Table 1: Summary of UEG/EMCG statements and recommendations for MC

Section and number	Statement/Recommendation	Level of evidence	Grade of recommendation	Voting
Section 1	Epidemiology and risk factors			
1.1	The pooled overall incidence rate of MC is estimated to be 11.4 (95% CI: 9.2-13.6) cases per 100,000 person-years. The incidence of CC and LC ranges from 0.6 to 16.4 cases per 100,000 person-years and from 0.6 to 16.0 cases per 100,000 person-years, respectively.	High	NA	100 %
1.2	The pooled overall prevalence of MC is estimated to be 119 (95% CI, 73 to 166) per 100,000 persons, with an overall prevalence of 50.1 per 100,000 person-year for CC and 61.7 per 100,000 persons for LC.	High	NA	94 %
1.3	The pooled frequency of MC in patients with chronic watery diarrhoea is 12.8% (95% CI, 10-16), with significant heterogeneity (I^2=93.6%).	Moderate	NA	100 %
1.4	Former, but especially current smoking is associated with an increased risk of both CC and LC.	Moderate	NA	100 %
1.5	The risk of developing CC or LC is higher in women than in men.	High	NA	100 %

1.6	There is insufficient evidence to evaluate the influence of smoking cessation on the disease course.	Low	NA	78 %
1.7	Chronic or frequent use of PPI, NSAID or SSRI is associated with an increased risk of MC. However, this does not imply a causal relationship.	Low	NA	94 %
1.8	We suggest to consider withdrawal of any drugs with a suspected chronological relationship between drug introduction and onset of diarrhoea.	Very low	Weak in favour	97 %
1.9	MC does not increase the risk of colorectal cancer or adenoma. A special surveillance colonoscopy program is not recommended.	Low	Strong in favour	100 %
Section 2	Pathogenesis			
2.1	Pathogenesis of MC is complex and multifactorial. It may include luminal factors, immune dysregulation and genetic predisposition.	Low	NA	100 %
Section 3	Clinical manifestation			
3.1	The most common symptom of MC is chronic watery, non-bloody diarrhoea, which is frequently associated with concomitant symptoms including faecal urgency, nocturnal stools and faecal incontinence.	Moderate	NA	97 %

3.2	MC diagnosis should be ruled out in patients fulfilling the criteria for functional bowel disease, especially in presence of MC risk factors and/or in absence of IBS-therapy response.	Moderate	NA	93 %
3.3	Health-related quality of life (HRQOL) is impaired in patients with MC, depending on the activity and severity of the disease and concomitant comorbidities	Moderate	NA	100 %
3.4	In the absence of a formally validated metric of disease activity, disease activity and clinical remission in MC should be assessed by the Hjortswang criteria (clinical remission: mean of <3 stools per day and a mean <1 water stool per day during a one-week registration).	Moderate	NA	100%
Section 4	Diagnosis			
4.1	Endoscopic findings are recognized with increased frequency in patients with MC, however they are non-specific.	Low	NA	95 %
4.2	The histopathologic criteria of CC are a thickened subepithelial collagenous band ≥ 10 μm combined with an increased inflammatory infiltrate in lamina propria. The criteria apply to Hematoxylin-Eosin stained slides.	Moderate	NA	89 %
4.3	The histopathologic criteria of LC are an increased number of intraepithelial lymphocytes ≥ 20 per 100 surface epithelial cells combined with an increased inflammatory infiltrate in lamina	Moderate	NA	100 %

	propria and a not significantly thickened collagenous band (< 10 µm). The criteria apply to Hematoxylin-Eosin stained slides.			
4.4	Incomplete MC (MCi) comprises incomplete CC (defined by a thickened subepithelial collagenous band > 5 µm but < 10 µm) and incomplete LC (defined by > 10 IELs but < 20 IELs and a normal collagenous band). Both types show a mild inflammatory infiltrate in the lamina propria. The criteria apply to Hematoxylin-Eosin stained slides.	Low	NA	95 %
4.5	We recommend ileocolonoscopy with biopsies from at least the right and left colon.	High	Strong in favour	100 %
4.6	We recommend against histological monitoring in patients with MC.	Very low	Strong in favour	100 %
4.7	Faecal calprotectin is not useful to exclude or monitor MC.	Moderate	NA	100 %
4.8	We recommend screening for coeliac disease in patients with MC.	High	Strong in favour	100 %
4.9	Testing for bile acid diarrhoea is not part of routine diagnostic work up in MC.	Low	NA	83 %
4.10	Testing for bile acid diarrhoea can be considered in patients who experience non-response to budesonide treatment.	Low	Strong in favour	82 %
Section 5	Treatment			

5.1.1	We recommend using oral budesonide to induce remission in patients with CC.	Moderate	Strong in favour	100 %
5.1.2	We recommend using oral budesonide to induce remission in patients with LC.	Low	Strong in favour	100 %
5.2.1	Oral budesonide is effective to maintain remission in patients with CC.	Moderate	Strong in favour	94 %
5.2.2	We suggest using oral budesonide to maintain remission in patients with LC.	Very low	Weak in favour	84 %
5.3.1	There is no increased risk of serious adverse events with budesonide in MC.	Low	NA	100 %
5.3.2	The risk of osteoporotic bone fractures seems not be increased in budesonide treated MC patients, although prolonged use might be associated with a decrease of bone mineral density	Low	NA	97 %
5.4	We recommend against treatment with mesalazine in patients with MC for induction of remission. There are no studies for maintenance.	Low	Strong against	94 %
5.5	There is not enough evidence to recommend bismuth subsalicylate in patients with MC.	Very low	Strong against	92 %
5.6	There is not enough evidence to recommend the use of loperamide in MC. Given the documented effect in patients with	Very low	Strong in favour	100 %

	chronic diarrhoea the experts opinion favours the use of this drug in mild disease.			
5.7	In patients with MC and bile acid diarrhoea we suggest treatment with bile acid binders.	Very low	Weak in favour	100 %
5.8	There is not enough evidence to recommend antibiotics for treatment of MC.	Very low	Strong against	100 %
5.9	We recommend against use of probiotics for treatment of MC.	Low	Strong against	100 %
5.10	We recommend against the use of prednisolone or other corticosteroids than budesonide for the treatment of MC.	Low	Strong against	100 %
5.11	We recommend treatment with thiopurines, anti-TNF drugs or vedolizumab in selected patients with MC who fail to respond to budenoside to induce and maintain clinical remission. We recommend against the use of methotrexate in patients with MC.	Low	Strong in favour	97 %
5.12	Surgery can be considered in selected MC patients as last option if all medical therapy fails.	Very low	Weak in favour	100 %