

Microscopic colitis:

a guide for general practice

INTRODUCTION

Irritable bowel syndrome (IBS) affects 10%–20% of the population¹ but other conditions have similar symptoms. Microscopic colitis is a cause of chronic, non-bloody, watery diarrhoea, particularly in older patients in whom the impact on quality of life can be significant. Microscopic colitis affects 0.12% of the population but 12.80% of those with unexplained chronic, watery diarrhoea. The median age at diagnosis is 60,² reflecting an older population than those typically diagnosed with other types of inflammatory bowel disease. Risk factors include smoking and long-term use of proton-pump inhibitors, non-steroidal anti-inflammatory drugs, and selective serotonin reuptake inhibitors, although a causal relationship has not been established.²

DIAGNOSIS IS DEPENDENT ON HISTOLOGICAL FINDINGS

The most common symptom in microscopic colitis is chronic, non-bloody, watery, diarrhoea, frequently associated with faecal urgency, the passage of stools at night, and faecal incontinence. Cramping abdominal pain may be present. These symptoms can be severe enough to make patients effectively housebound. Patients may be diagnosed with diarrhoea-predominant IBS but the symptoms do not respond to the standard therapies recommended by the National Institute for Health and Care Excellence (NICE).¹ The diagnosis depends on characteristic histological findings. Patients may be referred to an urgent cancer pathway; colonoscopic findings are typically normal, but 4.77% of patients with normal colonoscopy findings have microscopic colitis confirmed on histology from biopsies.³

INVESTIGATION AND TREATMENT

Microscopic colitis cannot be diagnosed in primary care. A number of straightforward investigations are required in line with NICE.¹ It is important to consider red-flag

symptoms that may indicate an underlying colorectal or ovarian cancer and refer or investigate, respectively. Patients may be referred to a suspected colorectal cancer pathway, receive a colonoscopy without biopsies or a CT colonoscopy, and be discharged back to primary care without a diagnosis (Figure 1).

Inflammatory causes should be excluded with a full blood count and a C-reactive protein (CRP) or erythrocyte sedimentation rate (ESR) test, and coeliac disease with a serology test (assuming the patient has been consuming gluten daily for at least 6 weeks).¹ Coeliac disease is present in 3%–4% of patients with microscopic colitis,² reflecting an overlap with other autoimmune conditions. NICE states that the following tests are not necessary to confirm a diagnosis of IBS in adults: ultrasound, rigid/flexible sigmoidoscopy, colonoscopy, barium enema, thyroid function test, faecal ova and parasite test, faecal occult blood, and hydrogen breath test (for lactose intolerance and bacterial overgrowth).¹

A faecal calprotectin test can be a useful additional test in adults with normal investigations but whose symptoms persist. If a faecal calprotectin is <100 µg/g then IBS is the likely diagnosis in 98% of this group of patients. If the patient is aged ≥50 years and the symptoms still persist after a trial of the usual initial therapies for IBS, a routine referral to gastroenterology is recommended for consideration of colonoscopy with biopsies or the exclusion of other pathologies such as bile acid diarrhoea.⁴

The initial treatment for most patients with microscopic colitis is oral budesonide at a dose of 9 mg/day for a period of 6–8 weeks; 81%–84% of patients respond successfully to treatment compared with 36%–43% given a placebo. Patients may enter and stay in remission at this point; however, some studies have shown that patients may need long-

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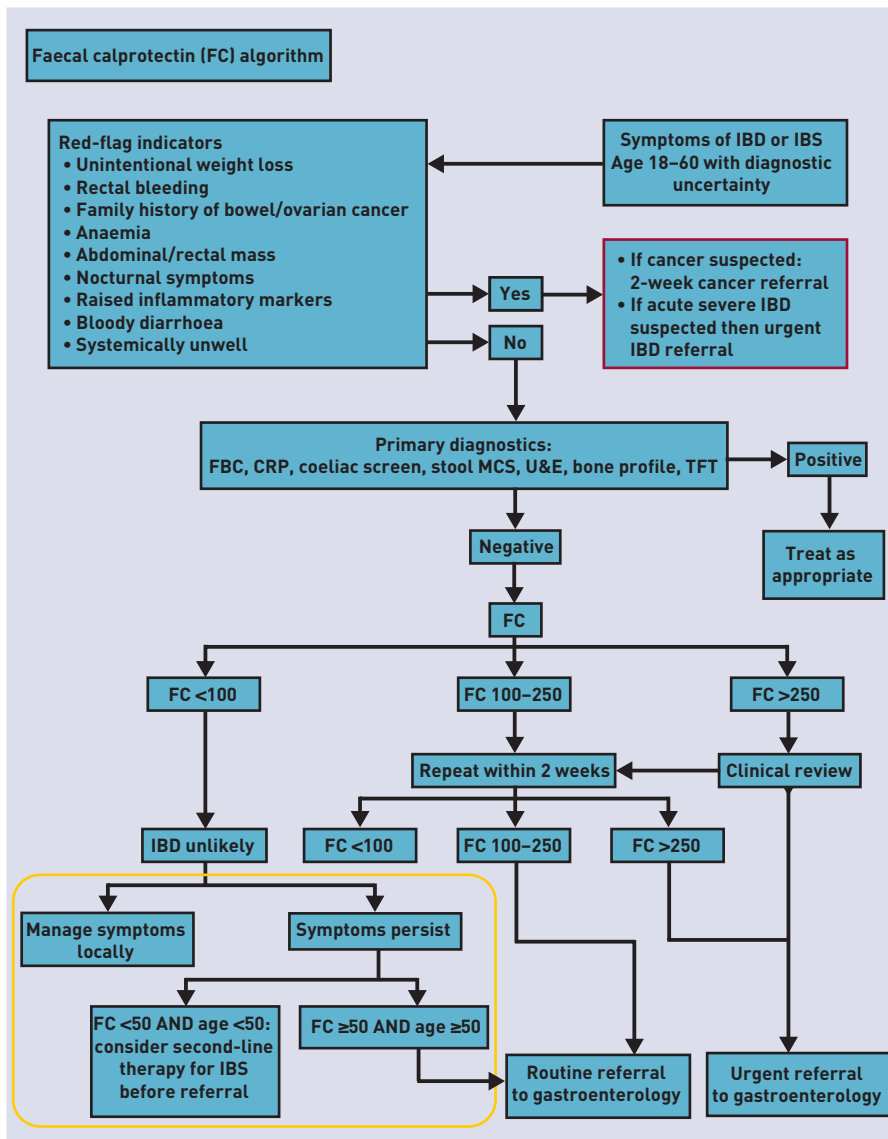


Figure 1. Investigation of patients with lower gastrointestinal symptoms.^a

^aSection highlighted in yellow shows where patients with microscopic colitis may be overlooked.⁵

Copyright © National Institute for Health and Care Excellence. CRP = C-reactive protein. FBC = full blood count. IBD = inflammatory bowel disease. IBS = irritable bowel syndrome. MCS = microscopy, culture, and sensitivity. TFT = thyroid function test. U&E = urea and electrolytes.

Box 1. Summary

- Microscopic colitis is a subset of inflammatory bowel disease.
- Patients typically have profuse watery diarrhoea, often with urgency, incontinence, and nocturnal symptoms.
- Primary care investigations are usually normal.
- The bowel mucosa usually appears normal, and biopsies are needed for a histological diagnosis.
- Treatment is with oral budesonide 9 mg/day for an initial period of 6–8 weeks.

term budesonide (for at least 6 months) at 3 mg or 6 mg/day but this should be titrated according to clinical response.

Prednisolone, loperamide, bismuth, mesalazine, antibiotics, or probiotics are not recommended treatments. Thiopurines or biologics may be used to treat patients who do not respond to budesonide. A summary of the information on microscopic colitis is shown in Box 1.

Provenance

Freely submitted; externally peer reviewed.

Competing interests

Kevin Barrett has received honoraria for speaking at and attending events organised by Thermo Fisher Scientific, Tillotts, Dr Falk, Ferring, Bimuno, and Norgine.

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