Disease/Medical Condition

ULCERATIVE COLITIS

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

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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 — flare-up — and/or there are active oral lesions). 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-tumour necrosis factor drugs — anti-TNFs — such as infliximab, adalimumab, certoluzimab, and golimumab, as well as monoclonal antibody drugs such as vedoluzimab], JAK1 inhibitors [e.g., tofacitinib], etc.).
- Is antibiotic prophylaxis required? ................................ No, not typically (although extended use of corticosteroids and/or immunosuppression 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.
- 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.

1  JAK = Janus kinase

cont’d on next page...
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 260,000 Canadians live with IBD (slightly fewer with UC than Crohn’s disease).
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Related signs and symptoms (cont’d)

- 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

- College of Dental Hygienists of Ontario
  http://www.cdho.org/Advisories/CDHO_Advisory_Ulcerative_Colitis.pdf
- Crohn’s and Colitis Canada
  https://crohnsandcolitis.ca/
- Centers for Disease Control and Prevention
  http://www.cdc.gov/ibd/
- Crohn’s & Colitis Foundation
  https://www.crohnscolitisfoundation.org
- Mayo Clinic
- WebMD
- The Impact of Inflammatory Bowel Disease in Canada: 2012 Final Report and Recommendations. Toronto: Crohn’s and Colitis Foundation of Canada; 2012.
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References and sources of more detailed information (cont’d)


* 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.

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