Dramatic And Long Lasting Efficiency (13 Years) Of Oral 5 Aspirin

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Abstract

Introduction: Could 5 ASA be an option in case of cortico-resistant and/or intolerant ulcerative colitis?
Case report: A 55-year-old woman was referred for a recent, moderately severe, left-sided ulcerative colitis. The response to corticotherapy was initially fair, then mediocre, complicated by a severe depression. The patient rejected colectomy. Corticotherapy was switched to 3g/d oral PentasaR. Bleeding stopped and rectal mucosa switched to pink within 3 days. Colonoscopy, performed 10 days later, evidenced deep and large ulcerations in the process of cicatrization.
After 13 years of 5-ASA, the patient remains asymptomatic with progressive disappearance of mucosal scars.
Conclusion: Oral 5 ASA could be worth a trial in some cases of severe flare-ups of ulcerative colitis when corticoids are inefficient or poorly tolerated and if colectomy is not possible, as an alternative to cyclosporin. The quick and long-lasting efficiency in the present case are to be emphasized.

INTRODUCTION

Five-ASA is usually used per os only for moderate intensity flares-up of ulcerative colitis (UC)([1]). For more severe cases, corticotherapy is the corner stone of the medical treatment ([1], [2]). However, its efficiency is not constant ([3]), neither is its tolerance. In these cases, surgery is usually mandatory ([1]). Nevertheless, the patient may decline the operation. Ciclosporine is another option, at least for the short term ([4]). We report herein, among a severe flare-up of UC, the dramatic and very long lasting effect of oral 5ASA.

CASE REPORT

A 55-year-old woman was seen for a, 15 stools per day, bloody diarrhea, evolving since 4 month. A cautious colonoscopy disclosed a typical UC pattern with moderately deep, round ulcerations and a very congestive mucosa, stopping abruptly after the splenic flexure. Pathology data were evocative of UC. Upper GI endoscopy, gastric and duodenal pathology data and barium follow-through were normal. Intra muscular methyl-prednisolone 120 mg o.d. during 5 days, improved the diarrhea and was switched to 60 mg prednisone p.o. However, 10 days later, the result was poor, with 8 bloody stool, abdominal colicky pain, anorexia, fatigue and weight loss, together with the occurrence of a severe depression. Proctoscopy disclosed a dark red, very congestive, haemorrhagic rectal mucosa. A trial of tixocortol enema, 250 mg o.d, was poorly tolerated and stopped. She declined a trial of 5 ASA enemas. An antidepressant, medifoxamine 50 mg t.i.d., did not improve the depression.

Moreover, this depression made her very uncooperative and difficult to manage. Because of worsening and vomiting, IM Methyl-prednisolone 120 mg o.d. was started again, leading to a moderate and transient improvement.

However, her state worsened again with 5 bloody stools a day. Temperature was 38°C, the pulse rate 90/MN with a persistent weight loss. Hemoglobin was 90 g/l, WBC 10,000G/l, ESR 47 mm/1h, serum proteins 47 g/l and albumin 23 g/l. Therefore, a colectomy was suggested, but the patient, very depressive, rejected it absolutely. Corticotherapy was stopped and 5 ASA, as PentasaR, 3 g/d p.o. was started. Dramatically, within three days, bloody stools disappeared and depression as well. Diarrhea decreased more slowly over 15 days. Three days after starting 5 ASA, proctoscopy disclosed a dramatic improvement of the mucosal pattern. Its color had switched from dark red to a normal pink. A cautious colonoscopy, performed one week later, disclosed an impressive worsening of the ulcerations. They looked deep, rail-shaped, with numerous pseudo-polyps and large surfaces of naked muscularis propria. These lesions contrasted with an almost normal mucosa, pink colored, moderately edematous, not

friable nor haemorrhagic. Reepithelialization was beginning at the margins of the ulcerations. Right colon and ileum were normal. Unfortunately, no picture was taken at the moment. Microscopic examination disclosed severe, deep UC lesions with round cell infiltration, edema and numerous cryptic abscesses, contrasting with an almost normal superficial epithelium. The general state of health normalized within a month and biological data within three months. A control colonoscopy showed only an important cicatricial pseudo-polyposis of the left colon, covered by a normal-appearing mucosa. Microscopic examination confirmed this improvement.

Since that time she remained asymptomatic, except for mild attacks when 5 ASA dosage was tapered to less than 2 g/d. Depression did not recur. The last control showed a normal mucosa, with an important regression of the scars. Microscopic examination was almost normal.

DISCUSSION

To the best of my knowledge, the use of 5 ASA per os for severe flare-up of UC has not been studied. As a local treatment, its efficiency is well known ([1],[2],[3], [5]). However, some authors state, without further details, that they use salazopyrine ([3]) or oral 5 ASA, in association with corticoids, among severe flare-up. It is, therefore, difficult to know which is the relative importance of the salicylate compound ([3]). Most frequently, corticotherapy is efficient and well tolerated ([2]). In other cases, urgent colectomy ([1], [3], [5], [6]) offers a high rate of cure. It should not be postponed, a too long medical treatment leading to an increase of operative death ([2], [3], [6] [7],[8]). However, in case of a disputable efficiency, of a left-sided colitis ([7], 10) and of an uncertainty on its exact type ([6],[7], [11]), the decision to operate on may be difficult ([7], [9]).

The trial of ciclosporin is a recent option but it is costly, its tolerance is far from perfect and the later treatment is not yet established ([4]).

Clinical and biological criteria remain useful but their sensitivity for predicting the necessity of surgery is questioned ([1], [8], [10], [11], [13], [14]). The safety and the importance of a cautious colonoscopy for the decision to operate on have been underlined ([9], [14], [15]). The shape and the depth of the ulcerations ([9], [11], [14]), have a great prognostic value. The present case is in keeping with the notion that the anatomical state can be severely worsening when the improvement is not clear-cut ([10], [11]).

Sometimes, corticosteroids induce a depression ([16],[17],[18],[19]) which worsens the general state of health and can contribute to a poor cooperation of the patient, like in the present case. The depressive symptoms arise usually within the two first weeks of treatment ([19]). Female gender ([19]), systemic lupus erythematosus ([18], [19]), total daily dose ([18]) and the peak concentration of corticosteroids ([20]), increase the probability of depression, but a previous episode of psychiatric reaction, even if steroid-induced ([19]) does not.

The diagnosis of ulcerative colitis is certain in the present case because of the typical macroscopic and microscopic features. A 4-month evolution before the diagnosis, the left-sided continuous extension with a clear-cut upper limit, microscopic data and later attacks excludes a transient infectious colitis ([1]). A Crohn's disease is excluded by the initial features and the follow-up. The clinical and biological data allow to classify the present attack as severe, according to the established criteria ([7], [13]). The type of the ulcerations is evocative of UC and confirms, a posteriori, its severity ([9], [11], [14]).

The dramatic effect of oral 5 ASA led to the resolution of this severe flare-up. The resolution of the mucosal congestion at proctoscopy was particularly impressive, taking in account the delay of 3 days. It is most improbable that the 8 days of IM corticotherapy, leading to a disputable effect, could be responsible, through a delayed action, for the long-lasting resolution of the UC. Moreover, this long-lasting efficiency of 5 ASA is to be underlined.

SUMMARY

In summary, 5 ASA could be efficient in some cases of severe cortico-resistant and/or cortico-intolerant flare-up of UC. This possibility could by of a peculiar interest in developing countries where ciclosporin is not available. However, 5ASA may worsen an UC flare-up. ([21]).

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