Disease/Medical Condition

ULCERATIVE COLITIS

(also referred to as “UC”, “idiopathic proctocolitis”, and “inflammatory bowel disease” [IBD]; IBD is an umbrella term that also includes Crohn’s disease and indeterminate/undifferentiated IBD)

Date of Publication: June 14, 2013

Is the initiation of non-invasive dental hygiene procedures* contra-indicated? No

■ Is medical consult advised? No (assuming patient/client is already under medical care for ulcerative colitis)

Is the initiation of invasive dental hygiene procedures contra-indicated?** Possibly, but not typically

■ Is medical consult advised? Possibly (depends on severity and level of control of the disease, including the presence/absence of oral lesions)

■ Is medical clearance required? Possibly (e.g., if the disease is unstable and/or there are active oral lesions). Also, medical clearance may be required if patient/client is being treated with medications associated with immunosuppression +/- increased risk of infection (e.g., corticosteroids [e.g., prednisone], azathioprine, 6-mercaptopurine, methotrexate, cyclosporine, sulfasalazine, biologic response modifier drugs [e.g., anti-tumor necrosis factor drugs – anti-TNFs – such as infliximab and adalimumab], etc.)

■ Is antibiotic prophylaxis required? No, not typically (although extended use of corticosteroids may warrant consideration of antibiotic prophylaxis)

■ Is postponing treatment advised? Possibly, but not typically (depends on severity and level of control of the disease, including presence/absence of oral lesions, as well as medical clearance for patients/clients on medications associated with immunosuppression)

Oral management implications

■ The patient/client with inflammatory bowel disease should be evaluated to determine the severity and level of control of the disease, as well as the types of medications being used. Patients/clients who have fewer than four bowel movements per day with little or no blood, no fever and few symptoms (coupled, when available, with an erythrocyte sedimentation rate – ESR – below 20 mm/hour, ESR being a blood test that is a non-specific indicator of inflammation) are considered to have mild disease, and typically can receive dental hygiene care. Patients/clients with moderate to severe disease (the latter defined as six or more bowel movements per day with blood, fever, anemia and an ESR greater than 30 mm/hour) are potentially poor candidates for invasive dental hygiene care, and they should be referred for medical care and clearance.

■ Patients/clients with UC often take anti-inflammatory medications, corticosteroids and immunomodulators, which can impact oral care (see above and below). However, aspirin and most other non-steroidal anti-inflammatory drugs (NSAIDs) are to be avoided, as they tend to worsen gastrointestinal tract signs and symptoms. Acetaminophen can be used as an alternative for pain control.

■ Chronic and/or high dose use of corticosteroids by patients/clients with IBD can lead to suppression of adrenal function and reduce the ability to withstand stress.

■ The use of immunosuppressants (i.e., azathioprine and 6-mercaptopurine) is associated with the development of pancytopenia (reduced number of red and white blood cells, as well as platelets) in approximately 5% of treated persons. This may lead to increased bleeding time and risk of infection. Presence of fever without an obvious cause in this select population should prompt expedited referral to a physician.

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Oral management implications (cont’d)

- The severity and progression of IBD are highly variable and can impact routine professional oral care. Most patients/clients experience intermittent flare-ups, with reduced signs and symptoms (or none) between acute attacks. Only urgent oral care is advised during acute exacerbations of gastrointestinal disease.
- Elective professional oral care should be scheduled during periods of remission when complications are absent. Flexibility in the scheduling of appointments may be required given the unpredictable nature of the disease.

Oral manifestations

- Aphthous-like lesions occur in up to 20% of patients/clients with UC. These ulcers generally erupt during flare-ups of gastrointestinal disease, and they are typically located on the buccal, labial, and alveolar mucosa, as well as the soft palate, uvula, and retromolar area. Mildly painful, the lesions may be of a minor type (i.e., discrete, “punched out”, round-oval lesions less than one centimetre in diameter) or major type (i.e., larger than one centimetre in diameter, lasting longer and being deeper and more painful than the minor variety). The presence of irregular margins and granularity may be helpful in distinguishing UC oral lesions from “regular” aphthous ulcers (canker sores).
- Pyostomatitis vegetans affects some patients/clients with ulcerative colitis and may aid in the diagnosis of UC when it precedes the onset of intestinal disease. This form of stomatitis results in elevated papillary, vegetative projections or pustules on a red base on the labial mucosa, gingiva, and palate; the tongue is rarely involved. Without treatment, the red appearance worsens with eventual degeneration into an ulcerative and pus-producing mass, along with possible fissuring. Patient/client discomfort is proportional to the degree of ulceration of the lesions. As with aphthous-like lesions, medical control of the colitis improves the pyostomatitis vegetans. Oral lesions that persist after anti-inflammatory drug therapy may respond to applications of topical steroids. Surgical removal of the vegetative growths is sometimes employed.
- Dental hygienists should be alert to the presence of yellow pustules on the oral mucosa as possibly indicative of UC. The pustules of pyostomatitis vegetans reflect the microabscesses (without the granulomas characteristic of Crohn’s disease) seen microscopically. Patients/clients who receive a diagnosis of pyostomatitis vegetans without prior diagnosis of UC should be investigated by a gastroenterologist (i.e., physician specializing in intestinal diseases) for bowel disease.
- Approximately 10% of patients/clients with UC develop IBD-associated arthritis of the temporomandibular joints.
- As is the case with bowel manifestations, the clinical distinctions between the oral manifestations of UC and Crohn’s disease may be blurred with overlapping clinical features. Nonspecific clinical changes such as dry mouth (xerostomia), bad breath (halitosis), and gastric reflux may be seen.
- As with other autoimmune diseases, compromise of the immune system (be it from the disease or the treatment) elevates the risk of periodontal disease.
- The UC medication sulfasalazine has been associated with toxic effects on bone marrow, resulting in anemia, agranulocytosis (low white blood cell production), and thrombocytopenia (low platelet production), which can manifest respectively as a bald tongue, oral infection, or bleeding.
- Corticosteroid treatment of UC can result in osteopenia, which may involve the alveolar bone. The use of corticosteroids (such as prednisone) can also lead to oral candidiasis and other oral infections as a result of immunosuppression.
- Biologic response modifier drugs, such as anti-tumour necrosis factor drugs (e.g., infliximab and adalimumab), can cause sore throat and nasal congestion.

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Related signs and symptoms

- Ulcerative colitis is a chronic autoimmune disease that causes the large bowel (i.e., colon and rectum) to become inflamed and ulcerated. The first sign of UC is often a progressive loosening of the stool. The stool is often bloody and may be associated with abdominal cramping, as well as severe urgency to have a bowel movement. The diarrhea may begin slowly or quite suddenly. Loss of appetite and subsequent weight loss are common, as are fatigue, nausea, and fever. Anemia may occur in cases of severe bleeding. The signs and symptoms of UC tend to come and go, with fairly long periods between flare-ups.

- In contrast to Crohn’s disease (the other major form of inflammatory bowel disease), UC is confined to the rectum and colon (hence the term “colitis”), affects only the top layers of the colon, and is continuous in distribution.

- The usual age at onset is 15–30 years, although UC may begin at any age. Prevalence of inflammatory bowel disease in Canada is 0.7%, meaning that more than 233,000 Canadians live with IBD (slightly fewer with UC than Crohn’s disease).

- Complications of UC are less frequent than in Crohn’s disease. Complications include bleeding from deep ulcerations, rupture of the bowel, failure of the patient/client to respond to the usual medical treatments, and severe abdominal bloating. Ulcerative colitis elevates the risk of colorectal cancer.

- While there are a variety of medications for symptom control, many patients/clients with UC will undergo some form of surgery. Surgery may involve either a temporary or permanent ostomy (i.e., the creation of an opening between the remaining bowel and the body surface, using an external appliance to store fecal waste).

- While there is no medical cure for ulcerative colitis, a “cure” of sorts exists in the form of a total colectomy; i.e., surgical removal of the entire colon (large bowel), including the rectum. Some forms of colectomy lead to the “pelvic pouch procedure” (which involves the creation of an internal pouch of small bowel to store fecal waste), which is associated with infertility in about 50% of women of childbearing age.

- UC can also involve parts of the body other than the gastrointestinal tract, including the joints, eyes, skin, and liver. Fatigue is also a common feature. Children with UC may fail to develop or grow properly, although growth retardation tends to be less than that found in children with Crohn’s disease.

- Patients/clients with IBD have elevated rates of anxiety and depression. They often require emotional support and physical rest throughout the course of their disease, particularly during flare-ups.

References and sources of more detailed information

- Crohn’s and Colitis Foundation of Canada  http://www.ccfc.ca
- US Centers for Disease Control and Prevention  http://www.cdc.gov/ibd/
- Canadian Journal of Gastroenterology  http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2657699/

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References and sources of more detailed information (cont’d)

- The Impact of Inflammatory Bowel Disease in Canada: 2012 Final Report and Recommendations. Toronto: Crohn’s and Colitis Foundation of Canada; 2012.

* Includes oral hygiene instruction, fitting a mouth guard, taking an impression, etc.

** Ontario Regulation 501/07 made under Dental Hygiene Act, 1991. Invasive dental hygiene procedures are scaling teeth and root planing, including curetting surrounding tissue.

Date: June 8, 2013