Table 3. Summary of key concept statements for the management of ulcerative colitis

Diagnosis, assessment, monitoring, and prognosis of ulcerative colitis
1. The diagnosis of UC should be suspected in patients with hematochezia, increased stool frequency, or bowel urgency
2. Infectious etiologies should be excluded at the time of diagnosis
3. Colonoscopy with intubation of the ileum and biopsies of affected and unaffected areas should be obtained to confirm the diagnosis of UC, with mucosal biopsies interpreted by a pathologist, preferably one with expertise in gastrointestinal pathology
4. Categories of disease extent include (i) proctitis (within 18 cm of anal verge, distal to rectosigmoid junction), (ii) left-sided colitis (extending from sigmoid to splenic flexure), (iii) extensive colitis (beyond splenic flexure which includes those with involvement of the entire colorectum [pancolitis])
5. If the terminal ileum is normal, further evaluation of the stomach and small bowel by upper endoscopy and cross-sectional imaging is not needed unless there are other symptoms or findings to suggest proximal gastrointestinal involvement or a diagnosis of Crohn's disease rather than UC
6. Definitions of disease severity are needed to guide treatment decisions; definitions should be based on (i) patient-reported outcomes (bleeding, normalization of bowel habits, bowel urgency), (ii) the inflammatory burden (endoscopic assessment including extent and severity and markers of inflammation including FC, CRP, and serum albumin), (iii) disease course (need for hospitalization, need for steroids, failure to respond to medications), and (iv) disease impact (HRQoL and social functioning)
7. Endoscopic severity should be reported using a validated endoscopic scale such as the Mayo Endoscopic Score or the UC Endoscopic Index of Severity
8. Disease assessment and monitoring in response to therapy and during maintenance and periods of suspected relapse may be performed with FC, CRP, endoscopic assessment with flexible sigmoidoscopy or colonoscopy, and/or intestinal ultrasound
Goals for managing patients with ulcerative colitis
9. UC is a chronic condition for which therapy is required to induce and maintain remission; therapeutic decisions should be categorized into those for (i) induction and (ii) maintenance, with goals of obtaining and maintaining a steroid-free remission and obtaining biological response through reduction in biomarkers or endoscopic improvement
10. Strategies for management of UC should reflect the patient's and provider's goals and recognize the chronic nature of the disease
11. Symptomatic remission relates to improvement in PROs while endoscopic healing is defined as restoration of intact mucosa without friability. Deep remission is a combination of symptomatic remission and endoscopic healing and is a preferred goal of management. Corticosteroid-free remission is defined based on symptoms and endoscopic findings without corticosteroid use for a sustained period of time (usually more than 12 wk)
12. Initial treatment of UC should focus on restoration of normal bowel frequency and control of the primary symptoms of bleeding and bowel urgency. An endoscopically healed mucosa is associated with sustained remission and reduced risk of colectomy
13. Histologic remission is associated with some improved clinical outcomes but has not yet been validated prospectively as a preferred target for treatment
14. Control of mucosal inflammation may reduce dysplasia risk
15. Given the chronic nature of UC and the therapies for UC, monitoring for disease-related and drug-related complications is important. This should incorporate preventive strategies as outlined here and in a separate guideline from the ACG (100).
16. Routine visits are recommended to monitor for relapse and address health maintenance needs
17. Patients with UC should be screened for coexistent anxiety and depressive disorders, and when identified, patients should be provided with resources to address these conditions
Induction and maintenance of remission in mildly to moderately active UC
18. Patients with mildly to moderately active UC and a number of prognostic factors associated with an increased risk of hospitalization or surgery should be treated with therapies for moderate-to-severe disease (Table 8). Each prognostic factor carries a different weight and must be discussed in a shared decision-making fashion with the patient. For example, age alone is a weaker prognostic factor than severe endoscopic activity. However, young age combined with another factor may represent sufficient criteria to treat using therapies with proven efficacy in patients with moderate-to-severe UC
19. Patients with mildly to moderately active UC should be reassessed to determine response to induction therapy within 8 wk
20. There is not sufficient evidence for routine use of probiotics, prebiotics, or other alternative therapies as primary induction therapy for patients with mildly to moderately active UC
21. There is not sufficient evidence of an optimal approach to fecal microbial transfer as a primary induction treatment for patients with mildly to moderately active UC
22. Patients with previously mildly to moderately active UC who have achieved remission should be treated with maintenance therapy with demonstrated efficacy in prevention of relapse
23. In patients with previously mildly to moderately active UC who have achieved remission, there is insufficient evidence to recommend the use of a probiotic as primary or adjunctive therapy for maintenance of remission
Induction of remission in moderately to severely active UC
24. Patients with mildly to moderately active UC who are not responsive (or are intolerant) to 5-ASA therapies should be treated as patients with moderate-to-severe disease