Do you often suffer from diarrhoea? At times on a daily basis and occasionally even at night? And sometimes so severely that it’s a struggle to reach the toilet on time? Is the diarrhoea of a watery consistency?

If these symptoms sound familiar, it may well be possible that you are suffering from microscopic colitis. Once diagnosed, microscopic colitis is easy to treat.

To date, microscopic colitis has attracted very little public attention, one of the reasons being that this condition was only first discovered around 20 years ago. However, the disorder is becoming more and more frequent.

While women over 50 are particularly prone, the disease can, of course, also affect men. It can occur at virtually any age and is even found among children. The crux of the matter is that this type of inflammatory bowel disease cannot be detected by a “normal” colonoscopy.

Read on to find out more about microscopic colitis.
Frequent diarrhoea?

Microscopic colitis

What is microscopic colitis?

The term microscopic colitis is used to describe an inflammation in the large intestine, or more specifically the colon (colitis). The inflammation cannot be detected by a standard colonoscopy, a procedure in which the intestinal mucosa is examined using an endoscope. Instead, it can only be diagnosed by taking tissue samples during a colonoscopy (biopsy), which are then later examined under a microscope.

The fact that the inflammation can only be perceived by a microscope is what lends it its name microscopic colitis.
What are the symptoms of the disease?

Chronic diarrhoea is a typical symptom of microscopic colitis. Sufferers must use the toilet at least three times daily and it is not uncommon for them to be afflicted by diarrhoea as many as ten or 15 times a day. Their stools are watery but do not contain any blood. Furthermore, some patients report that they even experience diarrhoea at night and often the urge to defaecate is so strong that they are unable to reach the toilet in time. In this case, doctors speak of the involuntary passage of stool or bowel incontinence.

The diarrhoea may stop for weeks or even months at a time and in some patients, the disease seems to subside completely, only for veritable bouts of diarrhoea to restart and continue for weeks. When this happens, the symptoms may remain absent for many months or even years, before the condition flares up with renewed chronic diarrhoea.

In addition to diarrhoea, some patients report cramping abdominal pain and weight loss which began when the symptoms of microscopic colitis were first noticed.
Frequent diarrhoea?

What are the differences between microscopic colitis and irritable bowel syndrome?

Although the symptoms of microscopic colitis initially appear similar to those of irritable bowel syndrome, there are considerable differences between the clinical characteristics of the two diseases.

While diarrhoea is the most prominent symptom of microscopic colitis, in irritable bowel syndrome, it only represents one symptom amongst many. Patients suffering from irritable bowel syndrome are more likely to complain of general bowel irregularities and often actually experience alternating stages of constipation and diarrhoea.

Additionally, patients suffering from irritable bowel syndrome nearly always complain of abdominal pain, a feeling of fullness, bloating, flatulence and the sensation of not having completely emptied their bowels, which are all symptoms rarely associated with microscopic colitis.

Characteristic of this disease, on the other hand, are nighttime bouts of diarrhoea and weight loss, both of which are rarely seen in people suffering from irritable bowel syndrome.
What are the differences between microscopic colitis and other inflammatory bowel diseases?

Other inflammatory bowel diseases, such as Crohn’s disease and ulcerative colitis, can be detected during a colonoscopy thanks to clearly visible signs of inflammation in the intestinal mucosa. This inflammation is often characterised by ulcers in the colon, fistulas, a narrowing of the colon (stenosis) and other complications.

The stools often contain blood, particularly in cases of ulcerative colitis. Unlike as is generally the case with microscopic colitis, the general health of patients suffering from Crohn’s disease and ulcerative colitis is often impaired, resulting in fever and physical weakness. While ulcerative colitis or Crohn’s disease mainly develop in young people, microscopic colitis usually first emerges in patients over 50.

What causes the disease?

The reasons why some people develop microscopic colitis are not entirely clear. Certain people’s genes make them more prone to the condition, meaning, in medical terms, they have a genetic predisposition for the disease. It is possible that, together with an increased disposition, certain environmental factors could trigger the disease. Triggers for the inflammation of the colon are suspected to be, amongst others, certain drugs, smoking, infections and food intolerances. Scientists are also still undecided as to why microscopic colitis is significantly more prevalent in women than in men.
How is the disease diagnosed?

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How dangerous is the disease?

The inflammation of the bowel associated with microscopic colitis can only be detected by taking tissue samples from the intestinal mucosa and examining these under a microscope. Diagnosing the disease therefore requires a colonoscopy to obtain tissue samples, which are then prepared for microscopic analysis.

Doctors distinguish between the two forms of the disease, lymphocytic and collagenous colitis. Collagenous colitis shows a thickened layer of collagen in the intestinal mucosa when examined under the microscope. Lymphocytic colitis, on the other hand, does not cause such changes but instead, is detected by an increase in lymphocytes, which are a type of white blood cell. Distinguishing between the two forms of the disease does not affect the way it is treated.
How can microscopic colitis be treated?

Microscopic colitis is treated with a tried-and-tested corticosteroid that is released in the colon but is not – or hardly – absorbed by the organism as a whole. This means that the medicine, which contains the active ingredient budesonide, is generally well tolerated. Budesonide’s ability to treat the condition has been tested in three clinical studies around the world, in which it was found that around 80 percent of patients suffering from the disease responded well to the drug.

These favourable results meant that the active ingredient has officially been approved by health authorities worldwide for the treatment of collagenous colitis and, to date, it remains the only treatment option. Budesonide is not yet approved for treatment of the other form of the disease, lymphocytic colitis.

Budesonide is generally taken for a duration of six to eight weeks. Once the diarrhoea stops, attempts can be made to end the course of medicine, but in some patients, this unfortunately results in the diarrhoea returning.

In these cases, patients are usually treated with budesonide once again until the diarrhoea has subsided, after which, it is recommended that the medicine is taken at a reduced dose on a long-term basis.
In comparison with other inflammatory bowel diseases (IBD), our knowledge about MC remains limited. More research is needed to investigate the aetiology and pathophysiology of MC, but above all more clinical studies are needed to improve the medical care of MC patients.

To address these apparent shortcomings, physicians dedicated to the understanding of MC met in September 2010 in Stockholm, Sweden, to found the European Microscopic Colitis Group (EMCG). The primary objective of the EMCG is to create awareness of MC among patients, general practitioners, gastroenterologists, surgeons and pathologists regarding all aspects of MC, and to eliminate misconceptions. Another aim is to promote collaboration among the EMCG members in clinical trials and basic science.

Evidence-based guidelines from the EMCG have recently been published (Münch et al., J Crohns Colitis. 2012;6:932-45). Current members of the EMCG are

- Andreas Münch, Linköping, Sweden
- Daniela Aust, Dresden, Germany
- Peter Engel, Roskilde, Denmark
- Johan Bohr, Örebro, Sweden
- Ole Kristian Bonderup, Silkeborg, Denmark
- Fernando Fernández Bañares, Barcelona, Spain
- Henrik Hjortswang, Linköping, Sweden
- Ahmed Madisch, Hannover, Germany
- Lars Munck, Koege, Denmark
- Magnus Ström, Linköping, Sweden
- Curt Tysk, Örebro, Sweden
- Stephan Miehlke, Hamburg, Germany
- Signe Wildt, Copenhagen, Denmark

For more information please see www.emcg-ibd.eu or contact the authors as stated below.