Letter to the Editor

Does Disease Extent Matter when Scoring the UCEIS?

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We welcome the interest shown by colleagues in Rome about the Ulcerative Colitis Endoscopic Index of Severity [UCEIS] and their suggestion that it might be enhanced by segmental scoring at full colonoscopy. When the score was being developed, the international working group felt that a major goal was for the score to be simple, not to replicate the relative complexity of endoscopic scoring systems for Crohn’s disease. As it happens, some of the descriptors developed for the UCEIS were explored by colleagues at the Mayo Clinic when developing the Ulcerative Colitis Colonoscopic Index of Severity [UCCIS]. This index scored disease activity in segments, as have Menasci and colleagues, showing correlation with the simple clinical colitis activity index, patient-defined remission and, interestingly, the C-reactive protein [CRP] as well as other biological markers of disease activity.

So confirmation by Menasci and colleagues that a complete colonoscopy correlates with clinical disease activity is encouraging. The question about whether any practical advantage is gained for predicting the course of disease by increasing the complexity of the scoring system must remain open until the UCEIS is subject to long-term prospective studies. Preliminary work from Japan suggests that the UCEIS is more responsive to change following treatment for active UC [with tacrolimus] than the Mayo Clinic endoscopy subscore. This is not surprising, given that the UCEIS represents a 9-point scale [0–8] of three descriptors [vascular pattern, bleeding, and ulceration], scoring the worst affected area at flexible sigmoidoscopy, in contrast to the 4-point scale [0–3] of the Mayo Clinic endoscopy subscore, where descriptors overlap between levels.

There is no substantial evidence that variation in disease severity throughout colonic segments is related to outcomes. Indeed, assessing the most severely affected segment directs the clinician to biologically severe disease in colitis of limited extent, where a total colonic score would ‘dilute’ such severity in distal disease. The extent of disease is an important factor in decision-making, but probably best separated from the worst affected area. More affected segments are most likely to be distal, offering the advantage of assessment at flexible sigmoidoscopy rather than complete colonoscopy.

Our report on the UCEIS in acute severe colitis confirms that the UCEIS provides clinically relevant prognostic information. An additional paper on the UCEIS also published in J Crohns Colitis on the lack of impact of clinical information on endoscopic scoring is encouraging: clinical information should not influence an independent endoscopic score. Clinical disease activity and endoscopic disease activity should measure different things, or one becomes redundant. There are many further areas to explore with the UCEIS, which currently provides a common language for reporting endoscopic activity in ulcerative colitis.

References