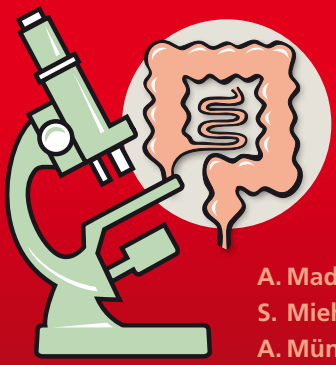

Microscopic colitis

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Detect with confidence and treat effectively

***Microscopic colitis* is a chronic inflammatory bowel disease which has become more widely known in recent years.**

One of the reasons that *microscopic colitis* is still too rarely diagnosed is its similarity to irritable bowel syndrome.

In cases of persistent (> 4 weeks), watery diarrhoea, *microscopic colitis* should always be considered. Commonly women over the age of 50 are affected.

Diagnosis is only possible by means of colonoscopy and biopsies with histopathological examination. The course of the disease is benign, but it significantly impairs quality of life.

Once detected, *microscopic colitis* can be effectively treated in most cases. The drug of choice is oral budesonide. Because the disease frequently recurs, regular doctor-patient contact is desirable, and not uncommonly long-term therapy is required to relieve persistent symptoms.

This information is intended to help detect the disease more quickly in order to be able to offer patients effective therapy.

Microscopic colitis

Definition and epidemiology

Microscopic colitis is a chronic inflammatory bowel disease with watery diarrhoea as its main symptom and usually with a chronic-recurrent course. Depending on the histological presentation, a distinction is made between **collagenous and lymphocytic** colitis. The increasing prevalence of the disease is explained not only as a result of improved diagnostics, but also because of its increased incidence. The cause of *microscopic colitis* is still unclear. The prevalence is equivalent in relation to age to that of Crohn's disease and ulcerative colitis.

When should microscopic colitis be considered?

The clinical picture of *microscopic colitis* is characterised by chronic watery diarrhoea (frequently also at night), sometimes associated with spasmodic abdominal pain and weight loss. The watery consistency of the stools can result in faecal incontinence.

These complaints cause considerable impairment to the quality of life. *Microscopic colitis* commonly occurs after the age of 50, but it can also occur in younger patients and in rare cases even in children. It is more common among women.

Despite the typical clinical symptoms, diagnosis cannot be made solely on the basis of symptomatology. Besides the various differential diagnoses in chronic diarrhoea, the most important differential diagnosis in similar symptoms is diarrhoea-dominant irritable bowel syndrome.

However, in the case of irritable bowel syndrome, the ROME III criteria specify that chronic abdominal pain absolutely must predominate, while in *microscopic colitis* this occurs in only around one half of cases as an accompanying symptom.

How is microscopic colitis diagnosed?

In patients with chronic diarrhoea (longer than 4 weeks) a complete colonoscopy is an essential examination for establishing the diagnosis, but also for differential diagnosis of other inflammatory bowel diseases or malignancies. In *microscopic colitis* the findings of colonoscopy are typically unremarkable. The diagnosis is made solely on the basis of the histopathological examination of stepwise biopsies of the colonic mucosa.

Collagenous colitis is characterised by thickening of the subepithelial collagen layer to over 10 µm (norm 3-5 µm), whereas *lymphocytic colitis* shows an increase in intra-epithelial lymphocytes to over 20/100 epithelial cells.

The faecal calprotectin test is not helpful in the diagnosis of *microscopic colitis.*

Drug treatment of microscopic colitis

Conclusive data is available only for oral budesonide. In recent years three placebo-controlled studies have been conducted worldwide which examined the efficacy of 9 mg budesonide daily in patients with acute *collagenous colitis.* The response rate is approx. 80 %.

According to a Cochrane analysis of *collagenous colitis* one in two patients (NNT = 2) benefit from therapy with budesonide, which demonstrates the high effectiveness of the substance. Two current studies also demonstrate that budesonide in a dose of 6 mg daily is also effective in maintaining remission in *collagenous colitis.*

Budenofalk® 3mg capsules and Budenofalk® 9mg are licensed worldwide as the only preparations for the treatment of collagenous colitis. Therapy of *lymphocytic colitis* with budesonide is comparably effective, although it is not yet officially licensed.

If symptoms persist despite treatment with budesonide, specialist investigation is required.

Checklist

When should microscopic colitis be considered?

- Intermittent or persistent, also nocturnal watery diarrhoea for several weeks (stool frequency ≥ 3/day)
- Commonly over 50 years of age
- Predominantly women
- Accompanying abdominal pain
- Faecal incontinence complaints
- Smokers
- Concurrent medication (PPI (lanzoprazole), SSRI (sertraline), NSAID, acarbose, ranitidine and ticlopidine)
- Concurrent autoimmune diseases (rheumatism, thyroid disease, diabetes, coeliac disease)

Further diagnostic investigation with colonoscopy and biopsies in the complete colon for histopathological assessment are required to make a diagnosis or to exclude *microscopic colitis.*

Differential diagnosis irritable bowel syndrome – microscopic colitis

	Irritable bowel syndrome	**Microscopic colitis**
First occurrence of disease	Commonly younger than 50 years of age	Commonly older than 50 years of age
Stool consistency	Soft – **variable** – hard	Watery/soft
Abdominal pain/discomfort	Obligatory	Variable
Nocturnal diarrhoea	Very rare	Possible
Feeling of incomplete bowel evacuation	Common	No
Weight loss	Rare	Common
Faecal incontinence	Rare	Common
Feeling of fullness/bloating	Common	Rare
Accompanying autoimmune disease	No	Yes