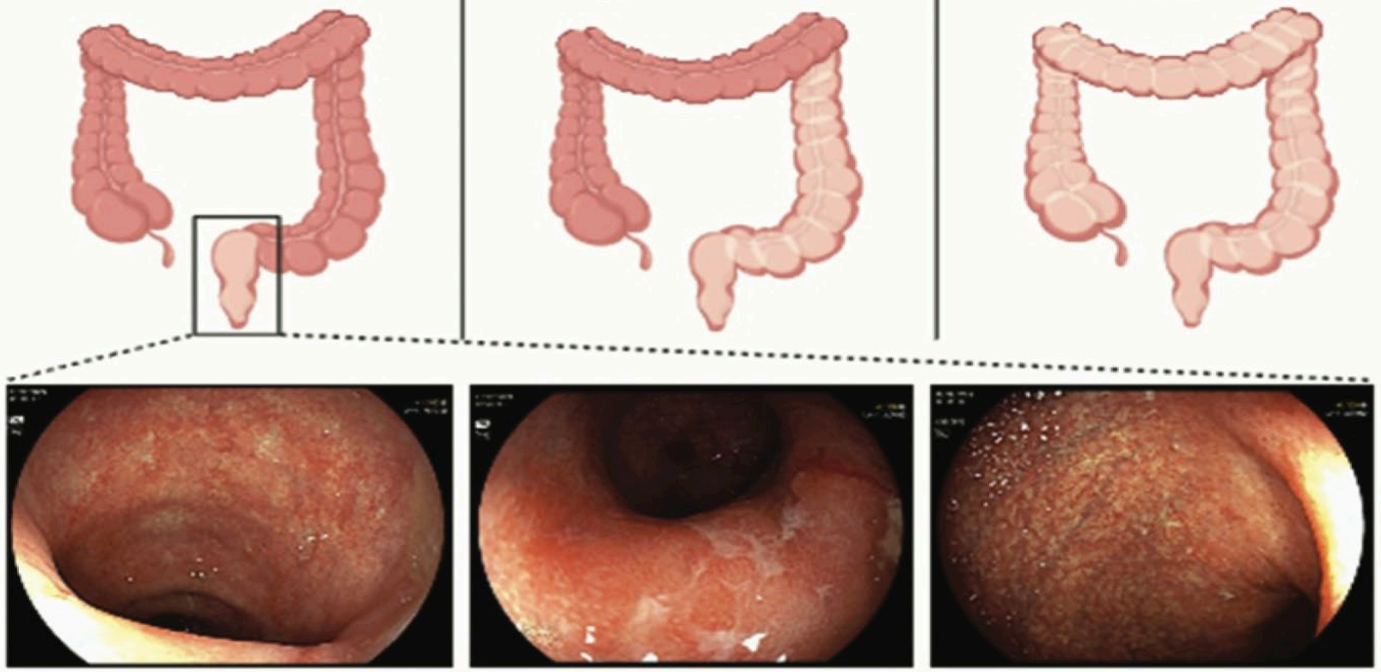
Montreal classification

E1	E2	E3
Ulcerative proctitis	Left sided UC (distal UC)	Extensive UC (pancolitis)
Involvement limited to the rectum	Involvement limited to colorectum distal to the splenic flexure	Involvement extends proximal to the splenic flexure



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Clinical Presentation of UC/UP

- Common symptoms of UC include;
  - -rectal bleeding and loose stools (> 90% of patients),
  - -increased stool frequency (> 3×/d),
  - -tenesmus, nocturnal bowel movements, fecal incontinence,
  - -and abdominal pain
  - -and bowel urgency (50-60% of cases), even during their remission's phases
  - -patients may also report fatigue

Q; 4

What is the differrential diagosis of UP?

- Proctitis is usually caused by underlying medical conditions
- These include:

-sexually transmitted infections, infections from bacteria (Salmonella, Shigella)

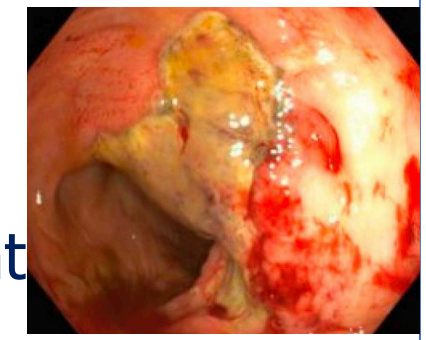
-IBD; CD or UC

-anal trauma, such as from vigorous anal sex

-antibiotic use, such as from the bacteria *C-difficile*

-radiation treatments for ovarian or prostatic cancer





- About 30% of people who have IBD also have proctitis at some point

Q; 5

Which of following risk factors are not predictor; proximal extension of UP?

1-Smoking

2-Chronic active or refractory disease

3-Need for corticosteroids or IMMs

4-Gender, and age at onset

- In the Norwegian study with 10 years of follow-up, 42% of UP patients showed proximal extension to left-sided or total colitis

- These data would indicate that the majority of UP cases remain as UP over time

- Factors that predicted proximal extension of UP included:
  - -smoking, chronic active or refractory disease
  - -and a need for Cs or IMMs
  - -but not gender, age at onset or whether there was a history of appendectomy

Open Journal of Gastroenterology, 2016, 6, 239-248

- Follow-up colonoscopy 2 months later that confirms;
  - -the isolated UP (Mayo 2)
  - -without disease progression to other colonic segments, confirmed by Biopsy

- Simple Clinical Colitis Activity Index (SCCAI) questionnaire, which reveals a score of 8 (indicating active disease or recurrence)

- Her gastroenterologist reviews the patient;
  - -recent clinical history, medical findings, disease symptoms,
  - -and the impact of the disease on her QoL

- Based on the results of the PRO2 score/SCCAI questionnaire;
  - -her disease presentation, and worsening bowel symptoms,
  - -her gastroenterologist concludes; she now has moderate to severe isolated UP

(B) The SCCAI Tool Scoring

Symptom	Score
Bowel Frequency (day)	
1-3	0
4-6	1
7-9	2
> 9	3
Bowel Frequency (night)	
1-3	1
4-6	2
Urgency of Defecation	
Hurry	1
Immediately	2
Incontinence	3
Blood in Stool	
Trace	1
Occasionally frank	2
Usually frank	3
General Well Being	
Very well	0
Slightly below par	1
Poor	2
Very poor	3
Terrible	4
Extracolonic features	1 per manifestation

(B) The SCCAI Tool Scoring

Symptom	Score
Bowel Frequency (day)	
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Extracolonic features	1 per manifestation

Overall Goals of Therapy in UC

The ACG recommends including;

-symptom resolution

-and the restoration of intact mucosa (endoscopic healing),

-attaining steroid-free remission,

-prevent and treat complications

-and preventing hospitalizations and the need for surgery (ie, colectomy)

-Improve QoL

Q; 6

According to current guidelines and patient,s treatment preferences

What would be the most appropriate next therapy for her worsening disease?

1-JAKi

2-Methotrexate

3-Anti TNF (Remicade or Adalimumab)

4-S1P receptor modulator

5-VDZ

6-UST

7-Tacrolimus

8-Appendectomy

Drug-related factors


Indication


Efficacy


Mucosal healing


Safety profile


Rapidity of onset


Corticosteroid use


Cost

Patient-related factors


Age and gender


Comorbidities (including EIM)


Pregnancy


Current and prior therapies


Surgery


Convenience/mode of administration



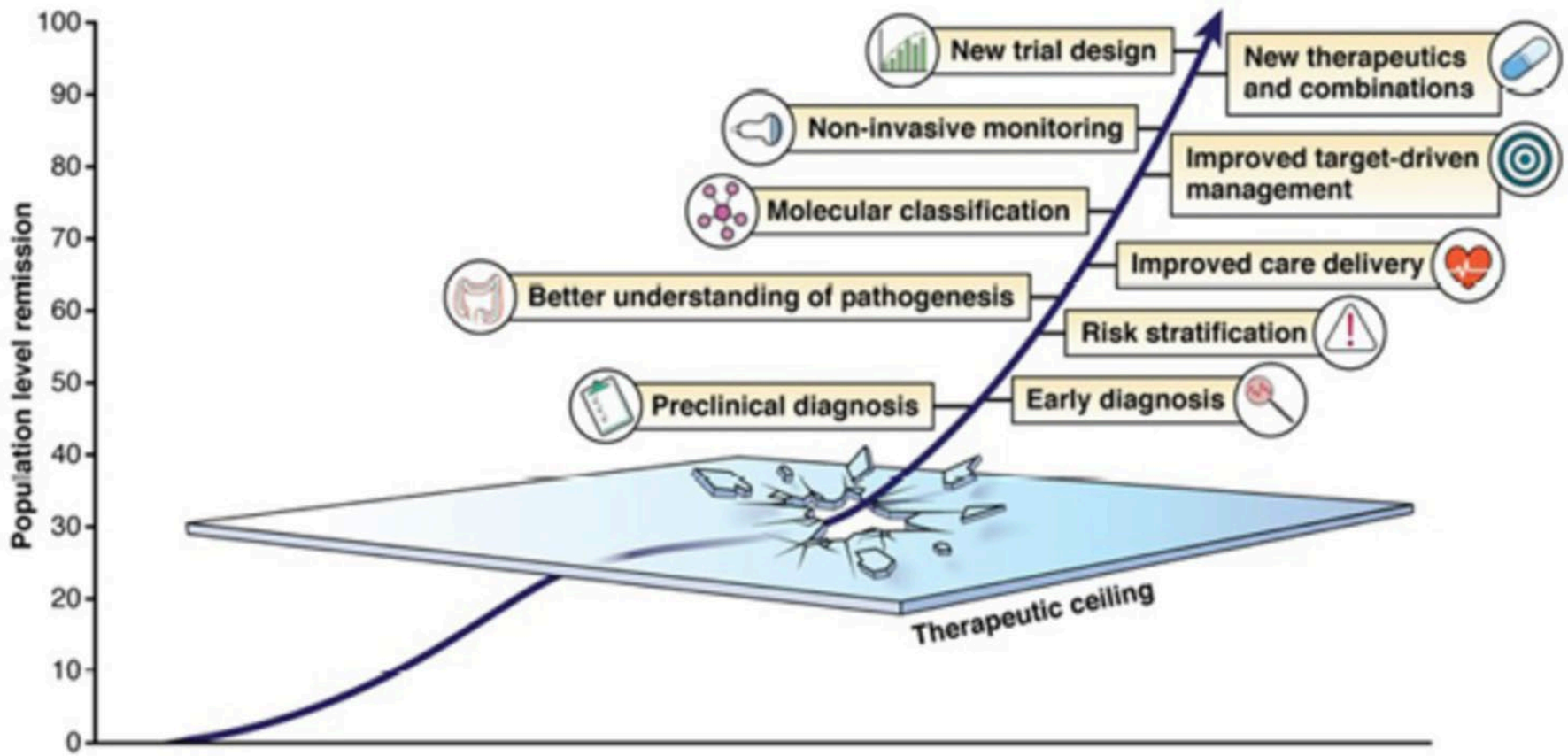
Precision medicine may guide the future of treatment

Digestive Disease Week 2024

- The recent study showing;

  -approximately 10%-20% of patients with UP require an advanced therapy

Focus points for advancing care in IBD



AGA Recommendation:

- In adult outpatients with moderate-to-severe UC who are naïve to advanced therapies the AGA suggests using;

ADVANCED THERAPY-NAÏVE PATIENTS (FIRST-LINE THERAPY)	
SUGGEST using a HIGHER efficacy, or INTERMEDIATE efficacy medication, rather than a lower efficacy medication. *(Conditional recommendation, low certainty of evidence)*	
HIGHER EFFICACY MEDICATIONS:	Infliximab, Vedolizumab, Ozanimod, Etrasimod, Upadacitinib*, Risankizumab, Guselkumab
INTERMEDIATE EFFICACY MEDICATIONS:	Golimumab, Ustekinumab, Tofacitinib*, Filgotinib*, Mirikizumab
LOWER EFFICACY MEDICATIONS:	Adalimumab

Gastroenterology 2024;167:1307–1343

Managing UC and UP

FDA-approved advanced therapies for moderate to severe UC (AGA,ACG)

- Patients with UC may be considered for treatment with;
  - -anti-TNF agents (IFX, ADA, golimumab) as first-line therapy,
  - -anti-integrin(VDZ) and IL12/23 antagonists(UST) may also be considered

- JAK inhibitors (Tofa, UPA) can be considered after failure of anti-TNF therapy

Systematic review of therapeutic options for refractory proctitis

Systemic therapies

MONOCLONAL ANTIBODIES

*3 retrospective case series (*n* = 158)

*Clinical remission

--- TNF-I (*n* = 143) : 50 – 64%

---Vedolizumab (*n* = 15): 67%

AZATHIOPRINE

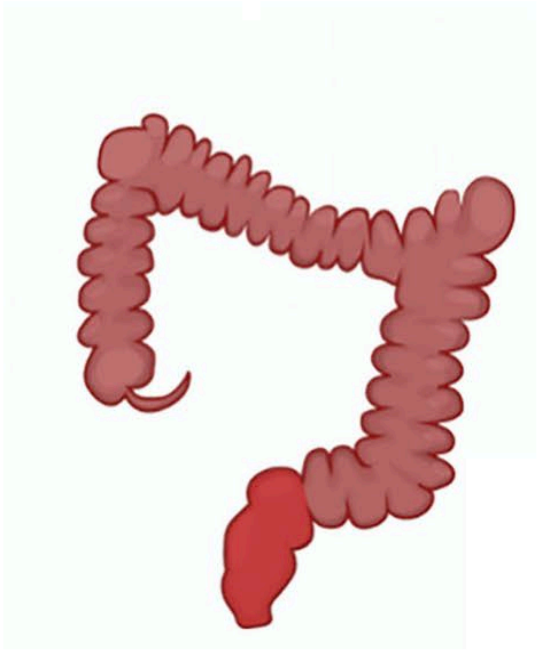
*2 retrospective case series (*n* = 44)

*Clinical remission: 14.3 – 26%

APPENDICECTOMY

*1 prospective case series (*n* = 30)

*Clinical remission: 40%



Local therapies

TOPICAL TACROLIMUS

*2 randomized controlled trials (RCTs).

1 pilot study, 2 retrospective case series (*n* = 163)

*Clinical remission: 42 – 52.3%

Journal of Gastroenterology and Hepatology 38 (2023) 496–509

- A comprehensive literature search was performed to examine the effectiveness of UST in UC patients admitted between January 2019 and December 2021
- A total of 14 eligible studies were identified
- The pooled clinical remission rate was;

  -55.0% at week 8,

  -36.1% at week 16,

  -46.6% at month 6,

  -and 38.6% at month 12

  -AEs; 10.9%

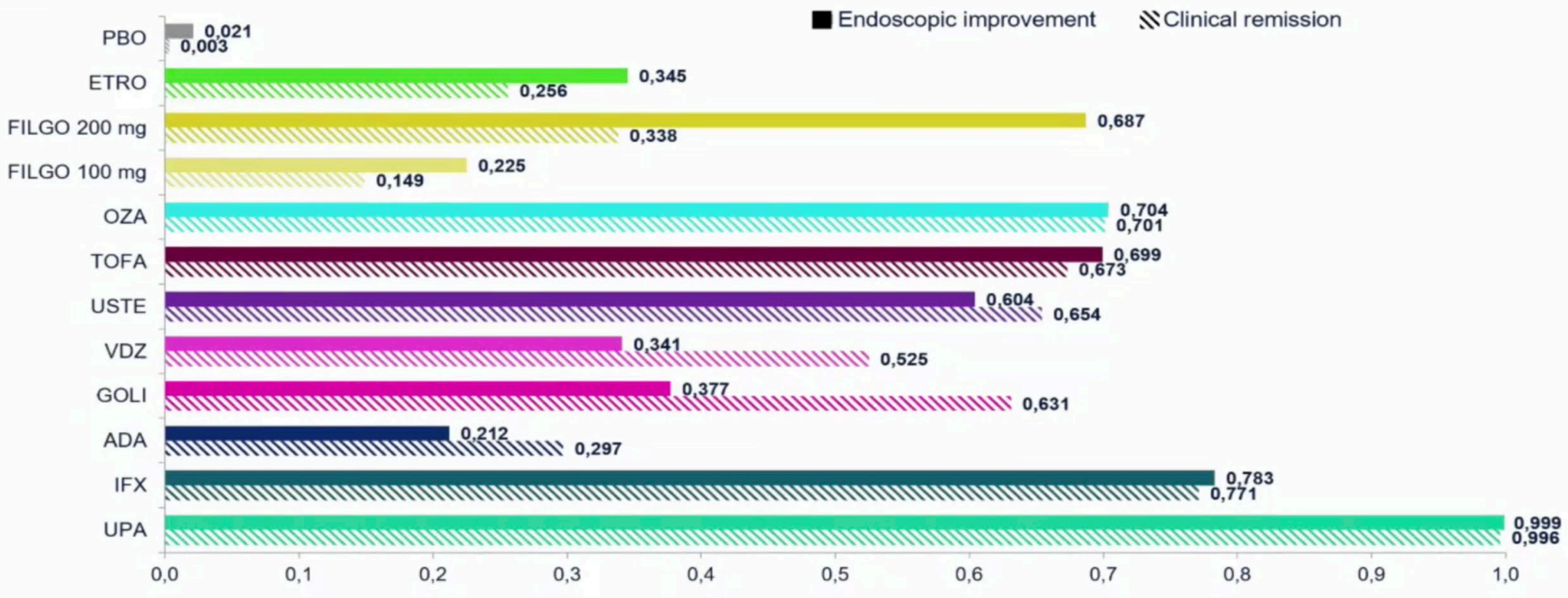
- The early use of UST prior to other biologic agents, such as anti-TNF-a agents or VDZ;

  -it may be maximize therapeutic strategy to use UST in UC treatment

Nagoya J. Med. Sci. 85. 402–427, 2023

Network meta-analysis:

SUCRA values for induction of clinical remission and endoscopic improvement (overall population)



ADA, adalimumab; ETRO, etrolizumab; FILGO, filgotinib; GOLI, golimumab; IFX, infliximab; OZA, ozanimod; PBO, placebo; SUCRA, surface under the cumulative ranking; TOFA, tofacitinib; UPA, upadacitinib; USTE, ustekinumab; VDZ, vedolizumab.

Figure adapted from Lasa JS, et al. *Lancet Gastroenterol Hepatol*. 2022;7:161–70 (supplementary data).

Medical therapy for UP

- Medications for UP are similar to those employed in UC
- The **ACG** recommends;

  -rectal 5-ASA at a dose of 1 g/d for induction of remission
- The **AGA** recommends;

  -rectal therapy over oral therapy, 5ASA suppository for mild to moderate

- Cs may be added on to 5-ASA therapy (eg, oral prednisone or budesonide) for those with inadequate response to optimized 5-ASA

- For those who are refractory to combination (oral and topical) 5-ASA and Cs;

  -advanced therapy is indicated

  -one third (31%) of patients with UP may have refractory/steroid-dependent disease

Q; 7

Why might topical treatments be preferred over oral or parental treatments?

- The local concentration achieved with topical therapy likely exceeds the concentration obtained with some of the common oral therapies, and that applies to any form of UC
- Any treatment a patient takes by mouth, and that does not work systemically by absorption, has to travel 18 to 20 feet to reach the colon
- Rectal topical therapies are essentially placed at the site of action

Q; 8

Which advanced therapies have been studied for the treatment of UP?

- The only one that has been studied in a clinical trial thus far is the S1P receptor modulator Etrasimod in the ELEVATE trial
- This class of drugs was approved in UC 3 years ago
- Etrasimod was the first systemic advanced therapy in the past 3 decades to undergo a clinical trial that included patients with UP
- The results for Etrasimod in the UP group were at least as good as those for patients with more extensive UC
- *The POLARIS trial of the S1P receptor modulator Ozanimod has also enrolled patients with UP*

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Other studies should be noted in the management of refractory UP patients

- There are data on anti–TNF agents that show effectiveness in refractory UP
- The data suggest that biologics and other small molecules such as TOFA are also effective for UP
- That is why the ELEVATE trial was a significant breakthrough; it was a controlled, RCT that included UP patients (***Etrasimod***)

Gastroenterology & Hepatology February 2025 - Volume 21, Issue 2

Topical calcineurin inhibitor (tacrolimus)

- Systematic review identified five studies examining the use of Tacrolimus suppositories and enemas in refractory UP patients
- Three of these studies were prospective clinical trials, including two RCTs
- Dieren et al. conducted a pilot study of topical tacrolimus for distal colitis refractory to 5-ASA and/or steroid therapy

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JAK inhibitors

- Tofacitinib offers a promising therapeutic option for patients with UP, even in cases of multiple biologic exposure
- Other small molecules may also be offered to patients with UP (recently suggested; ELEVATE UC trial)
- These findings, along with our study, support the idea of including patients with UP in phase 2/3 UC trials
- Tofacitinib may offer a therapeutic option for patients with refractory UP

***Journal of Crohn's and Colitis*, 2024, 18, 424–430**

- A JAK inhibitor would not be an option for her at this time

- JAKi agents would only be considered after failure of response or intolerance to anti-TNF-α therapy

- Biologic agents, such as;

  -monoclonal antibodies, are delivered either IV or SC,

  -these would not be appropriate options for patient given her strong preference for oral therapy

- Clinical studies have demonstrated a lack of efficacy for ***MTX*** monotherapy in UC

Managing isolated UP with S1P receptor modulators

- Most advanced therapies do not have a specific indication for isolated UP;

  -and clinical trials in UC have historically excluded patients with isolated UP

- The ELEVATE trial program investigating ***Etrasimod*** in patients with moderate to severe UC included;

  -a subgroup of patients with isolated UP (defined as < 10 cm of rectal involvement)

- In a recent post hoc analysis of data from ELEVATE, patients with isolated UP who received Etrasimod were shown;

  -to have significant improvement in clinical remission rates compared with placebo at weeks 12 (Etrasimod, 42.9%, vs placebo, 13.6%; *P* <.01)

  -and 52 (Etrasimod, 44.4%, vs placebo, 11.1%; *P* < .001)

- These data suggest that Etrasimod may be safe and effective to use in patients with isolated UP who fail to respond to oral and/or topical 5-ASA treatment

Journal of Crohn's and Colitis, 2024, 18, 1270–1282

- Personal preference for an oral therapy,

  -an S1P receptor modulator would be the most appropriate next therapy for her

- She and her gastroenterologist decided to try an S1P receptor modulator

- After discussing the benefits and risks of the 2 available S1P receptor modulators ***Ozanimod*** and ***Etrasimod***;

  -ultimately decided that SIP(Ozanimod) was a more suitable option to manage her disease

  -she current use of antidepressant medication and weekly alcohol intake

- Her doctor recommends; Etrasimod given its favorable pharmacodynamic profile compared with Ozanimod and the recent demonstration of its efficacy/safety in patients with isolated UP

- Necessary prevention and safety monitoring strategies associated with the use of these drugs are discussed with patient before initiating therapy

Journal of Crohn's and Colitis, 2024, 18, 1270–1282

Q; 9

Which of the following monitoring strategies should be performed before initiating patient on an S1P receptor modulator?

1-Assess urine protein

2-Evaluate electrolytes

3-Performed ECG and check blood pressure

4-Check serum lipid and glucose levels

Safety of S1P Receptor Modulators

- Common AEs observed in ≥ 5% of patients in clinical trials included;
  - -headache, elevated liver tests,
  - -and dizziness

- Special warnings and precautions with ozanimod and etrasimod include;
  - -an increased risk of infections (which can be serious/life-threatening),
  - -transient decrease in heart and AV conduction delays,
  - -hypertension, liver injury, macular edema,
  - -skin malignancies, fetal risk, posterior reversible encephalopathy syndrome,
  - -and respiratory effects

Drug-drug interactions of interest

- The use of S1P receptor modulators, particularly ozanimod, is contraindicated with concomitant use of certain medications
  - -increase norepinephrine or serotonin levels
  - -or drugs eg, MAOIs, SSRIs, tricyclic agents,
  - -and tyramine, leading to serious AEs, such as hypertensive crisis

- Consumption of certain foods/alcoholic beverages should be avoided, such as;
  - -those containing high levels of tyramine (eg, soy sauce, aged cheddar cheese)
  - -and alcoholic beverages (eg, unpasteurized craft beer, wine),
  - -as S1P receptor modulators may interfere with the metabolism of tyramine
  - -antiarrhythmic and QT-prolongation drugs, β- and Ca channel blockers,
  - -anticancer drugs, IMMs
  - -and rifampin

Table 6. Key Monitoring Recommendations When Using S1P Receptor Modulators[38,39,62]

Warning or AE of Interest	Monitoring Recommendations/Best Practice Considerations

Infections	• Ozanimod:
	  • Check CBC prior to starting therapy
	  • Monitor for infections during treatment and 3 mo after stopping therapy
	• Etrasimod:
	  • Check CBC prior to starting therapy
	  • Monitor for infection during treatment and for 5 wk after treatment discontinuation
	  • Avoid using live attenuated vaccines during and up to 5 wk after treatment

Bradyarrhythmia and AV conduction delays	• Perform ECG to assess for preexisting cardiac conduction problems • Refer patient to cardiology for further consultation when: • Conduction abnormalities are detected • Patients are on therapies that decrease heart rate

Q; 10

Is there a role for Appendectomy in the Management of Refractory UP?

- Refractory UP patients, 10% not responding to biologics, or having inadequate response to biologics;

  -after undergoing an appendectomy,

  -40% of patients entered remission

- The most of physician;

  -reluctant to send a patient for appendectomy for a perfectly normal appendix,

  -especially since surgeons are frequently not familiar with this literature

- *It is not common or part of any standard in the United States or Western Europe*

***Journal of Crohn's and Colitis*, 2024, 18, 424–430**

Systematic review of therapies for refractory ulcerative proctitis

- Prospective case series of 30 adult patients with refractory proctitis who underwent appendicectomy in the absence of acute appendicitis

- All patients underwent colonoscopy months prior to appendicectomy and had exposure to CS, and topical and oral 5ASA

- Disease activity; using the SCCAI with median score at baseline of 9 (range 7–12)

- At last follow up (median duration 14 months [range 9–32 months]);
  - -12 patients (40%) were in clinical remission as defined by SCCAI score of 0,
  - -27 patients (90%) were deemed to have had a clinical response, defined as any improvement in SCCAI

- No patients had perioperative complications or worsening of proctitis activity

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Lancet Gastroenterol Hepatol

Appendicectomy plus standard medical therapy versus standard medical therapy alone for maintenance of remission in ulcerative colitis (ACCURE): a pragmatic, open-label, international, randomised trial

The ACCURE Study Group*

Methods

- Eligible patients were aged 18 years or older, had established UC and were in remission, but had required treatment for an episode of active disease within the preceding 12 months

- Remission was defined as a Mayo score of 2 or lower, with stool frequency, rectal bleeding, and physician's global assessment sub-scores of 0 or 1, confirmed by a Mayo endoscopic score of 0 or 1 within 3 months before randomization

Lancet Gastroenterol Hepatol 2025 April 11, 2025

Results

- Between Sept 20, 2012, and Sept 21, 2022, 1386 patients were screened
- 201 patients were randomly assigned to the appendicectomy group (n=101), and the control group (n=100)

- The 1 year relapse rate was significantly lower in the appendicectomy group than in the control group;
  - -36% of 99 patients (Appendectomy Case)
  - -56% of 98 patients (Control)
  - -AEs occurred in 11% of patients in the appendicectomy group and 10% of patients in the control group

- Two cases of low-grade appendiceal mucinous neoplasm were incidentally found in appendix specimens in appendicectomy group
- Serious AEs occurred in two (2%) of 96 patients who underwent appendicectomy and none in the control group
- There were no deaths

Lancet Gastroenterol Hepatol 2025 April 11, 2025

انجمن حمایت از بیماران مبتلا به بیماریهای التهابی روده ایران

ueg week

ACCURE-trial

THE EFFECT OF APPENDECTOMY ON THE CLINICAL COURSE OF ULCERATIVE COLITIS (ACCURE):

Preliminary results of an international, randomized, clinical trial

E. Visser[1], W.A. Bemelman[1], G.R.A.M. D'Haens[2], T.D. Pinkney[3], C.J. Buskens[1], on behalf of the ACCURE study group

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[2] Department of Gastroenterology and Hepatology, Amsterdam University Medical Center, Amsterdam, the Netherlands.
[3] Academic Department of Surgery, University of Birmingham, Birmingham, UK.

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انجمن حمایت از بیماران مبتلا به بیماریهای التهابی روده ایران

Results

Safety

	Appendectomy (N=85)	Control (N=83)	P value[1]
Colitis associated AE	49.4%	67.5%	**0.02**
Suspected relapse	40.0%	61.4%	
Exacerbation of symptoms	5.9%	3.6%	
Abdominal pain	1.2%	3.6%	

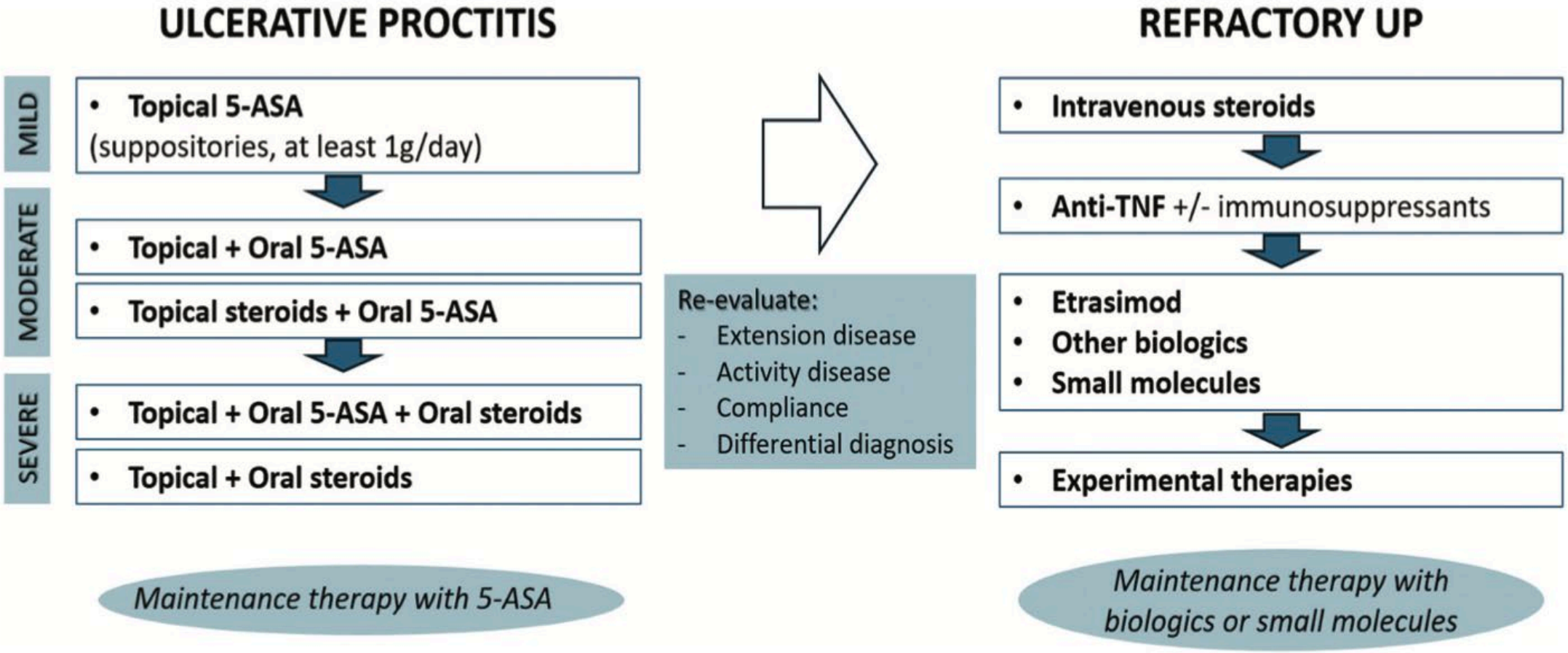
[1]chi-square test

Abbreviations: AE: adverse event.

Conclusion

Appendectomy in patients with UC has the possibility to **decrease** the rate of colitis-associated adverse events significantly.

This suggests that the final analysis of the primary outcome (relapse rate) may demonstrate that **appendectomy is superior to standard medical therapy alone in maintaining remission in these patients**.



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Back to case

- The patient follows up with her doctor after 3 months on ***Ozanimod***
- Her FC level has decreased from 465 µg/g to 185 µg/g
- Her symptoms of fecal urgency, rectal bleeding, and stool frequency have also improved markedly
- Six months later, she is in clinical remission (SCCAI score, 1) and endoscopic healing (Mayo score 1)

Q; 11

According to the STRIDE-II Recommendations

What should be an important in short term treatment goal?

1-Clinical remission

2-Clinical response

3-Endoscopic healing

4-Normalization of CRP levels

- According to the STRIDE-II recommendations, clinical response is a short-term treatment goal, specifically, this includes;

  -a decrease of at least 50% in PRO2,

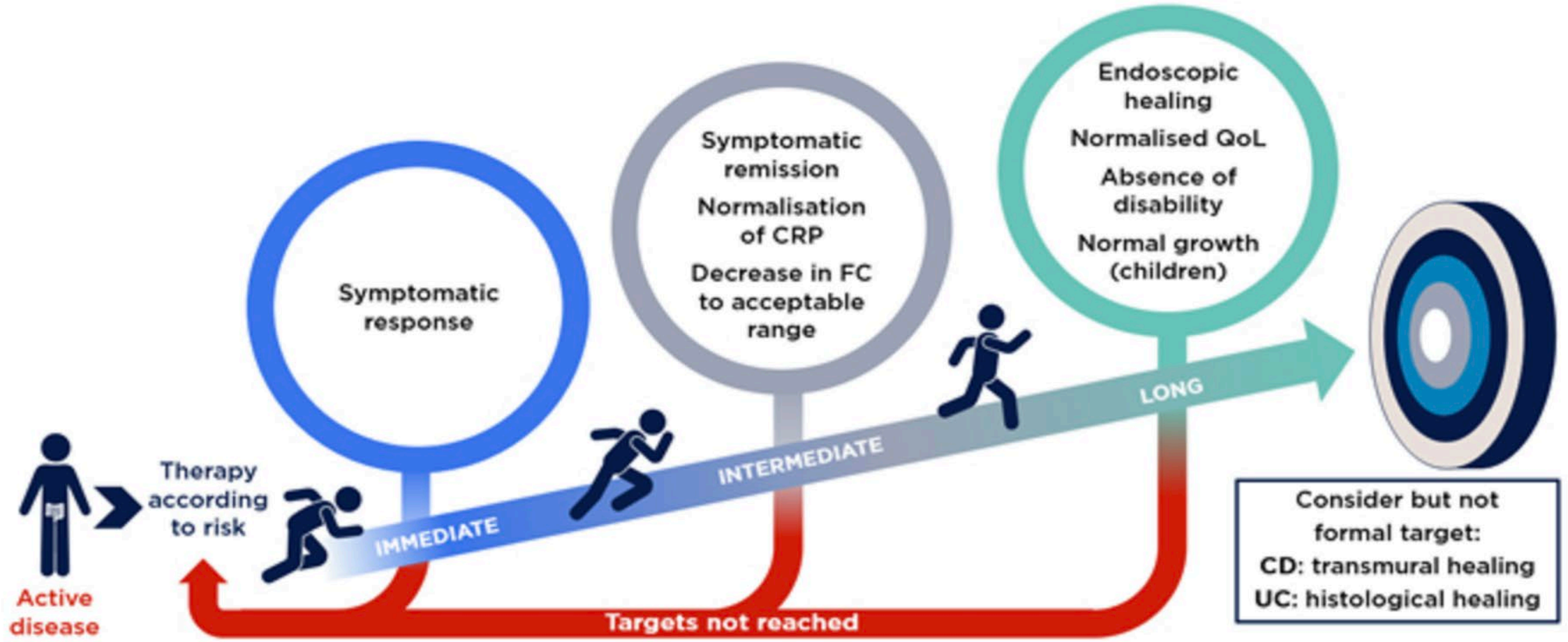
  -notably, rectal bleeding and stool frequency

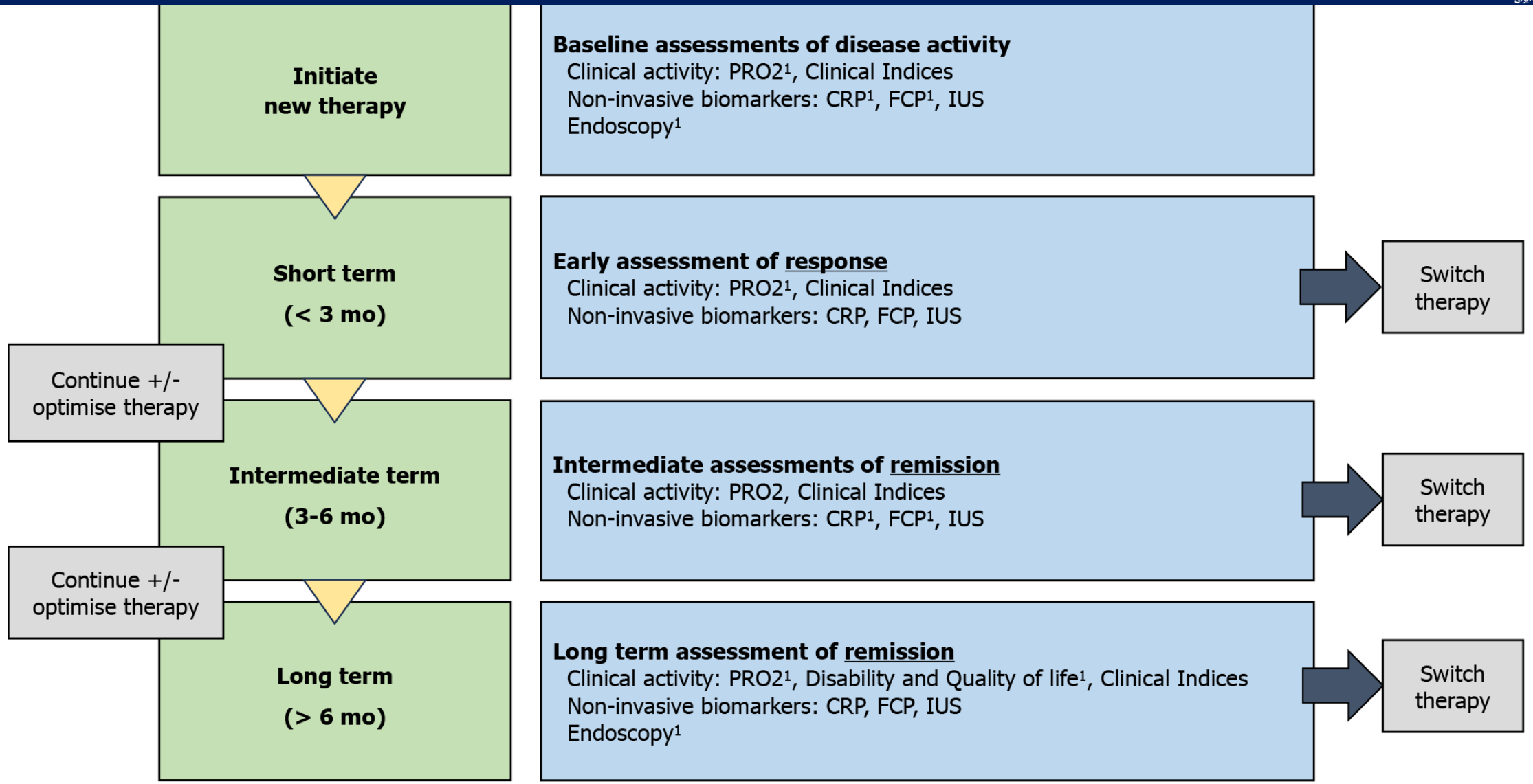
- Clinical remission and normalization of serum biomarkers, such as;

  -CRP, are intermediate goals for patients with UC,

  -endoscopic healing is considered in a long-term goal

STRIDE-II evidence-based consensus recommendation





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Take Home Message in Ulcerative Proctitis

- ***In patients with mild to Moderate Disease;***

  -conventional therapies such as rectal mesalamine and rectal CS

  -patients who is remission want stope their topical therapy (5ASA)

  -consider just on demand therapy as needed

- ***In patients Moderate to Severe;***

  -treated with systemic CS, followed by S1P given the ELEVATE trial data

- ***In patients with more Refractory Disease;***

  -tacrolimus is a great option

- Sequence therapy used for other forms of UC;

  -including small molecules and biologics

- Treating patients with UP to the target of endoscopic or histologic remission

  -prevents disease extension, which otherwise occurs in 30% to 40% of these patients