Microscopic colitis

Information for patients
Gastroenterology
What is microscopic colitis?

Microscopic colitis is a term we use to describe both lymphocytic colitis and collagenous colitis. It is called microscopic colitis because the bowel usually looks normal during colonoscopy but when samples (biopsies) are taken, changes to the tissues can be seen under the microscope. It is not a rare condition and recent studies suggest that microscopic colitis affects approximately 1 person in 1,000 of the general population.

There are two types of microscopic colitis:

- Lymphocytic colitis (LC)
- Collagenous colitis (CC)

Both affect the lining of the large bowel (colon). They are not related to Crohn's disease and ulcerative colitis, which are more severe forms of inflammatory bowel disease (IBD).

How do we diagnose microscopic colitis?

For us to diagnose the condition you will need to have either a colonoscopy or a flexible sigmoidoscopy. During this examination, we will take small samples of tissue from your bowel (a biopsy).

Because there is no visible inflammation in microscopic colitis, the only way that we can diagnose it is to take tissue samples during your colonoscopy or flexible sigmoidoscopy examination. (For more information on these, please ask for the information leaflets).

If someone has CC or LC, then the biopsies will show changes to the lining (mucosa) of the colon.
What causes microscopic colitis?

It is unclear what causes microscopic colitis, although possible causes are thought to include damage to the lining of the colon by viruses, bacteria, and certain drugs; particularly non-steroidal anti-inflammatory drugs (NSAIDs) such as Ibuprofen or Aspirin, statins which are prescribed to lower cholesterol levels, and beta-blockers which are used to treat certain heart conditions amongst other things.

Previous researchers have suggested that microscopic colitis may occur as a result of an autoimmune response, which means that the body's immune system destroys certain cells within the body for no obvious reason. This is thought to occur in 30-50% of those diagnosed with microscopic colitis.

It is reported that coeliac disease (gluten intolerance) is associated in 5-25% of those diagnosed with microscopic colitis and that the association with auto-immune disease is stronger in those with collagenous colitis.

In 10-20% of people who have microscopic colitis there is an association with thyroid disease and patients who have had an organ transplant have a much stronger likelihood of developing microscopic colitis than the general population.

Who is affected by microscopic colitis?

Both lymphocytic colitis (LC) and collagenous colitis (CC) most commonly affect people over the age of 50, usually between the ages of 50 and 60, although some cases of CC have been reported in people younger than 45. It is unclear why age is a factor.

CC is more frequently diagnosed in women, but LC is thought to affect women and men equally.

Some people can have both LC and CC, but they will not have them at the same time.
What symptoms am I likely to experience?

The symptoms of CC and LC are very similar and often include large amounts of watery, non-bloody diarrhoea. This may happen with every bowel movement you have or may only affect you now and then for varying lengths of time. You may also experience cramping abdominal pain or weight loss.

What treatment might I receive?

The condition has been known to settle on its own, but most people will find that it comes back. How we treat your CC or LC depends on how badly you are affected.

You may be asked to make some lifestyle changes to lessen the amount of diarrhoea you have. These would include reducing the amount of caffeine that you have in your diet, for example drinking decaffeinated tea, coffee and cola, and reducing the amount of foods such as chocolate. It is also advisable to stop smoking as cigarette smoking has been proven to be associated with microscopic colitis. Your GP practice will be able to offer support with stopping smoking.

Your doctor may also suggest to your GP that a review of your medication may be helpful to see whether alternative medications may be more suitable. Your doctor will discuss this with you if they feel that it might help. It is important that you do not stop taking prescribed medication without first speaking to your GP.

Recent trials have shown that the steroid Budesonide is an effective treatment for moderate to severe microscopic colitis as response is usually quick and there are fewer side effects. Sometimes drugs such as Loperamide (Imodium) may be prescribed if symptoms are only mild.

Treatment with steroids is not a long-term option and your doctor will explain how to take your medication and how to reduce your dose over time. Although Budesonide is associated with having limited side
effects, it may be thought necessary to test your blood sugar at regular intervals and also for you to be prescribed a calcium and vitamin D supplement to offer protection to your bones.

Once you have stopped treatment, it is possible that your symptoms may come back in the future at some point. If this does happen, it might be necessary to arrange further investigation, such as endoscopy, to establish that the microscopic colitis is the cause of your symptoms and your medication will be reviewed and any necessary changes made.

Very rarely, there have been reports that some patients with CC or LC needed surgery to deal with their symptoms. However, here we have never needed to recommend this course of treatment.

**What if I have any further questions?**

If you have any questions after reading this information leaflet, please contact your IBD Nurse Specialist:

Royal Hallamshire Hospital **0114 271 2209**

Northern General Hospital **0114 226 9031**