

## **Resemblance between Ulcerative Colitis and Multiple Sclerosis**

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**I**t is very interesting to know that there is a resemblance between a GI illness and a neurological illness i.e. ulcerative colitis and multiple sclerosis.

The following are the similarities:

1. Though both the illnesses are uncommon illnesses, they are very important because if the diagnosis is missed the family physician will get a bad name.
2. Both these illnesses are extremely common in Western countries. In our country these are seen mainly among the upper middle class and high society patients.
3. At times, the differential diagnosis of ulcerative colitis from Crohn's disease of the large bowel could be extremely difficult though the blood tests of ANCA and ASCA and more detailed histopathological appearances may solve the issue. Diagnosis of ulcerative colitis should be thought of in any patient, who complains of mucus and/or blood in the stool. In all such patients, colonoscopy or multiple biopsies should be done.

In modern days, one should be hesitant to diagnose amoebic colitis, even if the stool test for amoeba is "so-called" positive. The diagnosis of amoebiasis should be made by serological and

histopathological criteria.

Similarly, multiple sclerosis till today should be diagnosed by exclusion method, though

- a. there is presence of more than one demyelinating lesion seen on MRI of the brain,
  - b. there is presence of oligoclonal proteins in the CSF,
  - c. Positive visual evoked potential studies point to the diagnosis, which is finally made by extensive investigations done to rule out other neurological illnesses.
4. Both these illnesses occur at a young age, which is very difficult for the family members to accept.
  5. Both the illnesses, when diagnosed at a young age will interfere with the profession in case of young man and marriage in case of a young lady.
  6. Both the illnesses are more common in females. Thus in a known case of young lady having ulcerative colitis or multiple sclerosis, marriage proposals should be carefully discussed.
  7. Both the illnesses start suddenly- in the form of acute bloody dysentery in case of ulcerative colitis, or sudden onset of any neurological symptom like blindness or paralysis in case of multiple sclerosis.
  8. In both the illnesses, the patients respond extremely well to large dose of steroids

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and drugs like Azathioprin which are being used for both the illnesses.

9. In both the illnesses, the patients can go into remission and remain absolutely free of complaints for months and years.
10. In both the illnesses, the patients can have sudden relapses and severe exacerbation with the patient needing hospitalization.
11. Both the illnesses can have a crippling end e.g. a patient of ulcerative colitis can develop such a severe exacerbation, that it may call for extensive surgery like total

removal of the colon or the patient may develop cancer of the colon, both of which could be fatal.

Similarly a patient of multiple sclerosis can end up with permanent paraplegia and loss of bladder function or other permanent neurological deficit and even die of the same.

12. Aetiology of both the conditions is unknown.

It appears to me, that it will take another 10-20 years or more to find out the cause of ulcerative colitis or multiple sclerosis.

#### **COMET'S PATH, AND THE NEW BIOLOGICALS IN RHEUMATOID ARTHRITIS**

Introduction of new biological agents that inhibit tumour necrosis factor (TNF), interleukin 6, and T and B cells has been accompanied by consistent and impressive improvements in disease activity, especially in patients with early rheumatoid arthritis.

Methotrexate treatment itself is associated with excellent responses in patients with early disease, as shown in Emery and colleagues' study in a total of more than 500 patients. 59% of patients who received methotrexate alone had no radiographic progression compared with 80% without progression on the combination of etanercept and methotrexate.

The patients on methotrexate monotherapy received a relatively high dose of weekly oral drug, at 19.6 mg per week. The authors acknowledge that the therapeutic value of methotrexate might have been enhanced further, relative to the combination, if methotrexate had been given parenterally rather than orally, because the bioavailability of methotrexate diminishes with oral dosing in the range of the mean doses administered in this study.

Therefore the relevant question is whether the difference between the clinical and radiographic response to methotrexate alone versus the combination is worth the additional cost, inconvenience, and potential toxic effects?

Rheumatoid arthritis can result in joint destruction, disability, time lost from work, and the need for orthopaedic interventions. Thus there is a need for more aggressive interventions. But what is the evidence that patients treated aggressively with the combination of methotrexate and biological agents function better and have improved outcomes over longer periods?

The hypothetical 10 year investigation will never be done for several good reasons. Outcomes of the combination interventions are simply too good when compared in the short term with that of methotrexate monotherapy.

We thus have a difficulty: how to show better outcomes in patients with a lesser disease burden who are given expensive drugs in combination with methotrexate over truly long-term treatment?

**Joel M Kremer, The Lancet, 2008; 372 : 347-48.**