Innovative GI

Understanding & Managing Microscopic Colitis

A Patient Guide to Microscopic Colitis Care

What Is Microscopic Colitis?

Microscopic colitis is a chronic inflammatory condition of the colon that causes persistent, watery diarrhea, usually without blood. It gets its name because the colon looks completely normal during a colonoscopy — the inflammation is only visible under the microscope, on biopsies taken during that same procedure. There are two main subtypes, **collagenous colitis** (a thickened band of collagen beneath the surface lining) and **lymphocytic colitis** (an increased number of immune cells within the lining) — both are managed the same way in practice. Microscopic colitis is most often diagnosed in people in their 60s, and women are affected roughly 2 to 3 times as often as men.

What Causes It?

- **The exact cause isn't fully understood**, but it's thought to involve an abnormal immune response within the colon lining, possibly triggered by something in the gut environment (a medication, bile acid, or bacterial factor) in someone with an underlying predisposition.
- **Certain medications are linked to higher risk**, particularly with regular, longer-term use: proton pump inhibitors, SSRIs, NSAIDs, aspirin, and statins have all been associated with increased odds of developing microscopic colitis in observational studies, with the combination of an NSAID and a PPI together carrying the highest risk. This doesn't mean any of these medications is unsafe for most people — it simply means we'll review your medication list together as part of your care.
- **Smoking** is also associated with higher risk.
- **Other autoimmune conditions occur more often alongside it** — celiac disease and autoimmune thyroid disease in particular are both meaningfully more common in people with microscopic colitis than in the general population, especially when microscopic colitis is diagnosed before age 50.
- **Increasing age and female sex** are the two strongest risk factors overall, though the reasons behind this pattern aren't fully known.

How It's Diagnosed

Diagnosis requires a colonoscopy with biopsies taken from multiple locations throughout the colon, since the tissue looks entirely normal to the eye — this is what distinguishes microscopic colitis from conditions like ulcerative colitis or Crohn's disease, where visible inflammation is usually present. Because there's nothing to see, biopsies aren't optional if microscopic colitis is suspected: a completely normal-looking colonoscopy does not rule it out.

How Microscopic Colitis Is Treated

Treatment usually starts with reviewing possible contributing factors, then moves to medication if needed — most people respond well once on an effective treatment. A study “compared to a dummy pill (placebo)” below means some patients got the real treatment and others a fake version, without knowing which, so researchers could isolate the treatment's true effect.

Reviewing Medications & Lifestyle

Goal: address any contributing factors first — a reasonable starting point for everyone, and sometimes enough on its own for mild cases.

• **Reviewing your medication list together**, particularly NSAIDs, PPIs, SSRIs, and statins, to see whether an alternative is reasonable for a medication you're taking.

Evidence: Please don't stop any prescribed medication on your own before discussing it with us or the prescribing provider — some of these treat conditions where stopping abruptly carries its own risks, so any change should be a shared decision.

• **Smoking cessation**, if applicable.

Evidence: Smoking is associated with a higher risk of microscopic colitis and may worsen disease activity, in addition to its many other well-known health effects.

Budesonide (Induction & Maintenance)

Goal: the most effective, best-studied treatment — considered first-line for both major subtypes.

• **Budesonide**, a corticosteroid that acts mainly within the gut lining rather than throughout the body, typically 9 mg daily for 6–8 weeks to induce remission.

Evidence: A placebo-controlled trial found 100% of patients responded to budesonide compared with 20% on placebo — one of the more dramatic treatment effects in gastroenterology. It also outperformed mesalamine directly in head-to-head trials for collagenous colitis.

• **Lower-dose maintenance therapy**, often continued for a longer period once remission is reached, particularly for collagenous colitis.

Evidence: Relapse after stopping treatment is common — studies report relapse in roughly a quarter to over half of patients, often within weeks of stopping, with cumulative relapse continuing to rise over the following few years. This is why many patients, especially those who relapse quickly after stopping, are kept on a lower maintenance dose rather than stopping altogether once symptoms improve.

Additional Options

Goal: alternatives for patients who can't take budesonide, don't respond to it, or have a specific contributing factor identified.

• **Cholestyramine**, a bile acid–binding medication, either alone or alongside another treatment.

Evidence: May help patients whose diarrhea has a bile acid component, which overlaps with microscopic colitis in some patients; evidence here is more limited than for budesonide, and it isn't recommended as an add-on to mesalamine specifically due to a lack of supporting trials for that combination.

• **Mesalamine**, an anti-inflammatory medication used for other forms of colitis.

Evidence: Has fallen out of favor for microscopic colitis specifically: trials have found it less effective than budesonide, and haven't clearly shown it outperforms placebo either. It's no longer considered a preferred option, though it may still come up in some treatment discussions.

• **Immunomodulator or biologic therapy** (such as azathioprine or, rarely, a biologic used in inflammatory bowel disease), reserved for the minority of patients with truly refractory disease that doesn't respond to budesonide.

Evidence: Evidence here comes mainly from smaller studies rather than large trials, so this route is considered only after more established options haven't worked.

What to Expect Over Time

The course of microscopic colitis varies quite a bit from person to person. In long-term studies, roughly 40% of patients reach sustained remission after treatment and stay well, around 11% have a mild, occasionally-active course, and about half have a more chronic, relapsing pattern that benefits from ongoing maintenance treatment. None of these patterns can be reliably predicted in advance, which is why follow-up and open communication with our office matter, especially if symptoms return after a period of feeling well.

When to Contact Our Office

- Diarrhea that doesn't improve with an appropriate treatment trial
- Blood in the stool — not typical of microscopic colitis, and worth a closer look
- Signs of dehydration — unusual thirst, dizziness, dark urine, or reduced urination
- Unintentional weight loss or new abdominal pain
- Symptoms returning after a period of remission, particularly after stopping or reducing treatment
- Before starting, stopping, or combining any medication or supplement in this guide

This guide supports your personalized plan and isn't a substitute for individualized medical advice. Check with your provider before starting, stopping, or combining anything mentioned here.