Synopsis of ECCO and ESPGHAN guidelines in the management of ambulatory pediatric ulcerative colitis

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Assessing and predicting the disease activity

- Classify the severity of the disease based on pediatric ulcerative colitis activity index. Look for the presence of systemic symptoms and complications.
- **Colonoscopic evaluation:**

  At diagnosis, before major therapeutic modifications and for cancer surveillance

  A standardized endoscopic activity index, including the Mayo endoscopic subscore or Ulcerative Colitis Endoscopic Index of Severity should be used during colonoscopic examinations.
- **Faecal calprotectin:**

  To be done in sustained clinical remission (>3 months) to assess endoscopic remission.

  Cut-off value

  <100mcg/g: remission

  >250 mcg/g predicts mucosal inflammation: consider endoscopic evaluation

Treatment of Mild-Moderate UC:

- **Oral 5-ASA:**

  Recommended first-line for induction and maintenance therapy. If no adequate response, combined with rectal 5-ASA

  For rectal therapy in isolated proctitis or left sided colitis, 5-ASA is preferred over steroids

  In case of intolerance or refractory to 5-ASA, rectal tacrolimus may be considered
- **Oral steroids:**

  Prednisolone: second line treatment for mild-moderate UC not responding to 5-ASA

  Second - generation oral steroids : beclomethasone dipropionate (BDP) and budesonide-MMX may be also considered in cases refractory to 5-ASA prior to oral prednisolone

  No role of steroids in maintenance of remission.
- **Immunomodulators:**

  Thiopurines: For maintaining remission in corticosteroid dependent or frequent relapser despite optimal 5-ASA treatment as well as in 5-ASA intolerant patients.

  Thiopurine metabolites measurement: patients with incomplete response on a stable thiopurine dosage, leukopenia or elevated transaminases, or suspected poor compliance

  Methotrexate: Rarely to be considered in cases with failure or intolerance to thiopurines when other alternatives are not possible or available.

  Oral tacrolimus: May be considered as steroid sparing option for bridging to thiopurines or vedolizumab
- **Biologics:**

  Infliximab: Chronically active or steroid-dependent UC, uncontrolled by 5-ASA and thiopurines, for both induction and maintenance of remission.

  Adalimumab or golimumab: can be considered in those with lose response or intolerance to infliximab. No role in those with primary non-response to infliximab.

  Vedolizumab: As a second line biologics after anti-TNF failure in chronically active or steroid-dependent patients.

It is customary to screen for latent tuberculosis with combination of patient history, chest X-ray, tuberculin skin test or interferon-gamma release assays (quantiferon) before initiating anti-TNF. Screening for hepatitis B and C viruses, varicella zoster virus, and HIV when appropriate, is also recommended if not done recently

- **Monitoring**:

  Complete blood counts, serum albumin, transaminases, gamma-glutamyl transferase and erythrocyte sedimentation rate: depending on symptoms and therapy, and at least every 3 months while on immunosuppressive medications and at least every 6-12 months otherwise

- **Colorectal cancer surveillance:**

  To be done after 8-10 years of disease duration

  Risk factors: extensive and severe disease and family history.

  Chromoendoscopy with targeted biopsies: helps in detecting dysplasia. If not available, random biopsies (quadrantic biopsies every 10 cm) and targeted biopsies of any visible lesion should be performed using high definition.