



Ulcerative Proctitis

Ulcerative proctitis is a mild form of ulcerative colitis, a chronic inflammatory bowel disease (IBD) consisting of fine ulcerations in the inner mucosal lining of the large intestine that do not penetrate the bowel muscle wall. In this form of colitis, the inflammation begins at the rectum, and spreads no more than about 20 cm (8") into the colon. About 25-30% of those diagnosed with ulcerative colitis might actually have ulcerative proctitis.

The cause of ulcerative proctitis is undetermined but there is considerable research evidence to suggest that interactions between environmental factors, intestinal flora, immune dysregulation, and genetic predisposition are responsible. It is unclear why the inflammation is limited to the rectum. There is a slightly increased risk for those who have a family member with the condition.

Although there is a range of treatments to help ease symptoms and induce remission, there is no cure. A diagnosis of ulcerative proctitis can occur at any point throughout life, with a high occurrence in young children and then again around 40-50 years of age. Progression of this disease to ulcerative colitis, extending farther up the bowel to involve the sigmoid colon, occurs in about 30-50% of those with ulcerative proctitis.

Symptoms/Complications

The presenting symptoms of ulcerative proctitis all relate to the rectum. Blood in the stool occurs in almost everyone with the disease. Diarrhea is a common symptom, although constipation can also develop as the body struggles to maintain normal bowel function.

Inflammation of the rectum may cause a sense of urgency to have a bowel movement, discomfort after having a bowel movement, and a sensation of incomplete emptying of the bowels. Systemic symptoms such as fever, tiredness, nausea, and weight loss are rare.

Ulcerative proctitis has very few complications but with increased irritation to the anal and rectal area, hemorrhoids

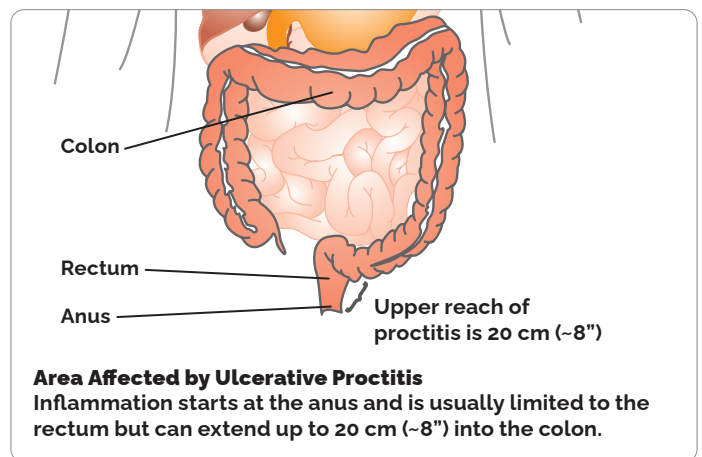
may occur. Only rarely do other complications occur, such as abscesses and extra-intestinal manifestations. Individuals with ulcerative proctitis are not at any greater risk for developing colorectal cancer than those without the disease.

Diagnosis

Typically, your physician makes a diagnosis of ulcerative proctitis after considering your medical history, doing a general examination, and performing a standard sigmoidoscopy. A sigmoidoscope is an instrument with a tiny light and camera, inserted via the anus, which allows the physician to view the bowel lining. Small biopsies taken during the sigmoidoscopy may help rule out other possible causes of rectal inflammation. Stool cultures may also aid in the diagnosis. X-rays are not generally required, although at times they may be necessary to assess the small intestine or other parts of the colon.

Management

The treatment of ulcerative proctitis is multi-faceted; it includes managing symptoms along with following therapies targeted to reduce the underlying inflammation.



Dietary and Lifestyle Modifications

As most nutrients are absorbed higher up in the digestive tract, persons with ulcerative proctitis generally do not have nutrient deficiencies; however, other factors may influence an individual's nutritional state. Disease symptoms may cause food avoidance, leading to food choices that might not provide a balanced diet. If bleeding is excessive, then modifications to the diet will be necessary to compensate for this.

Better overall nutrition provides the body with the means to heal itself. It is important to follow *Canada's Food Guide*, but some foods may irritate the rectum and increase symptoms, even though they do not affect the disease course. The customized recommendations of a registered dietitian can address your sensitive digestive tract.

Symptomatic Medication Therapy

The symptoms are the most distressing aspect of ulcerative proctitis; therefore, direct treatment of bloody diarrhea and pain will improve quality of life. Dietary adjustment may be beneficial and anti-diarrheal medications have a major role to play. Analgesics can be helpful for managing pain not controlled by drugs that address the underlying inflammation, listed below. Acetaminophen (Tylenol®) is preferred over medications called non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen (Advil®, Motrin®), aspirin, and naproxen (Aleve®, Naprosyn®), as they can irritate the gut.

There are two types of anti-diarrheal medications directed at preventing cramps and controlling defecation.

One group alters the muscle activity of the intestine, slowing down content transit. These include: non-narcotic loperamide (Imodium®); narcotic agents diphenoxylate (Lomotil®), codeine, opium tincture and paregoric (camphor/opium); and anti-spasmodic agents dicyclomine HCL and hyoscine butylbromide (Buscopan®).

The other group adjusts stool looseness and frequency by soaking up (binding to) water, regulating stool consistency so it is of a form that is easy to pass. Plant-based products are helpful such as inulin fibre (Benefibre®) and psyllium (ispaghula) husk (Metamucil®). Plant fibres are also useful to manage constipation, due to their stool regulating effects. Cholestyramine resin, a bile salt binder, can also help with stool looseness.

Individuals with ulcerative proctitis may be anemic from chronic blood loss. Adding iron supplements could help improve this condition, with oral heme iron polypeptide (e.g., Hemaforce 1, Hemeboost, OptiFer® Alpha, Proferrin®) being the preferred option, due to quick-acting and low side-effect profiles. Iron isomaltoside 1000 for injection (Monoferric™),

iron sucrose (Venofer®), and sodium ferric gluconate (Ferrlecit®) are indicated for intravenous (IV) treatment of iron deficiency anemia in adult patients who have intolerance or unresponsiveness to oral iron therapy.

Anti-inflammatory Medication Therapy

Since the inflammation of ulcerative proctitis is limited to a small area of the lower colon, and is relatively accessible, treatment is most successful when given rectally. Your physician might prescribe treatment for you in the typical manners described below, or use an approach designed specifically for your situation.

5-Aminosalicylic Acid (5-ASA): These medications, taken orally, include mesalamine (Mezavant®, Mezera®, Pentasa®, Salofalk®) and olsalazine sodium (Dipentum®). They are safe and well tolerated for long-term use. However, quicker results can occur when medication is used in a topical form, taken rectally. Salofalk® is available in 500 mg and 1 g suppositories. Salofalk® 1 g and Pentasa® 1 g suppositories are once-a-day therapies. Mezera® is available in a 1 g suppository or a 1 g foam enema. In a more difficult case, you may receive 5-ASA enema therapy (Salofalk® 4 g & 2 g/60 mL and Pentasa® 1 g, 2 g, or 4 g/100 mL) for a short course, followed by suppositories, as the inflammation improves. Some individuals may benefit from a combination of orally and rectally administered 5-ASA therapies in cases that do not respond fully to rectal therapy alone.

5-ASA helps to settle acute inflammation and, when taken on a long-term basis (maintenance), it tends to keep the inflammation inactive. It is important to continue your medicine regimen even if your symptoms disappear and you feel well again. Maintenance therapy can be at the full initial dosage or at a reduced dosage and interval, depending on the disease response. Typically, you will start on one type of preparation and, if there is inadequate response, then switch to another type. On some occasions, it may be necessary (and some patients prefer) to use an oral form of 5-ASA to keep the disease in remission.

Corticosteroids: You can also administer these rectally. They come in liquid preparation, thick foam, or suppository, including budesonide (Entocort®), hydrocortisone (Proctofoam-HC®) and betamethasone (Betnesol®). However, if you have significant diarrhea, then it might be difficult to hold these medications within the rectum.

You will need to use rectal medications nightly at first and, as the disease improves, then treatments become less frequent. Sometimes your doctor will stop treatment and start it again if you experience a flare up, and sometimes maintenance therapy

two to three times a week may be required long-term. Your pharmacist and physician can provide help on how to administer these medications and what to expect with their use.

Surgery

Although ulcerative proctitis can sometimes be resistant to therapy, it is rare to have surgery to treat this condition.

Outlook

With an appropriate treatment regimen, most individuals who have ulcerative proctitis manage their disease successfully. Further research is essential to uncover the cause, potential treatments, and possible prevention strategies for many digestive diseases and disorders.

Notes:

About the Gastrointestinal Society

The GI (Gastrointestinal) Society is a registered Canadian charity committed to improving the lives of people with gastrointestinal and liver conditions, supporting research, advocating for appropriate patient access to healthcare, and promoting gastrointestinal and liver health.

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