



Ulcerative colitis: management

NICE guideline

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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the [Yellow Card Scheme](#).

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should [assess and reduce the environmental impact of implementing NICE recommendations](#) wherever possible.

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This guideline replaces CG166 and ESNM58.

This guideline is the basis of QS81.

Overview

This guideline covers managing ulcerative colitis in children, young people and adults. It aims to help professionals to provide consistent high-quality care and it highlights the importance of advice and support for people with ulcerative colitis.

NICE has also produced a [guideline on colonoscopic surveillance for adults with ulcerative colitis, Crohn's disease or adenomas](#).

Who is it for?

- Healthcare professionals
- Commissioners and providers
- People with ulcerative colitis and their families and carers

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in [NICE's information on making decisions about your care](#).

[Making decisions using NICE guidelines](#) explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 Patient information and support

1.1.1 Discuss the disease and associated symptoms, treatment options and monitoring:

- with the person with ulcerative colitis and their family members or carers (as appropriate) **and**
- within the multidisciplinary team (the composition of which should be appropriate for the age of the person) at every opportunity.

Apply the principles in the [NICE guideline on patient experience in adult NHS services](#). **[2013]**

1.1.2 Discuss the possible nature, frequency and severity of side effects of drug treatment for ulcerative colitis with the person, and their family members or carers (as appropriate). Refer to the [NICE guideline on medicines adherence](#). **[2013]**

1.1.3 Give the person, and their family members or carers (as appropriate) information about their risk of developing colorectal cancer and about colonoscopic surveillance, in line with the [NICE guidelines on colorectal cancer prevention: colonoscopic surveillance in adults with ulcerative colitis, Crohn's disease or](#)

adenomas and suspected cancer: recognition and referral. [2013]

1.2 Inducing remission in people with ulcerative colitis

Treating mild-to-moderate ulcerative colitis with conventional treatment

Proctitis

- 1.2.1 To induce remission in people with a mild-to-moderate first presentation or inflammatory exacerbation of proctitis, offer a topical aminosalicilate as first-line treatment. [2019]

In May 2019, this was an off-label use of some topical aminosalicilates for children and young people. See [NICE's information on prescribing medicines](#).

- 1.2.2 If remission is not achieved within 4 weeks, consider adding an oral aminosalicilate. [2019]

In May 2019, this was an off-label use of some oral aminosalicilates for children and young people. See [NICE's information on prescribing medicines](#).

- 1.2.3 If further treatment is needed, consider adding a time-limited course of a topical or an oral corticosteroid. [2019]

- 1.2.4 For people who decline a topical aminosalicilate:

- consider an oral aminosalicilate as first-line treatment, and explain that this is not as effective as a topical aminosalicilate
- if remission is not achieved within 4 weeks, consider adding a time-limited course of a topical or an oral corticosteroid. [2019]

- 1.2.5 For people who cannot tolerate aminosalicilates, consider a time-limited course

of a topical or an oral corticosteroid. **[2019]**

Proctosigmoiditis and left-sided ulcerative colitis

- 1.2.6 To induce remission in people with a mild-to-moderate first presentation or inflammatory exacerbation of proctosigmoiditis or left-sided ulcerative colitis, offer a topical aminosalicylate as first-line treatment. **[2019]**
- 1.2.7 If remission is not achieved within 4 weeks, consider:
- adding a high-dose oral aminosalicylate to the topical aminosalicylate **or**
 - switching to a high-dose oral aminosalicylate and a time-limited course of a topical corticosteroid. **[2019]**
- 1.2.8 If further treatment is needed, stop topical treatments and offer an oral aminosalicylate and a time-limited course of an oral corticosteroid. **[2019]**
- 1.2.9 For people who decline any topical treatment:
- consider a high-dose oral aminosalicylate alone, and explain that this is not as effective as a topical aminosalicylate
 - if remission is not achieved within 4 weeks, offer a time-limited course of an oral corticosteroid in addition to the high-dose aminosalicylate. **[2019]**
- 1.2.10 For people who cannot tolerate aminosalicylates, consider a time-limited course of a topical or an oral corticosteroid. **[2019]**

Extensive disease

- 1.2.11 To induce remission in people with a mild-to-moderate first presentation or inflammatory exacerbation of extensive ulcerative colitis, offer a topical aminosalicylate and a high-dose oral aminosalicylate as first-line treatment. **[2019]**
- 1.2.12 If remission is not achieved within 4 weeks, stop the topical aminosalicylate and

offer a high-dose oral aminosalicylate with a time-limited course of an oral corticosteroid. **[2019]**

- 1.2.13 For people who cannot tolerate aminosalicylates, consider a time-limited course of an oral corticosteroid. **[2019]**

For a short explanation of why the committee made the 2019 recommendations and how they might affect practice, see the [rationale and impact section on inducing remission in people with mild-to-moderate ulcerative colitis](#).

Full details of the evidence and the committee's discussion are in [evidence review: induction of remission in mild-to-moderate ulcerative colitis](#).

Treating moderately to severely active ulcerative colitis

See the [MHRA's safety advice on Janus kinase \(JAK\) inhibitors \(April 2023\)](#). See terms used in this guideline for a description and examples of [JAK inhibitors](#).

- 1.2.14 If people with ulcerative colitis and their clinicians consider there to be a range of suitable medicines, after discussing the advantages and disadvantages of all the options, the least expensive should be used. Administration costs, dosages, price per dose and commercial arrangements should all be taken into account. **[2025]**

Adults

- 1.2.15 For medicines recommended as options for treating [moderately to severely active ulcerative colitis](#) in adults when conventional treatment has failed or cannot be tolerated, see NICE's technology appraisal guidance on:

- [etrasimod \(TA956, March 2024\)](#)
- [upadacitinib \(TA856, January 2023\)](#)
- [filgotinib \(TA792, June 2022\)](#)
- [tofacitinib \(TA547, November 2018\)](#)

- [vedolizumab \(TA342, June 2015\)](#)
- [infliximab \(TA329, February 2015\)](#)
- [adalimumab \(TA329, February 2015\)](#)
- [golimumab \(TA329, February 2015\)](#).

1.2.16 For medicines recommended as options for treating moderately to severely active ulcerative colitis in adults if a [TNF-alpha inhibitor](#) is unsuitable, has failed or cannot be tolerated, see NICE's technology appraisal guidance on:

- [guselkumab \(TA1094, August 2025\)](#)
- [risankizumab \(TA998, August 2024\)](#)
- [mirikizumab \(TA925, October 2023\)](#)
- [ozanimod \(TA828, October 2022\)](#)
- [ustekinumab \(TA633, June 2020\)](#)
- [vedolizumab \(TA342, June 2015\)](#).

1.2.17 For medicines recommended as options for treating moderately to severely active ulcerative colitis in adults if previous [biological treatment](#) has failed or cannot be tolerated, see NICE's technology appraisal guidance on:

- [etrasimod \(TA956, March 2024\)](#)
- [upadacitinib \(TA856, January 2023\)](#)
- [ozanimod \(TA828, October 2022\)](#)
- [filgotinib \(TA792, June 2022\)](#)
- [tofacitinib \(TA547, November 2018\)](#).

Children and young people

Some of the treatment options in recommendations 1.2.15 to 1.2.17 may also be available to

children and young people with moderately to severely active ulcerative colitis under the [NHS England commissioning medicines for children in specialised services policy](#).

- 1.2.18 Etrasimod is recommended as an option for treating moderately to severely active ulcerative colitis in young people aged 16 and 17 years when the condition has inadequately responded or lost response to conventional or biological treatment, or when such treatment cannot be tolerated. For full details, see [NICE's technology appraisal guidance on etrasimod \(TA956, 2024\)](#).
- 1.2.19 Infliximab is recommended as an option for treating severely active ulcerative colitis in children and young people aged 6 to 17 years when the condition has inadequately responded to conventional treatment, or when such treatment cannot be tolerated or it is contraindicated. For full details, see [NICE's technology appraisal guidance on infliximab \(TA329, 2015\)](#).

Reviewing treatment

- 1.2.20 Medicines listed in recommendations 1.2.15 to 1.2.19 should be given until they stop working or surgery is needed. People should be reassessed at least every 12 months to decide whether treatment should continue. For details, see the relevant NICE technology appraisal guidance. **[2025]**

Treating acute severe ulcerative colitis

The multidisciplinary team

- 1.2.21 For people admitted to hospital with acute [severe ulcerative colitis](#):
- ensure that a gastroenterologist and a colorectal surgeon collaborate to provide treatment and management
 - ensure that the composition of the multidisciplinary team is appropriate for the age of the person
 - seek advice from a paediatrician with expertise in gastroenterology when treating a child or young person

- ensure that the obstetric and gynaecology team is included when treating a pregnant woman. **[2013]**

Step 1 therapy

1.2.22 For people admitted to hospital with acute severe ulcerative colitis (either a first presentation or an inflammatory exacerbation):

- offer intravenous corticosteroids to induce remission **and**
- assess the likelihood that the person will need surgery (see the [recommendation on assess and document in the section on assessing likelihood of needing surgery](#)). **[2013]**

1.2.23 Consider intravenous ciclosporin or surgery for people:

- who cannot tolerate or who decline intravenous corticosteroids **or**
- for whom treatment with intravenous corticosteroids is contraindicated.

Take into account the person's preferences when choosing treatment. **[2013]**

In May 2019, this was an off-label use of ciclosporin. See [NICE's information on prescribing medicines](#).

Step 2 therapy

1.2.24 Consider adding intravenous ciclosporin to intravenous corticosteroids or consider surgery for people:

- who have little or no improvement within 72 hours of starting intravenous corticosteroids **or**
- whose symptoms worsen at any time despite corticosteroid treatment.

Take into account the person's preferences when choosing treatment. **[2013]**

In May 2019, this was an off-label use of ciclosporin. See [NICE's information on prescribing medicines](#)

- 1.2.25 Infliximab is recommended as an option for treating acute exacerbations of severely active ulcerative colitis only in people in whom ciclosporin is contraindicated or clinically inappropriate, based on a careful assessment of the risks and benefits of treatment in the individual. For full details, see [NICE's technology appraisal guidance on infliximab \(TA163, 2008\)](#). **[2008]**

Assessing likelihood of needing surgery

- 1.2.26 Assess and document on admission, and then daily, the likelihood of needing surgery for people admitted to hospital with acute severe ulcerative colitis. **[2013]**
- 1.2.27 Be aware that there may be an increased likelihood of needing surgery for people with any of the following:
- stool frequency more than 8 per day
 - pyrexia
 - tachycardia
 - an abdominal X-ray showing colonic dilatation
 - low albumin, low haemoglobin, high platelet count or C-reactive protein above 45 mg/litre (bear in mind that normal values may be different in pregnant women). **[2013]**

1.3 Information about treatment options for people who are considering surgery

These recommendations apply to anyone with ulcerative colitis considering elective surgery. The principles can also be applied to people requiring emergency surgery.

Information when considering surgery

- 1.3.1 For people with ulcerative colitis who are considering surgery, ensure that a specialist (such as a gastroenterologist or a nurse specialist) gives the person and their family members or carers (as appropriate) information about all available treatment options, and discusses this with them. Information should include the benefits and risks of the different treatments and the potential consequences of no treatment. **[2013]**
- 1.3.2 Ensure that the person and their family members or carers (as appropriate) have sufficient time and opportunities to think about the options and the implications of the different treatments. **[2013]**
- 1.3.3 Ensure that a colorectal surgeon gives any person who is considering surgery and their family members or carers (as appropriate) specific information about what they can expect in the short and long term after surgery, and discusses this with them. **[2013]**
- 1.3.4 Ensure that a specialist (such as a colorectal surgeon, a gastroenterologist, an inflammatory bowel disease nurse specialist or a stoma nurse) gives any person who is considering surgery and their family members or carers (as appropriate) information about:
- diet
 - sensitive topics such as sexual function
 - effects on lifestyle
 - psychological wellbeing
 - the type of surgery, the possibility of needing a stoma and stoma care.
- [2013]**
- 1.3.5 Ensure that a specialist who is knowledgeable about stomas (such as a stoma nurse or a colorectal surgeon) gives any person who is having surgery and their family members or carers (as appropriate) specific information about the siting, care and management of stomas. **[2013]**

Information after surgery

1.3.6 After surgery, ensure that a specialist who is knowledgeable about stomas (such as a stoma nurse or a colorectal surgeon) gives the person and their family members or carers (as appropriate) information about managing the effects on bowel function. This should be specific to the type of surgery performed (ileostomy or ileoanal pouch) and could include the following:

- strategies to deal with the impact on their physical, psychological and social wellbeing
- where to go for help if symptoms occur
- sources of support and advice. [2013]

1.4 Maintaining remission in people with ulcerative colitis

Proctitis and proctosigmoiditis

1.4.1 To maintain remission after a mild-to-moderate inflammatory exacerbation of proctitis or proctosigmoiditis, consider the following options, taking into account the person's preferences:

- a topical aminosalicylate alone (daily or intermittent) **or**
- an oral aminosalicylate plus a topical aminosalicylate (daily or intermittent) **or**
- an oral aminosalicylate alone, explaining that this may not be as effective as combined treatment or an intermittent topical aminosalicylate alone. [2013]

In May 2019, note that this was an off-label use of some aminosalicylates for children and young people. See [NICE's information on prescribing medicines](#)

Left-sided and extensive ulcerative colitis

1.4.2 To maintain remission in adults after a mild-to-moderate inflammatory exacerbation of left-sided or extensive ulcerative colitis:

- offer a low maintenance dose of an oral aminosalicylate
- when deciding which oral aminosalicylate to use, take into account the person's preferences, side effects and cost. **[2013]**

1.4.3 To maintain remission in children and young people after a mild-to-moderate inflammatory exacerbation of left-sided or extensive ulcerative colitis:

- offer an oral aminosalicylate (dosing requirements for children should be calculated by body weight, as described in the BNF)
- when deciding which oral aminosalicylate to use, take into account the person's preferences (and those of their parents or carers as appropriate), side effects and cost. **[2013]**

In May 2019, this was an off-label use of some oral aminosalicylates for children and young people. See [NICE's information on prescribing medicines](#).

All extents of disease

1.4.4 Consider oral azathioprine or oral mercaptopurine to maintain remission:

- after 2 or more inflammatory exacerbations in 12 months that require treatment with systemic corticosteroids **or**
- if remission is not maintained by aminosalicylates. **[2013]**

In May 2019, this was an off-label use of some brands of azathioprine and mercaptopurine. See [NICE's information on prescribing medicines](#).

1.4.5 To maintain remission after a single episode of acute severe ulcerative colitis:

- consider oral azathioprine or oral mercaptopurine

- consider oral aminosalicylates if azathioprine and/or mercaptopurine are contraindicated or the person cannot tolerate them. **[2013]**

In May 2019, this was an off-label use of some brands of azathioprine and mercaptopurine. See [NICE's information on prescribing medicines](#).

Dosing regimen for oral aminosalicylates

- 1.4.6 Consider a once-daily dosing regimen for oral aminosalicylates when used for maintaining remission. Take into account the person's preferences, and explain that once-daily dosing can be more effective, but may result in more side effects. **[2013]**

In May 2019, this was an off-label use of some oral aminosalicylates. See [NICE's information on prescribing medicines](#).

1.5 Pregnant women

- 1.5.1 When caring for a pregnant woman with ulcerative colitis:
- Ensure effective communication and information-sharing across specialties (for example, primary care, obstetrics and gynaecology, and gastroenterology).
 - Give her information about the potential risks and benefits of medical treatment to induce or maintain remission and of not having treatment, and discuss this with her. Include information relevant to a potential admission for an acute [severe inflammatory exacerbation](#). **[2013]**

1.6 Monitoring

Monitoring treatment

- 1.6.1 Ensure that there are documented local safety monitoring policies and procedures (including audit) for adults, children and young people receiving treatment that needs monitoring. Nominate a member of staff to act on abnormal results and communicate with GPs and people with ulcerative colitis and their family members or carers (as appropriate). **[2013]**

Monitoring bone health

Adults

- 1.6.2 For recommendations on assessing the risk of fragility fracture in adults, see the [NICE guideline on osteoporosis: assessing the risk of fragility fracture](#). **[2013]**

Children and young people

- 1.6.3 Consider monitoring bone health in children and young people with ulcerative colitis in the following circumstances:
- during chronic active disease
 - after treatment with systemic corticosteroids
 - after recurrent active disease. **[2013]**

Monitoring growth and pubertal development in children and young people

- 1.6.4 Monitor the height and body weight of children and young people with ulcerative colitis against expected values on centile charts (and/or z scores) at the following intervals according to disease activity:

- every 3 to 6 months:
 - if they have an inflammatory exacerbation and are approaching or undergoing puberty **or**
 - if there is chronic active disease **or**
 - if they are being treated with systemic corticosteroids
 - every 6 months during pubertal growth if the disease is inactive
 - every 12 months if none of the criteria above are met. **[2013]**
- 1.6.5 Monitor pubertal development in young people with ulcerative colitis using the principles of Tanner staging, by asking screening questions and/or carrying out a formal examination. **[2013]**
- 1.6.6 Consider referral to a secondary care paediatrician for pubertal assessment and investigation of the underlying cause if a young person with ulcerative colitis:
- has slow pubertal progress **or**
 - has not developed pubertal features appropriate for their age. **[2013]**
- 1.6.7 Monitoring of growth and pubertal development:
- can be done in a range of locations (for example, at routine appointments, acute admissions or urgent appointments in primary care, community services or secondary care)
 - should be carried out by appropriately trained healthcare professionals as part of the overall clinical assessment (including disease activity) to help inform the need for timely investigation, referral and/or interventions, particularly during pubertal growth.
- If the young person prefers self-assessment for monitoring pubertal development, this should be allowed if possible and they should be instructed on how to do this. **[2013]**
- 1.6.8 Ensure that relevant information about monitoring of growth and pubertal

development and about disease activity is shared across services (for example, community, primary, secondary and specialist services). Apply the principles in the [NICE guideline on patient experience in adult NHS services](#) in relation to continuity of care. [2013]

Terms used in this guideline

Biological treatment

A biological medicine is any medicinal product made by or derived from a biological (natural) source, for example, an animal cell or microorganism. This includes the anti-lymphocyte monoclonal antibodies, interleukin inhibitors and TNF-alpha inhibitors. Examples include vedolizumab (anti-lymphocyte monoclonal antibody), mirikizumab, risankizumab and ustekinumab (interleukin inhibitors), and adalimumab, golimumab and infliximab (TNF-alpha inhibitors).

Janus kinase (JAK) inhibitor

A targeted synthetic medicine that inhibits the inflammatory activity of the Janus kinase enzymes. They are given orally. Examples include filgotinib, tofacitinib and upadacitinib.

Mild, moderate and severe ulcerative colitis

In this guideline, the categories of mild, moderate and severe are used to describe ulcerative colitis:

- In adults these categories are based on the Truelove and Witts' severity index (see table 1). This table is adapted from the Truelove and Witts' criteria.
- In children and young people these categories are based on the Paediatric Ulcerative Colitis Activity Index (PUCAI; see table 2).

Table 1: Truelove and Witts' severity index

Topic	Mild	Moderate	Severe
Bowel movements (number per day)	Fewer than 4	4 to 6	6 or more plus at least 1 of the features of systemic upset (marked with*)
Blood in stools	No more than small amounts of blood	Between mild and severe	Visible blood
Pyrexia (temperature greater than 37.8°C)*	No	No	Yes
Pulse rate greater than 90 bpm*	No	No	Yes
Anaemia*	No	No	Yes
Erythrocyte sedimentation rate (mm/hour)*	30 or below	30 or below	Above 30

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Disease severity in table 2 is defined by the following scores:

- severe: 65 or above
- moderate: 35 to 64
- mild: 10 to 34
- remission (disease not active): below 10.

Table 2: Paediatric Ulcerative Colitis Activity Index (PUCAI)

Item	Points
1. Abdominal pain	–
No pain	0
Pain can be ignored	5
Pain cannot be ignored	10
2. Rectal bleeding	–
None	0
Small amount only, in less than 50% of stools	10
Small amount with most stools	20
Large amount (50% of the stool content)	30
3. Stool consistency of most stools	–
Formed	0
Partially formed	5
Completely unformed	10
4. Number of stools per 24 hours	–
0 to 2	0
3 to 5	5
6 to 8	10
>8	15
5. Nocturnal stools (any episode causing waking)	–
No	0
Yes	10
6. Activity level	–
No limitation of activity	0
Occasional limitation of activity	5
Severe restricted activity	10
Sum of PUCAI (0 to 85)	–

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Time-limited course of oral corticosteroids

A course of corticosteroids used to treat active disease, normally given for 4 to 8 weeks (depending on the steroid).

Tumour necrosis factor (TNF)-alpha inhibitor

A type of biological medicine that inhibits an inflammatory protein, tumour necrosis factor-alpha. Examples include adalimumab, golimumab and infliximab.

Recommendations for research

The guideline committee has made the following key recommendations for research. As part of the 2019 update, the guideline committee made an additional 3 recommendations for research on inducing remission in mild-to-moderate ulcerative colitis.

Key recommendations for research

1 The effectiveness of immunomodulators in inducing remission in proctitis

In a mild-to-moderate first presentation or inflammatory exacerbation of proctitis that is resistant to standard treatment, what is the effectiveness of topical immunomodulators, such as tacrolimus, in achieving clinical remission and what is the most effective formulation (suppository/ointment)?

For a short explanation of why the committee made the recommendation for research, see the [rationale on proctitis](#).

Full details of the evidence and the committee's discussion are in [evidence review: induction of remission in mild-to-moderate ulcerative colitis](#).

2 The effectiveness of immunomodulators in unresponsive ulcerative colitis

What is the effectiveness of oral tacrolimus and systemic (intramuscular/subcutaneous/oral) methotrexate in the induction of remission in mild-to-moderate ulcerative colitis unresponsive to aminosalicylates?

For a short explanation of why the committee made the recommendation for research, see the [rationale on extensive ulcerative colitis](#).

Full details of the evidence and the committee's discussion are in [evidence review: induction of remission in mild-to-moderate ulcerative colitis](#).

3 The relative effectiveness of corticosteroids for inducing remission in ulcerative colitis

What is the clinical and cost effectiveness of prednisolone, budesonide, and beclometasone in addition to aminosalicylates compared with each other and with aminosalicylate monotherapy for the induction of remission for people with mild-to-moderate ulcerative colitis?

For a short explanation of why the committee made the recommendation for research, see the [rationale on all extents of disease](#).

Full details of the evidence and the committee's discussion are in [evidence review: induction of remission in mild-to-moderate ulcerative colitis](#).

Other recommendations for research from the 2019 update

4 Induction of remission for people with moderate ulcerative colitis: prednisolone compared with aminosalicylates

What is the clinical and cost effectiveness of prednisolone compared with aminosalicylates for the induction of remission for people with moderate ulcerative colitis?

5 Induction of remission for people with moderate ulcerative colitis: prednisolone compared with beclometasone

What is the clinical and cost effectiveness of prednisolone plus an aminosalicylate

compared with beclometasone plus an aminosalicylate for induction of remission for people with moderate ulcerative colitis?

6 Induction of remission for people with subacute ulcerative colitis that is refractory to systemic corticosteroids

What are the benefits, risks and cost effectiveness of methotrexate, ciclosporin, tacrolimus, adalimumab and infliximab compared with each other and with placebo for induction of remission for people with subacute ulcerative colitis that is refractory to systemic corticosteroids?

Other recommendations for research from the 2013 guideline

7 Methotrexate, ciclosporin, tacrolimus, adalimumab and infliximab

What are the benefits, risks and cost effectiveness of methotrexate, ciclosporin, tacrolimus, adalimumab and infliximab compared with each other and with placebo for induction of remission for people with subacute ulcerative colitis that is refractory to systemic corticosteroids?

8 Regular maintenance treatment compared with no regular treatment

What is the clinical and cost effectiveness of regular maintenance treatment compared with no regular treatment (but rapid standard treatment if a relapse occurs) in specific populations with mild to moderate ulcerative colitis?

9 Risk tool that predicts the likely need for surgery

To develop and validate a risk tool that predicts the likelihood of needing surgery for adults admitted to hospital with acute severe ulcerative colitis.

10 Routine monitoring of bone density in children and young

people

In children and young people with ulcerative colitis receiving steroid treatment, what are the clinical benefits of routine monitoring of bone density, what tests should be done and how frequently?

11 Registry for drug treatments in pregnant women

A registry to collect data to answer 'What are the potential harms or benefits of drug treatments in pregnant women with ulcerative colitis?'

12 Information needs for surgery

What are the information needs of people with ulcerative colitis when they are considering surgery?

13 Sulphasalazine compared to high-dose branded mesalazine

What is the clinical and cost effectiveness of sulphasalazine compared to high-dose branded mesalazine for induction of remission for people with mild moderate ulcerative colitis?

14 Validity, reliability and accuracy of available adult risk tools as a predictor for the need for surgery

What is the validity, reliability and accuracy of available adult risk tools as a predictor for the need for surgery in people admitted into hospital with acute severe ulcerative colitis?

15 Paediatric Ulcerative Colitis Activity Index (PUCAI) as a predictor for surgery for children and young people

What is the validity, reliability and accuracy of the Paediatric Ulcerative Colitis Activity Index (PUCAI) as a predictor for surgery for children and young people admitted to hospital with acute severe colitis?

16 Second-line treatment strategies for induction of remission

after people have failed to respond to ASA mono or combination therapies

In people with mild to moderate ulcerative colitis, what are the best second-line treatment strategies for induction of remission after people have failed to respond to ASA mono or combination therapies?

17 Second-line treatment strategies for induction of remission after people have failed to respond to oral prednisolone

In people with subacute ulcerative colitis, what are the best second-line treatment strategies for induction of remission after people have failed to respond to oral prednisolone?

18 Best strategies for the induction of remission after people have failed to respond to tacrolimus

In people with mild to moderate ulcerative colitis, what are the best strategies for the induction of remission after people have failed to respond to tacrolimus?

19 National registry to identify the incidence of growth failure and/or pubertal delay

Establish a national registry to identify the incidence of growth failure and/or pubertal delay in ulcerative colitis and the relationship with treatment (to record treatment [steroids, ASA, immunomodulators] and growth [z scores]).

Rationale and impact

This section briefly explains why the committee made the recommendations and how they might affect practice. It links to details of the evidence and a full description of the committee's discussion.

Inducing remission in people with mild-to-moderate ulcerative colitis

Recommendations 1.2.1 to 1.2.13

Why the committee made the recommendations

Proctitis

The evidence showed that topical aminosalicylates (suppositories or enema) are the most effective treatments for achieving remission in people with mild-to-moderate proctitis, so these were recommended as first-line treatments. The evidence did not show any difference in effectiveness between enema and suppository.

Topical aminosalicylates alone are recommended for up to 4 weeks because the evidence showed that they were the most effective treatment within this timeframe. There was no direct evidence for combining topical and oral aminosalicylates for people with proctitis. However, evidence showed that this combination was effective for people with proctosigmoiditis, and the committee agreed that this evidence was also applicable to people with proctitis alone. The committee chose not to specify a dose for the oral aminosalicylate. It preferred to leave it open to clinical judgment depending on the specific situation (for example, the clinician could give a low dose if the person had not taken an aminosalicylate before, or a high dose if the person was already taking a low dose).

Some people will not achieve remission with topical and oral aminosalicylates. In clinical practice, oral or topical corticosteroids are commonly added at this stage, but there was no evidence on this combination. The committee agreed that, based on their experience, adding a topical or oral corticosteroid should be an option at this stage.

Despite the lack of direct evidence for the effectiveness of topical or oral corticosteroids, the committee agreed that, based on their experience, these should also be an option for people who cannot tolerate aminosalicylates.

Some people decline topical treatment, preferring oral to topical aminosalicylates. This is more common in children and young people, although proctitis is not common in this group. As the evidence showed that oral aminosalicylates are not as effective at inducing remission, the committee thought it was important to explain this to people who decline topical aminosalicylates.

There was cost-effectiveness evidence showing that using an immunomodulator as the next line of treatment after oral or topical corticosteroids and oral aminosalicylate produced greater health benefits at lower total costs than other strategies. However, the clinical evidence on topical immunomodulators was limited and it was unclear how applicable it was to UK clinical practice. Because of this, the committee recommended the sequence without this final treatment, and made a [recommendation for research on topical immunomodulators](#).

Proctosigmoiditis or left-sided ulcerative colitis

There is evidence that topical aminosalicylates are effective for achieving remission in people with mild-to-moderate proctosigmoiditis or left-sided ulcerative colitis. In the committee's experience topical aminosalicylates also work faster and more effectively than topical corticosteroids. Topical aminosalicylates alone are recommended for up to 4 weeks because the evidence showed that they were effective within this timeframe. Cost-effectiveness evidence also showed that treatment sequences starting with topical aminosalicylates produced greater health benefits and incurred lower total costs than other strategies.

There is no direct evidence for the effectiveness of high-dose oral aminosalicylates combined with either topical aminosalicylates or topical corticosteroids. However, there is evidence that topical treatments or high-dose oral aminosalicylates individually provide some benefit. Therefore, the committee agreed it was reasonable to recommend combinations of these if remission is not achieved. While there was limited evidence for oral corticosteroids, in the committee's experience an oral corticosteroid may benefit people with proctosigmoiditis or left-sided disease if further treatment is needed. As a result, they recommended oral corticosteroids with oral aminosalicylates instead of topical treatment for these people. This reflects current practice for people who do not achieve

remission with topical treatments and high-dose oral aminosalicylates.

Extensive ulcerative colitis

The evidence showed that people with mild-to-moderate extensive ulcerative colitis would benefit most from a combination of high-dose oral aminosalicylates with topical aminosalicylates as first-line treatment. High-dose oral aminosalicylates combined with topical aminosalicylates are recommended for up to 4 weeks, because in the committee's experience they are the most effective treatment within this timeframe. There is evidence that an oral corticosteroid combined with a high-dose oral aminosalicylate is also effective, so the committee recommended this combination if remission is not achieved with aminosalicylates alone. In people who cannot tolerate aminosalicylates, oral corticosteroids are recommended as they are also an effective treatment option.

The sequence of drugs recommended was more effective than starting with a high-dose oral aminosalicylate alone. There was some uncertainty around the cost effectiveness of this sequence. The data on the effectiveness of high-dose oral aminosalicylates combined with topical aminosalicylates was from an 8-week clinical trial. The committee believed that in practice, people whose disease did not respond to treatment within 4 weeks would switch to another treatment. When the cost-effectiveness analysis allowed for early switching, the combination of a high-dose oral aminosalicylate and topical aminosalicylate was not cost effective. However, if it was assumed that everyone continued treatment as described in the trial, the combination of a high-dose oral aminosalicylate and topical aminosalicylate was more likely to be cost effective. The committee took the uncertainty about the cost-effectiveness results in the different scenarios into account in recommending the combination as first-line treatment.

There was some evidence on methotrexate for inducing remission, but it did not show a clear benefit, and there was no evidence on oral tacrolimus. To address these gaps in the evidence, the committee made a [recommendation for research on the effectiveness of immunomodulators in unresponsive ulcerative colitis](#).

All extents of disease

Most of the evidence was for adults. However, the committee agreed to generalise the recommendations to all people with a mild-to-moderate exacerbation or first presentation of ulcerative colitis.

There is limited evidence on oral corticosteroids. In addition, the committee agreed that the use of oral corticosteroids is generally reserved for later lines of treatment because of concerns about side effects. It is not clear which corticosteroid is most effective for each extent of disease. There is also limited evidence on immunomodulators, specifically oral tacrolimus and systemic methotrexate for each extent of disease. The committee made a [recommendation for research on corticosteroids for the induction of remission in mild-to-moderate ulcerative colitis](#) to address these uncertainties.

How the recommendations might affect practice

The new recommendations classify the extents of ulcerative colitis differently. This more closely reflects current practice, so will be clearer and more informative for people with mild-to-moderate ulcerative colitis and healthcare professionals.

The recommendations in the 2013 guideline referred to specific corticosteroids. To better reflect the available evidence, the updated recommendations refer to aminosalicylates and corticosteroids as a class rather than recommending individual treatments. This allows healthcare professionals and people with mild-to-moderate ulcerative colitis to choose the most appropriate corticosteroid or aminosalicylate, depending on patient preference, availability and acquisition cost.

The new recommendations specify that courses of oral corticosteroids should be time-limited. This should address varying practice in prescribing for some corticosteroids.

[Return to recommendations](#)

Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the [NICE topic page on inflammatory bowel disease](#).

For full details of the evidence and the guideline committee's discussions, see the [evidence review and full guideline](#). You can also find information about [how the guideline was developed, including details of the committee](#).

NICE has produced [tools and resources to help you put this guideline into practice](#). For general help and advice on putting our guidelines into practice, see [resources to help you put NICE guidance into practice](#).

Update information

May 2019: This guideline is an update of NICE guideline CG166 (published June 2013) and replaces it.

We have reviewed the evidence on inducing remission for people with mild-to-moderate ulcerative colitis. These recommendations are marked **[2019]**.

Recommendations marked **[2008]** or **[2013]** last had an evidence review in 2008 or 2013. In some cases minor changes have been made to the wording to bring the language and style up to date, without changing the meaning.

Minor changes since publication

March 2026: We added links to relevant technology appraisal guidance in the [section on treating moderately to severely active ulcerative colitis](#).

February 2025: We added links to relevant technology appraisal guidance in the [sections on treating moderately to severely active ulcerative colitis](#) and [treating acute severe ulcerative colitis](#), and added new recommendations marked **[2025]** clarifying how to use medicines recommended in NICE technology appraisal guidance. We moved a recommendation on monitoring treatment into the section on monitoring, and added new definitions to [terms used in this guideline](#).

July 2019: The recommendations for research from the 2013 guideline were added.

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