Guided self management of ulcerative colitis with follow up on request, compared with traditional management, accelerates treatment provision, reduces visits to specialists and general practitioners, and does not increase morbidity

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van Illich believes that “the medical establishment has become a major threat to health”. He reasons that the rise of modern medicine has encouraged a culture of dependency on the medical establishment rather than promoting self caring approaches to illness. This extreme viewpoint has a surprising number of supporters; perhaps because it contains a grain of truth. Clinicians can be paternalistic and often set up services with little regard to patient preferences or whether this is the most cost effective method of delivering health care. It is therefore refreshing to read the paper by Robinson et al comparing guided self management with usual care for ulcerative colitis (UC) patients in a randomised controlled trial. Patients were more satisfied with guided self management, and patients with relapses took steroids earlier. There was also a statistically non-significant trend for relapses to be of shorter duration. The results seem compelling, so should there be widespread implementation of this management strategy for UC?

This was a well designed and clearly reported study but inevitably some questions remain. More than 80% of participants had distal UC and only 5% were receiving azathioprine, hence the results pertain mainly to patients with left sided disease not taking long term immunosuppression. There also needs to be longer follow up as the initial enthusiasm for guided self care may diminish with time. There is therefore the danger that patients will be left without specialist input in the long term. Robinson et al will continue to monitor the new system and these results will be important.

The authors highlight the trend towards a reduction in the length of relapses in those allocated to guided self management but are rightly cautious in interpreting this finding. There was also a trend towards a greater proportion of self managed patients to relapse (61% in the guided self management arm compared with 49% in the usual care group). This was not statistically significant and may reflect the fact that relapses were self reported. However, if there were a 12% difference in relapse rates this would be clinically important.

What is clear from the data is that UC patients are dissatisfied with the current system, with a staggering 94% (80/85) of those randomised to usual management preferring another approach. It is interesting that although a large number of patients in the self management group preferred this strategy, the proportion was significantly less than those allocated to usual care (82% (71/86); relative risk 0.88 (95% confidence interval 0.79–0.98); p=0.03). One interpretation of this result is that patients dislike the current system, and although they prefer the alternative it is not quite as good as they hoped. There may be an overestimation of the satisfaction with guided self management as neither the patients nor the investigators were blinded to the allocation group and this could have biased the results.

The paper highlighted individual cost items such as travel and number of clinic visits that were significantly less in the guided self management group. There were no data on overall cost either from a societal or NHS perspective, however, so it is difficult to establish which approach is more cost effective.

Despite these reservations this is an important study that highlights the deficiencies in the current system for managing UC. The alternative they propose is consistent with the current trend for patients to become more actively involved in their own care. The approach is also in keeping with the drive to teach medical students with problem based self directed learning. The evidence will be enough to convince some clinicians to
adopt guided self management for pa-


tients with left sided colitis in remission


and without the need for immunosup-


pression. Others may be more cautious


and want further trials from other


centres, and comparisons with other


strategies such as nurse led clinics and


telephone consultations.7 8


Gut 2002;51:309–310


REFERENCES


2 Edwards RH. Is it time for an Illich


collaboration to make available information


on the harms of medical care? BMJ


1999;318:58.


Establishing patient preferences for


gastroenterology clinic re-organisation using


conjoint analysis. Eur J Gastroenterol Hepatol


2002;14:429–33.


Guided self-management and patient-directed


follow-up of ulcerative colitis: a randomised


5 Troop N, Treasure J, Schmidt U. From


specialist care to self directed treatment. BMJ


6 Shin JH, Haynes RB, Johnston ME. Effect of


problem-based, self-directed undergraduate


education on life-long learning. Can Med


Assoc J 1993;148:969–76.


7 Nightingale AJ, Middleton W, Middleton SJ,


et al. Evaluation of the effectiveness


of a specialist nurse in the management of


inflammatory bowel disease. Eur J Gastroenterol Hepatol 2000;12:


967–73.


Welch HG. Telephone care as a substitute for


routine clinic follow-up. JAMA


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