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Maintenance therapy for ulcerative colitis has no impact on changes in the extent of ulcerative colitis

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Abstract

Background and aim: Although the efficacy of maintenance remission therapy in ulcerative colitis (UC) has been proved in many studies, little is known about its possible effect on the extent of the disease. The aim of the present multicenter Belgian study was to evaluate the potential role of UC maintenance therapy on the colonic extension of the disease.
Materials and methods: A total of 98 patients, 56 males, 42 females, mean age 52 years, range 22–82 years, from 12 medical centers in Belgium, with an acute exacerbation of well-established, endoscopically and histologically proven left-sided UC, were included. The colonic extension was endoscopically determined at the time of the initial diagnosis and at the actual

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flare-up. The mean duration of UC was 93+72 months, median was 84 months, and range was 3–372 months. Active smoking was reported in only 7% of patients, while the majority were no-smokers (63%) or ex-smokers (30%). The median colonic extension at the time of initial diagnosis was 25 cm, range 2–70 cm from the anal merge. Sixty-six percent of the patients had quiescent disease without flare-ups during last year. The χ^2-test was used for statistical analysis.
Results: 29/98 (29.6%) patients had not used any maintenance therapy in the last 3 months before the actual exacerbation. The most commonly used maintenance therapy was 5-ASA (43%), while combined therapy with 5-ASA, corticosteroids or immunosuppresives (mainly azathioprine) in all possible combinations was reported by 29.6% of patients. The extent of UC had not changed in 50.7% and 51.7% of patients, respectively, with and without maintaining therapy (NS, $p=0.99$). Some degree of regression was observed in, respectively, 21.7% and 20.7% (NS, $p=0.99$), and some degree of extension in, respectively, 27.5% and 27.6% (NS, $p=0.99$). Furthermore, no relationship was found between changes in colonic extent and type of maintaining therapy, smoking habits or disease activity during the last year before the acute exacerbation. A tendency of beneficial effect of maintenance therapy on disease extent was observed in patients with continuous active disease of short duration.
Conclusions: According to this multicenter study, maintenance remission therapy for left-sided UC was not found to have a statistically significant effect on colonic extension. Further long-term studies are necessary to confirm these results.

1. Introduction

Despite the progress that has been made in the management of ulcerative colitis (UC) in the last decades, its natural history is still characterized by periods of remission interspersed with exacerbations, while the therapy is aimed to keep the general condition of the patient stable, maintaining remission whenever possible.[1–3] The efficacy of long-term maintenance therapy for ulcerative colitis with aminosalicylates has been well established in many studies. Mesalazine is the drug of choice for maintaining remission in patients with ulcerative colitis.[4–7] For more serious cases maintenance therapy with immunosuppressives, such as azathioprine, has been proven effective in patients with steroid-dependent or steroid-resistant ulcerative colitis.[8–10]

However, little is known about the potential efficacy of maintenance therapy in modifying or changing the natural history of ulcerative colitis and the extent of the chronic inflammation.

The aim of the present multicenter study was to evaluate the role of long-term maintaining therapy for ulcerative colitis on the colonic extension during subsequent exacerbations.

2. Patients and Methods

In the present multicenter, cross-sectional study from 12 medical centers in Belgium, patients with actual exacerbation of well established, endoscopically and histologically proven left-sided UC were included. The same clinical questionnaire was used for all patients and included date of birth, sex, disease duration, smoking habits and date of initial diagnosis and actual and previous flare-ups.

The extension of UC was endoscopically determined at the time of the initial diagnosis and at the actual flare up. Colonic extension was classified in two groups: Left-sided colitis including (a) rectum, (b) sigmoid and (c) descending colon, and pancolitis including (d) colitis up to the transversum and (e) pancolitis. Disease was determined as inactive if no flare up was recorded in previous year.

Furthermore, a detailed history and chart review were retrospectively taken from all patients regarding their initial management and intake of maintenance therapy at the time of actual flare-up, as well as during 3 and 6 months before the actual UC exacerbation. According to UC maintenance remission therapy, all patients were classified in seven groups: (1) no therapy; (2) 5-aminosalicylate (5-ASA) only; (3) corticosteroids only; (4) immunosuppressive only; (5) 5-ASA and corticosteroids; (6) corticosteroids and immunosuppressives and (7) 5-ASA, corticosteroids and immunosuppressives.

Finally, the change in colonic involvement (regression or extension) between the actual UC exacerbation and the initial localization was defined as: (a) minimal if the

Table 1 Demographic and disease characteristics

Baseline characteristics	Left-side colitis ($n=98$)
Sex *n* (%)	
Male	56 (57%)
Female	42 (43%)
Age	
Median (range)	47 years (22–82)
Smoking	
Non-smoker	63%
Active smoker	7%
Ex-smoker	30%
Disease activity	
No flare-up in the previous year	66.3%
One or more flare-up in the previous year	33.7%
Duration of ulcerative colitis (UC)	
Mean+SD	93+72 months
Median (range)	84 months (3–372)