Microscopic Colitis

European Clinical Practice Guidelines

UEG & EMCG ٢٠٢١

الدكتورة لونه بسام سكر

معيدة في كلية الطب البشري-جامعة دمشق

13/11/2025

- Evidence-based recommendations using GRADE methodology
- ٣٩ statements covering diagnosis and treatment
- Consensus from ٣٢ experts across ١٤ European countries

What is Microscopic Colitis؟

"A clinical-pathological entity characterized by chronic watery (non-bloody) diarrhea, normal or almost normal endoscopic appearance of the colon, and distinct histologic patterns"

Collagenous Colitis

Thickened subepithelial collagen band ≤ mμ١٠

Lymphocytic Colitis

IELs ≤ ٢٠per ١٠٠ epithelial cells

Incomplete MC

Borderline features

Epidemiology

Incidence	Prevalence
١١,٤ per ١٠٠,٠٠٠ person-years	١١٩ per ١٠٠,٠٠٠ persons

Chronic Diarrhea Cases: ١٢,٨% of patients with unexplained chronic watery diarrhea have MC

- Female predominance
- Median age at diagnosis: >٦٠ years

Risk Factors

🚬 Smoking (MODERATE evidence)

•Current smoking • Stronger in CC • Former smoking

💊 Drug Exposure (LOW evidence)

•PPIs

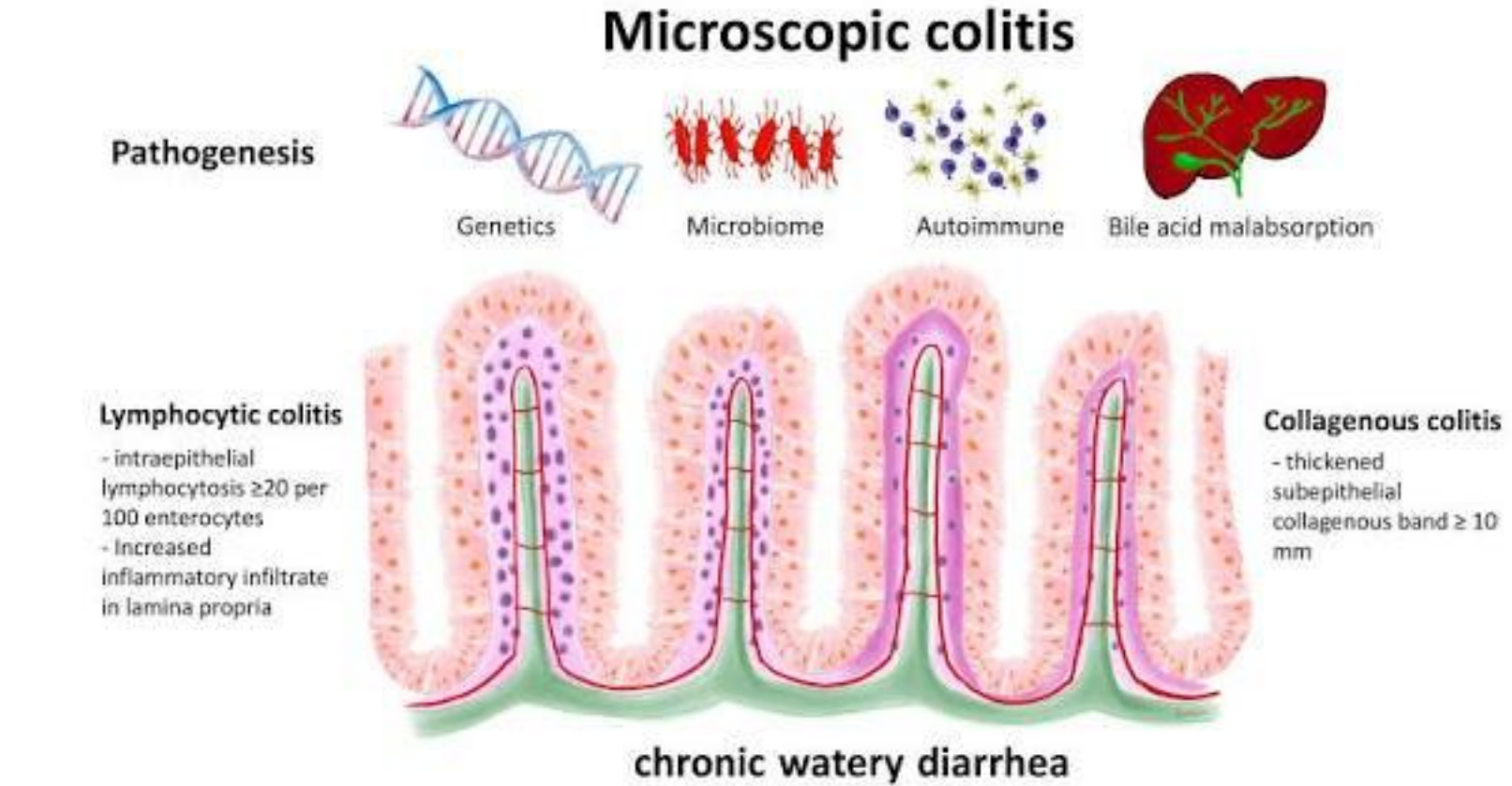
•NSAIDs

•SSRIs

♀ Female Gender (HIGH evidence)

⚠ Recommendation: Consider withdrawal of drugs with suspected chronological relationship to diarrhea onset

pathogenesis



Clinical Manifestations

Chronic Watery, Non-bloody Diarrhea
(Present in 84-100% of patients)

Common Associated Symptoms:
•Fecal urgency(٥٥%)
•Nocturnal stools(٣٥,٣%)
•Fecal incontinence(٢٦,٣%)
•Abdominal pain
•Weight loss

Quality of Life Impact:

HRQoL is significantly impaired, depending on disease activity and severity.

•Duration >٦ months before diagnosis in ٤٣%

Diagnostic Approach - Key Recommendations

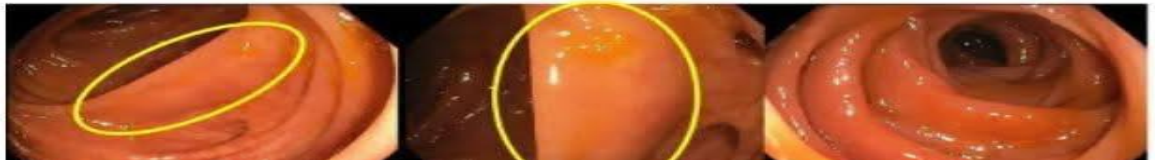
Endoscopy & Biopsies (STRONG recommendation)
Ileocolonoscopy with biopsies from at least right and left colon
•concordance between right and left colon
•Rectal biopsies alone are NOT sufficient

Microscopic Colitis: Not Always "Microscopic"

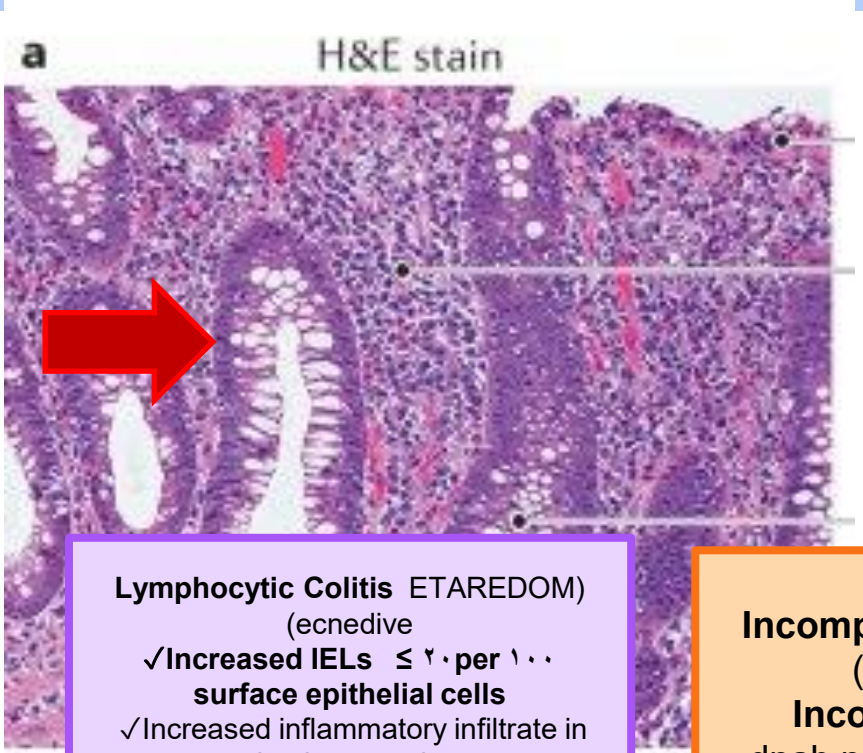
By Joel Joseph, MD, Troy Pleasant, MD and Klaus Mönkemüller, MD, PhD, FASGE, FJGES

Virginia Tech Carilion School of Medicine, Virginia, USA

80-year-old patient with ongoing watery diarrhea for several weeks. Colonoscopy images shown here. Note that there is significant patchy edema, hypervascularity, punctate erythema, thickened folds and patchy superficial erythema.

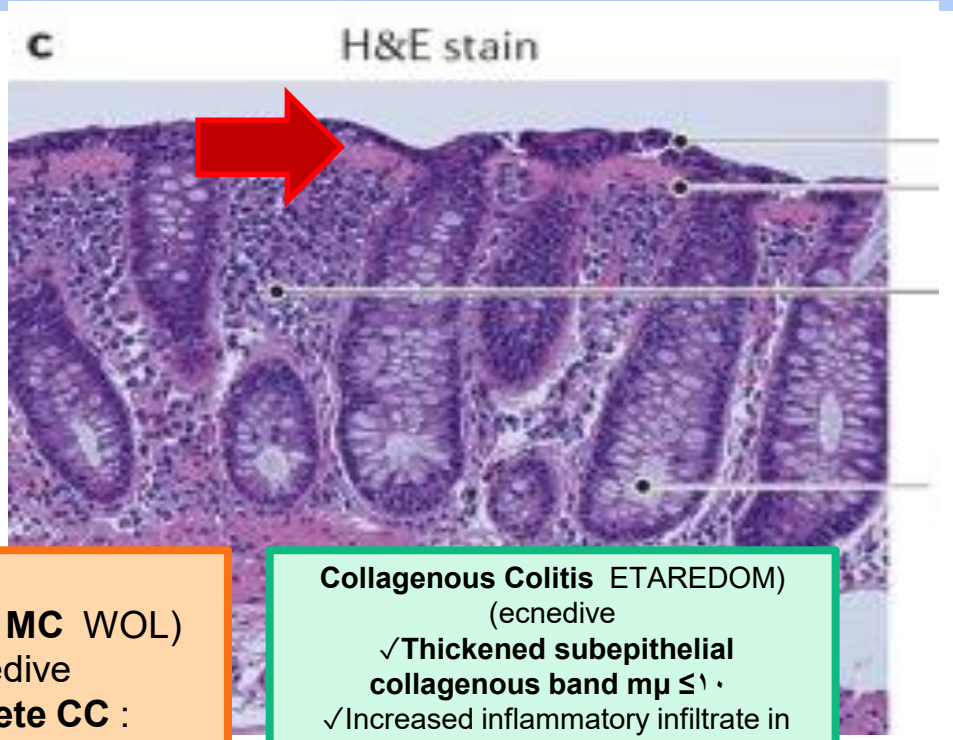


Histopathological Diagnostic Criteria



Lymphocytic Colitis ETAREDOM)
(ecnedive
✓**Increased IELs ≤ ٢٠per ١٠٠ surface epithelial cells**
✓Increased inflammatory infiltrate in lamina propria
✓Normal collagenous band
✓Mild epithelial damage

Incomplete MC WOL)
(ecnedive
Incomplete CC :
dnab negalloC5-10 mμ
Incomplete LC
IELs 10-20 per ١٠٠ cells



Collagenous Colitis ETAREDOM)
(ecnedive
✓**Thickened subepithelial collagenous band mμ ≤١٠**
✓Increased inflammatory infiltrate in lamina propria
✓May contain entrapped capillaries, RBCs, inflammatory cells
✓Focal epithelial damage, mucin depletion

Key Recommendations

✅ **DO Recommend**:
- Screen for celiac disease
  ٪۳٫۳ incidence
- Consider bile acid testing in budesonide non-responders

❌ **DO NOT Recommend**:
- Histological monitoring
- Fecal calprotectin for diagnosis/monitoring
- Special CRC surveillance

⚠️ Differential Diagnosis: Rule out MC in patients meeting criteria for functional bowel disease, especially with risk factors or lack of IBS therapy response **9%**

Treatment: First-Line Therapy - Budesonide

Budesonide: Gold Standard
Only licensed drug for treatment of microscopic colitis

Induction Therapy

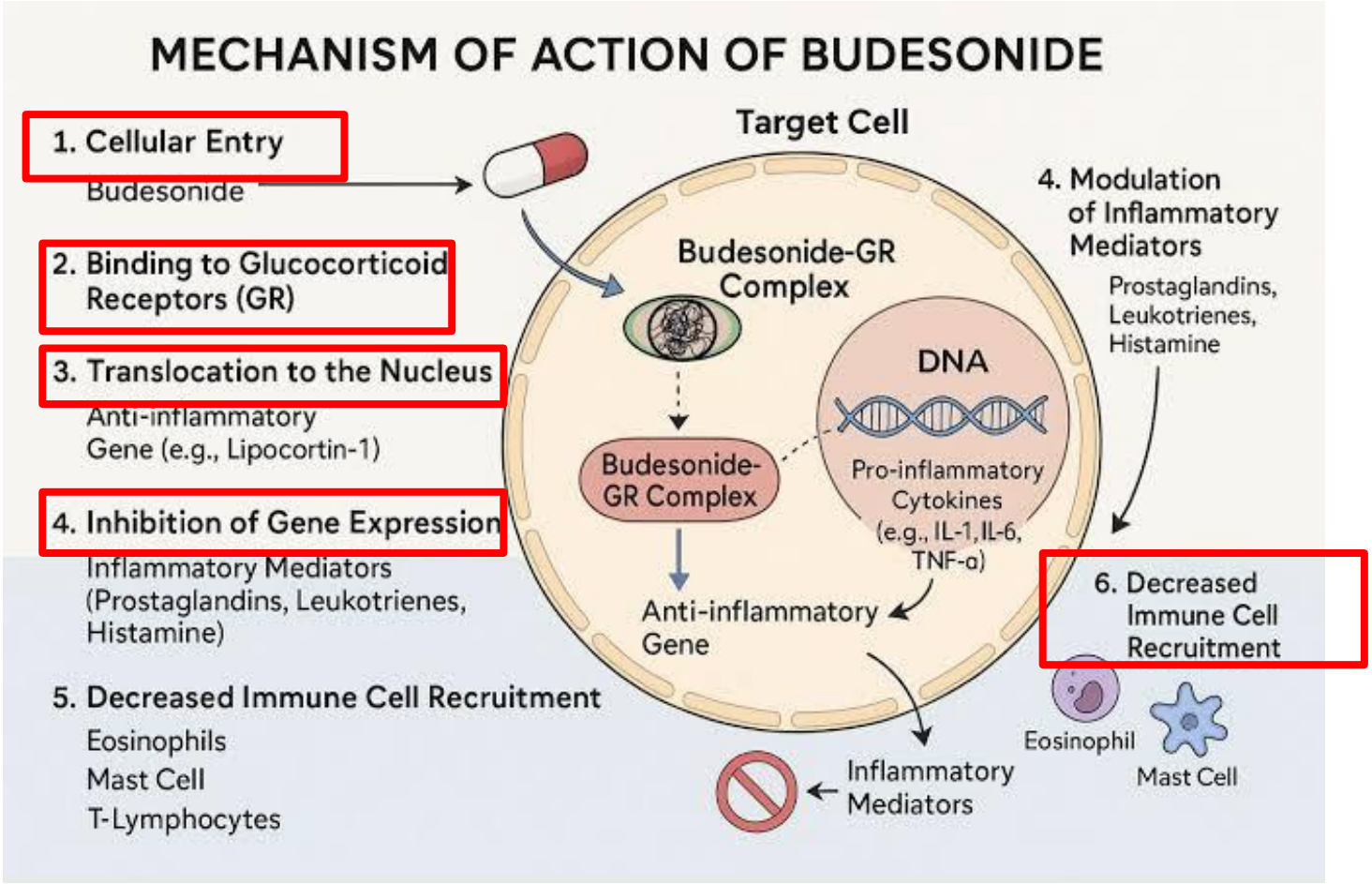
- ٩mg daily for ٨-٦ weeks
- Response: ٨١% vs ١٧% placebo

Maintenance Therapy

- ٦-٣ mg daily (low-dose)
- Maintenance: ٦٨% vs ٢٠%

Safety Profile (LOW evidence):
- No increased risk of serious adverse events
- Monitor BMD with prolonged use
- Consider calcium/vitamin D supplementation

MECHANISM OF ACTION OF BUDESONIDE



Treatment: Other Therapeutic Options

✅ Consider Using:

- Loperamide (in mild disease, on demand)
- Bile Acid Binders (if BAD confirmed)

❌ NOT Recommended:

- Mesalazine (STRONG AGAINST)
- Probiotics (STRONG AGAINST)
- Prednisolone (STRONG AGAINST)
- Antibiotics (STRONG AGAINST)

🔄 Refractory Disease (STRONG recommendation)

For budesonide non-responders or requiring >١ mg/day:

- Thiopurines (Azathioprine/-١ MP)
- Anti-TNF (Adalimumab/Infliximab)
- Vedolizumab

❌ Do NOT use Methotrexate

🏥 Surgery (WEAK recommendation)

Consider as last option if all medical therapy fails (VERY LOW evidence)

Disease Activity & Remission Criteria

Hjortswang Criteria for Clinical Remission

)MODERATE evidence - No formally validated metric exists)

Definition of Clinical Remission:

- Mean <٣ stools/day during1- week registration
- Mean <١ watery stool/day during1- week registration

Microscopic Colitis Disease Activity Index (MCDAI)

Proposed but not formally validated. Predicts:

- Number of unformed stools daily
- Nocturnal stools
- Abdominal pain, weight loss, fecal urgency & incontinence

Therapeutic Algorithm

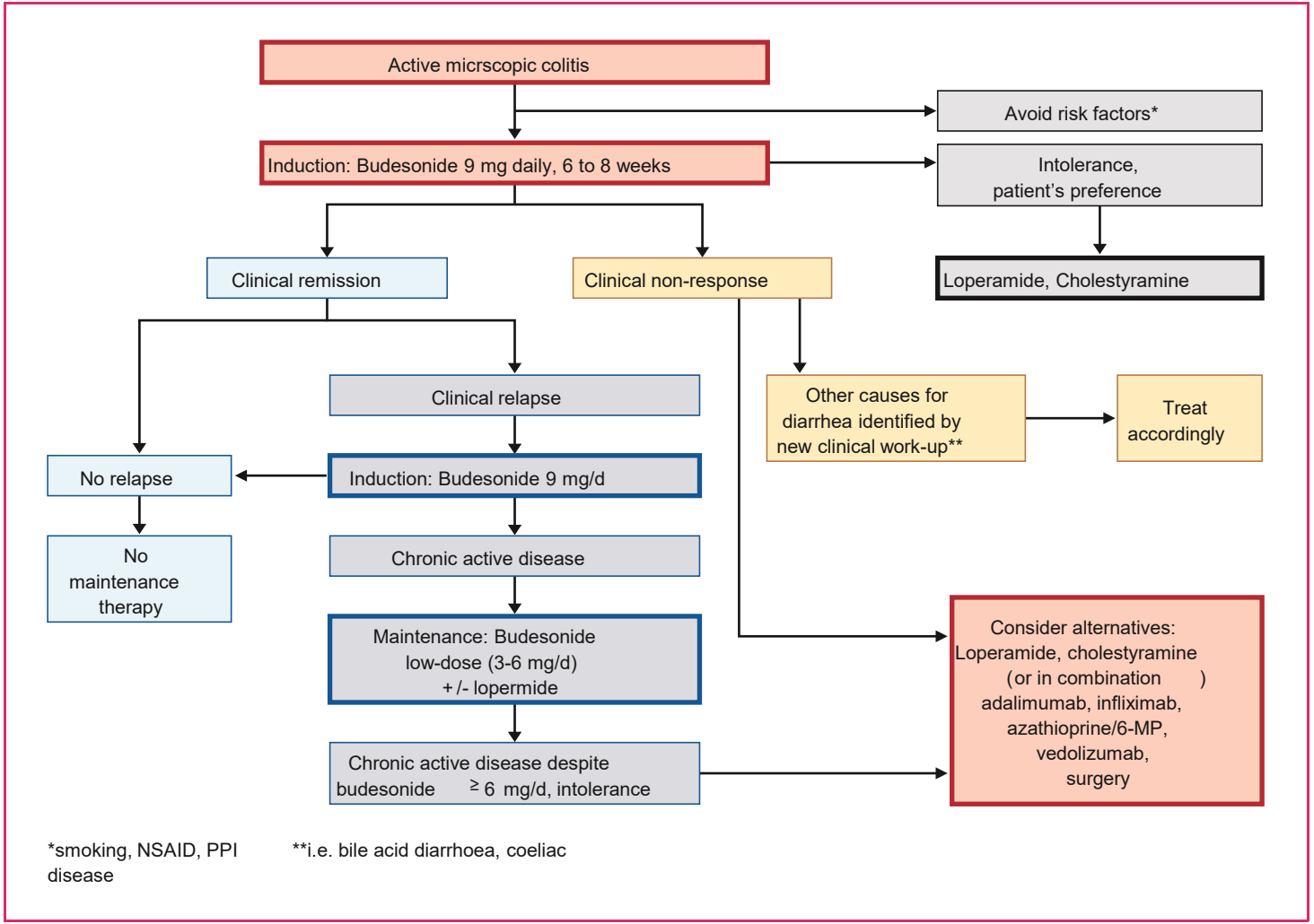
Step 1: Initial Management
•Avoid risk factors (smoking, NSAIDs, PPIs)
•Symptomatic relief: Loperamide ± Cholestyramine

Step 2 : Induction Therapy
Budesonide ٩ mg daily for ٨-٦weeks

✓Remission →Stop or Maintenance (٦-٣mg/day)

✗Non-Response →Check BAD, celiac; Consider alternatives

Step 3 : Refractory →Immunomodulators/Biologics/Surgery


Active micrscopic colitis
Avoid risk factors*
Induction: Budesonide 9 mg daily, 6 to 8 weeks
Intolerance, patient's preference
Loperamide, Cholestyramine
Clinical remission
Clinical non-response
Clinical relapse
Other causes for diarrhea identified by new clinical work-up**
Treat accordingly
No relapse
Induction: Budesonide 9 mg/d
No maintenance therapy
Chronic active disease
Maintenance: Budesonide low-dose (3-6 mg/d) + /- lopermide
Consider alternatives: Loperamide, cholestyramine (or in combination) adalimumab, infliximab, azathioprine/6-MP, vedolizumab, surgery
Chronic active disease despite budesonide ≥ 6 mg/d, intolerance
*smoking, NSAID, PPI
**i.e. bile acid diarrhoea, coeliac disease

Key Take-Home Messages

MC is underdiagnosed - Think of it!
%۱۲,۸of chronic watery diarrhea. Always biopsy even with normal colonoscopy.

Budesonide is first-line therapy

Options exist for refractory disease
Immunomodulators and biologics (anti-TNF, vedolizumab) effective.

Histology is key - Biopsy right AND left colon. Endoscopy insufficient.

Address modifiable risk factors
Consider stopping PPIs, NSAIDs, SSRIs if temporally related.

Screen for celiac disease۳,۳% incidence in MC .
Consider bile acid testing in non-responders.

Thank You