**Transcript Details**
This is a transcript of an educational program. Details about the program and additional media formats for the program are accessible by visiting: https://reachmd.com/programs/gi-insights/top-tips-for-managing-microscopic-colitis/13187/

**ReachMD**
www.reachmd.com
info@reachmd.com
(866) 423-7849

---

Top Tips for Managing Microscopic Colitis

Dr. Buch:
Microscopic colitis can have a variety of symptoms ranging from very mild to debilitating. Microscopic colitis is treatable, which is why today we're taking a look at those symptoms and how we can help alleviate them.

This is *GI Insights* on ReachMD. I'm Dr. Peter Buch, and joining me today is Dr. Donna Cipolla. Dr. Cipolla is a gastroenterologist with over 30 years of clinical experience. She is a Castle Connolly top doctor and has been prominently featured in *Connecticut Magazine* this year.

Dr. Cipolla, it's great to have you join us here today.

Dr. Cipolla:
Thank you, Dr. Buch, for the invitation. I'm very honored to join you and your staff.

Dr. Buch:
To start us off, Dr. Cipolla, can you tell us what is the usual clinical presentation of microscopic colitis?

Dr. Cipolla:
The usual clinical presentation of microscopic colitis is a female patient, since it's more common in the female population, and in an older patient who's usually older than 50 to 60 who presents with a chronic, watery, non-bloody diarrhea. That's the classic, typical presentation that I have seen.

Dr. Buch:
And what are the risk factors for the development of microscopic colitis?

Dr. Cipolla:
Well, the risk factors appear to be several-fold. Number one, for whatever reason it seems to be more prominent in the female ex population. We're not really sure why, but it may be related to the fact that we also see the presence of autoimmune diseases more commonly presenting in patients with microscopic colitis, and autoimmune diseases tend to be more prevalent in the female sex. That's one risk factor. Another risk factor, as I mentioned, is age. It usually tends to present in patients greater than 60 years of age. A third risk factor may be—we're not sure if it's actually a risk factor or just an association—is certain medications that they present on that may either trigger it or exacerbate it, and these include proton pump inhibitors statins, medications used to lower cholesterol, antidepressant medications called SSRIs, and some studies report H2 blockers as well. There's also been some evidence that people who smoke, either past or present, are at higher risk of getting microscopic colitis at a younger age and also presenting with more frequent severe symptoms and also that they don't respond as well to the medication.

Dr. Buch:
Is there not also an association with NSAID use?

Dr. Cipolla:
Yes. As a matter of fact, NSAIDs are probably the most common medication associated with microscopic colitis, in particular if it is also in combination with either a PPI or a statin, and usually, the duration has been found to be at least 4 to 12 months. If there's that period of time and there's an overlap in particular of those drugs with the NSAID, they seem to be more likely associated with it.

Dr. Buch:
For those just joining us, this is *GI Insights* on ReachMD. I'm Dr. Peter Buch, and today I'm discussing microscopic colitis with Dr. Donna

Cipolla.

So Dr. Cipolla, if we shift our focus over to treatment, we have quite a few options available, including bismuth subsalicylate, mesalamine, prednisone, and budesonide. So among those options, which is the medication of choice, and why?

Dr. Cipolla:
Current medication of choice is budesonide, which is a steroid-like medication that has a lot less side effects than the classic oral medication that people probably have commonly heard of called prednisone. The reason we prefer to use budesonide over the others is because it has a greater efficacy in terms of getting a patient into remission and keeping them into remission, so that they get better sooner and they stay better longer. In addition, it has a lot less side effects than some of the other medications you mentioned, like the mesalamine or the Pepto-Bismol, and it's also ease of administration. It's a one-time dose in the morning versus mesalamine, which is 4 times a day, and Pepto-Bismol, which is 3 pills 3 times a day, so the ease of convenience as well is something we take into consideration when we consider picking a medication.

Dr. Buch:
And that's changed over the years. I remember you and I used to use other medications as the medication of choice, but the key right now is budesonide.

Dr. Cipolla:
That's correct.

Dr. Buch:
With that in mind, Dr. Cipolla, how would you approach a patient with microscopic colitis who does not respond to budesonide?

Dr. Cipolla:
Well, first thing I would want to make sure is that I had the correct diagnosis. Sometimes there can be other things going on that you're not aware of that might be compounding the picture. For example, the patient may have microscopic colitis, but they may also have a concurrent diagnosis of something called celiac sprue, which is an autoimmune disease to gluten in their diet. If that's the case, it's found that about 50–70% of patients who have microscopic colitis have a concurrent celiac sprue diagnosis, so that workup would need to be entertained, because if they had celiac sprue, it's not going to respond to the therapy for microscopic colitis, such as we've just discussed with budesonide. It would need a gluten-free diet. The other thing that you would want to consider is whether or not they have an underlying irritable bowel disease. That is not going to respond to budesonide. Another possibility could be that they have a bile salt-induced diarrhea. There is an overlap of patients with microscopic colitis that also have a bile-induced diarrhea, and if that's the case, then another medication like cholestyramine, if added to therapy, will improve their symptomatology and response to therapy. Those would be the things that I would want to be considering at the top of the list.

Other things would be dietary adherence. Are they inadvertently taking lactose in their diet and they're lactose intolerant, or are they taking artificial sweeteners which might be giving them a diarrhea from that component unrelated to the microscopic colitis, or are they inadvertently taking some NSAIDs that they don't realize they're doing? Are they still smoking? So those would be the kind of things that I would try to assess as the next step in why they aren't responding.

Dr. Buch:
Excellent review. Thank you. And if we keep our focus on budesonide for just another moment, should we be concerned about long-term budesonide use in microscopic colitis?

Dr. Cipolla:
Well, as I mentioned, it is a steroid, and, steroids as a category of medications are known to have some serious, long-term side effects. Budesonide happens to be what we consider the safest of the oral steroid medications because of the way it's metabolized in the body and the amount that actually gets to the tissues, so it's thought to be a much safer medication. That being said though, anybody on long-term steroids, including budesonide, we do monitor for things like bone loss and would recommend a bone density study. We also would refer them to an ophthalmologist because we want to screen for glaucoma or cataracts. Monitor for blood pressure because some people can develop high blood pressure. They can develop high blood sugars with prolonged steroid use; it’s a much, much rarer chance to happen with budesonide, but certainly, if they're on it greater than 6 months to a year, those would be things that I would be considering and I would be looking for when I saw them in follow-up.

Dr. Buch:
Thank you. And before concluding, Dr. Cipolla, is there anything else you would like to share with our audience today?

Dr. Cipolla:

I think I'd like to tell them that we have good therapy for microscopic colitis, but unfortunately, the majority of people don't respond to the first round of treatment with budesonide, so it is common that we do have to add additional things to therapy like, Imodium to help control the diarrhea, sometimes a bile salt resin binder, cholestyramine, and sometimes we also have to continue the budesonide for a longer term in terms of a maintenance dose. It is usually not the same dose as we use to get them into remission, but sometimes they need to maintain a lower dose of maybe 1 or 2 pills a day for 6 months to 12 months in order to maintain that remission and get them well, so just so they're aware that not everybody gets better the first time around after 6–8 weeks of therapy with budesonide. But in general, patients do very well. There's no long-term sequelae in terms of worrying about this progressing into a colon cancer or into a classic inflammatory bowel disease like Crohn's disease or ulcerative colitis.

Dr. Buch:
Well, you've certainly given us a lot to think about when it comes to diagnosing and treating microscopic colitis. And I want to thank you, Dr. Cipolla, for sharing your insights with us on this very important topic. It was great having you on the program today.

Dr. Cipolla:
Thank you, Dr. Buch, and thank you for the invitation.

Dr. Buch:
For ReachMD, this is Dr. Peter Buch. To access this episode and others from this series, visit ReachMD.com/GIInsights where you can Be Part of the Knowledge. Thanks for listening and see you next time.