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# Comprehensive Patient Care in the Treatment of Ulcerative Colitis

With this special issue of the *Journal of Current Clinical Care* (JCCC), we aim to provide community healthcare professionals (HCPs) with practical clinical insight and support in managing patients with ulcerative colitis (UC)—both those who are newly diagnosed as well as those who have responded to medical therapy and are in remission. The articles included here address day-to-day care for a newly or recently diagnosed population, where treatment selection with first-line therapy such as 5-Aminosalicylates (5-ASA) may be appropriate. Further, each article references concrete clinical experience, giving a sense of how real-world patient care has influenced practice. Physicians invest substantial time and resources in patient counselling and education at the time of diagnosis, and this supplement seeks to share best practices and ideas to improve both dialogue and, most importantly, clinical outcomes.

While the etiology of Ulcerative Colitis is largely unknown, it is a chronic condition for which there is no cure. Upon learning of their diagnosis, patients may struggle to accept the limitations often imposed by such chronic conditions, and incomplete information regarding prognosis and treatment options only further interferes with ongoing care—trouble that often manifests around medication adherence. Newly diagnosed patients need their physicians' counselling and support. Patients have many questions about their condition, and studies show that the better they understand their disease and its management, the more they adhere to treatment regimens. Yet many practitioners are forced to guesstimate, through trial and error, how much time is required to optimize the impact from patient counselling.

In their article, James Gregor, John Howard, Nitin Khanna, and Nilesh Chande, of London Health Sciences Centre, Western University, explain that most patients have similar questions upon their diagnosis with UC. They are often anxious and frustrated, and some are skeptical that ongoing therapy is needed. It is up to the physicians who manage their care to educate these patients about UC and to convince them that maintenance therapy is crucial, even during remission. As Dr. Gregor and colleagues assert, "Informed patients are one of the most important assets available in the management of patients with ulcerative colitis." To this end, they present 10 frequently asked questions—five general and five disease-extent specific—and their answers to help physicians effectively communicate with their patients.

Geoffrey C. Nguyen, of the Mount Sinai Hospital Centre for Inflammatory Bowel Disease, addresses medication adherence during pregnancy. 5-Aminosalicylates have a positive safety profile, and decades of clinical use emphasize this fact.[1] However, concerns have

been raised about some formulations using an enteric coating that contains dibutyl phthalate (DP). Toxicology studies suggest that certain phthalates may be associated with endocrine and reproductive toxicities. While the extent of risk of DP in humans is unknown, the potential effects on reproductive development in fetuses suggest that special consideration is warranted when deciding which 5-ASA formulation to prescribe to a female patient of child-bearing age. Given the correlation of patients' perception of potential harm imposed by drug therapy with rates of non-adherence, Dr. Nguyen emphasizes that physicians must communicate to their female patients the importance of taking their medication to "prevent disease relapse, which may have the most adverse effects on pregnancy." He advocates pursuing this discussion prior to pregnancy, with all female patients of child-bearing age, as changing 5-ASA formulations involves a hypothetical and small possibility of relapse.

The importance of patient education and the value of a tacit contract between the patient and care provider for adherence to treatment regimens is illustrated in a case report from Dr. Brian Bressler, of St Paul's Hospital, University of British Columbia. This real-life scenario profiles a young adult with moderately active left-sided ulcerative colitis. Dr. Bressler stresses that the patient's treatment plan had to involve "appropriate education" to first obtain and then extend disease remission. In this case, Dr. Bressler shows that when patients with UC feel well, they often struggle with adhering to their medical regimen; however, they must accept the idea of and commit to long-term adherence. In addition to discussing treatment options for moderately active left-sided UC, and the importance of adherence, Dr. Bressler also addresses concerns related to self-administration of enemas.

Medical therapies for UC are effective, but as the condition is characterized by recurrence, early detection of symptoms is valued. Calprotectin levels in stool correlate not only with the degree of clinical severity of UC but also with the presence or absence of mucosal inflammation. In an effort to extend remission in UC, current research has focussed on laboratory testing results with fecal calprotectin to help guide medication adjustments, with the aim of mitigating the risk of flares or full-blown relapses. In his article "Optimizing Targets in Patient Management of Ulcerative Colitis," A. Hillary Steinhart, of Mount Sinai Hospital/ University Health Network and the University of Toronto, states that "patients who have greater degrees of active mucosal inflammation despite the absence of clinical symptoms are at higher risk of developing a symptomatic flare in the near term." As a result, there has been increased interest in detecting mucosal inflammation in asymptomatic patients, surveillance that is usually performed using flexible sigmoidoscopy or colonoscopy. Because these tests are invasive, patients in clinical remission may oppose repeated endoscopic evaluations. Fecal calprotectin testing offers a non-invasive means of monitoring patients in clinical remission. As such testing is easy and non-invasive—indeed, the possibility of performing home testing of fecal calprotectin has been explored—patients may be more likely to use it regularly to monitor their mucosal inflammation.

These articles are intended to address the practical issues of day-to-day care in managing patients with UC. It is our sincere hope that this special issue of the *JCCC* will provide additional insight and perspective, arming HCPs with concrete tools to facilitate successful outcomes.

## Reference

1. Karagozian R, Burakoff R. The role of mesalamine in the treatment of ulcerative colitis. Ther Clin Risk Manag 2007;3(5):893–903.