North Carolina Society of Gastroenterology
2026 Annual Meeting

Tiny Findings, Major Impact: Understanding Microscopic Colitis

Anne Peery, MD, MSCR
Associate Professor of Medicine
UNC Chapel Hill

Joint Providership

Disclosures: None

Objectives:

As a result of this presentation, physicians/APPs will be able to diagnosis and manage microscopic colitis

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Case

Tearful 70yo woman h/o depression and osteoarthritis presented with watery diarrhea and fecal incontinence

- Diagnosed microscopic colitis 1 year ago
- Diarrhea improved on budesonide; not on maintenance therapy
- SSRI, NSAIDS, and PPI stopped
- Does not leave home due to GI symptoms

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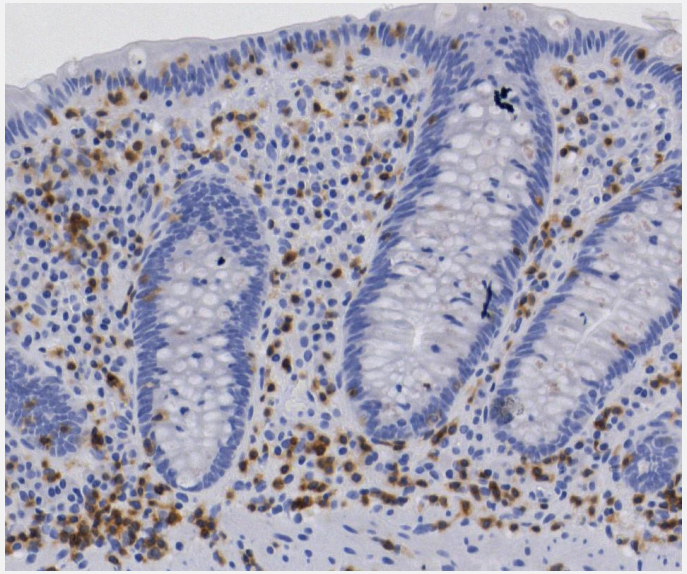
Microscopic colitis

Inflammatory bowel disease characterized by chronic watery diarrhea

- Mucosa often appears normal, but microscopic inflammation present
- Subtypes: lymphocytic, collagenous, and incomplete microscopic colitis
- Lifetime risk: 0.9% women and 0.4% in men



Lymphocytic colitis

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Microscopic colitis is a burden

Common symptoms beyond diarrhea

- Urgency (93%)
- Fecal incontinence (68%)
- Weight loss (65%)
- Nocturnal BMs (62%)
- Abdominal pain (52%)

These symptoms often lead to reduced quality of life and social isolation

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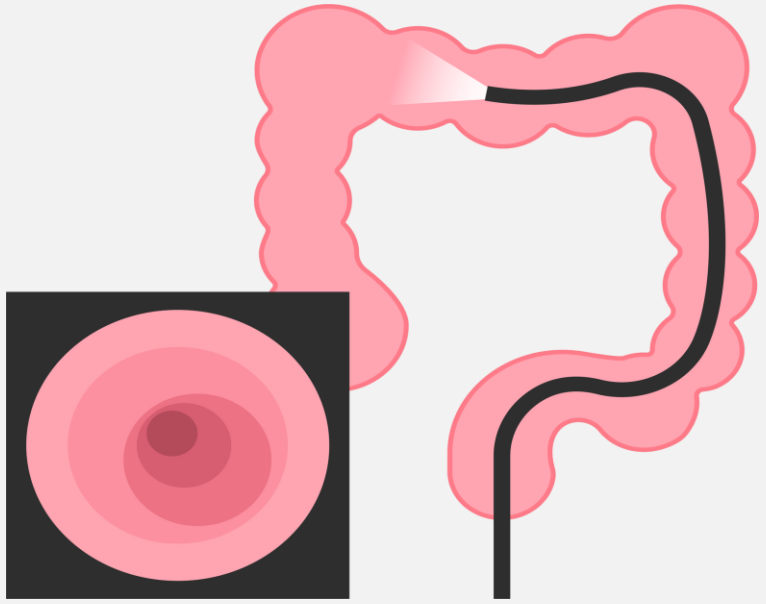
Microscopic colitis is common

In patients who have a colonoscopy for chronic diarrhea and get biopsied, 15-30% will be diagnosed with microscopic colitis.



Take biopsies!

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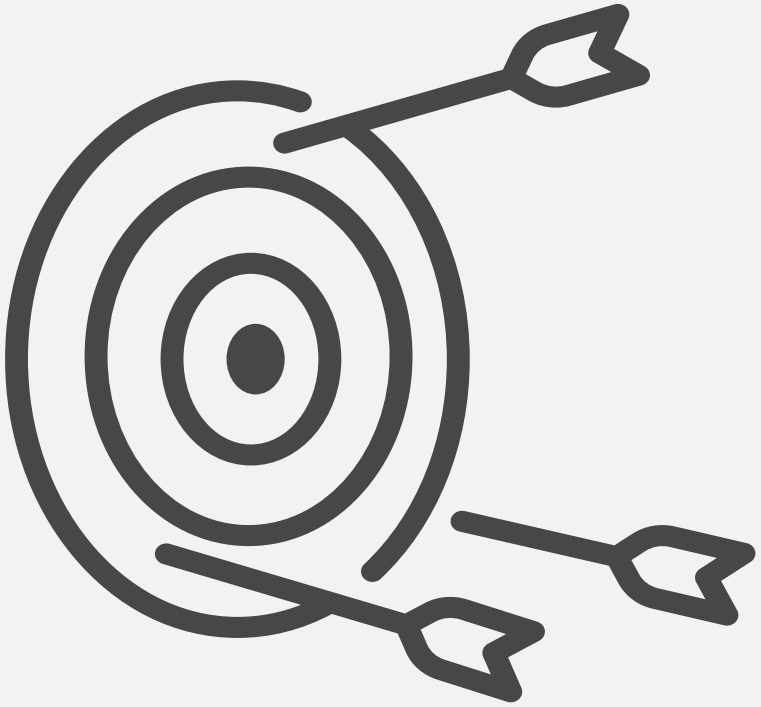
Microscopic colitis gets missed

Prevalence of microscopic colitis is 4% among patients with IBS-D.



Microscopic colitis gets misdiagnosed as IBS

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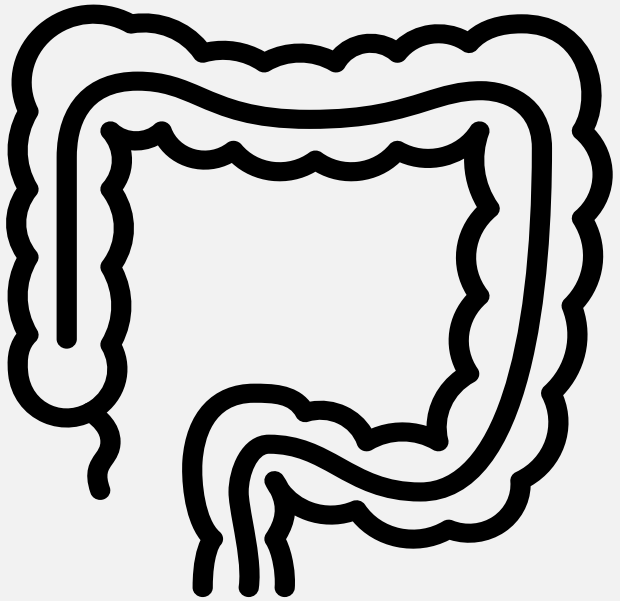
Microscopic colitis gets missed

Consider diagnosis in any patient with chronic, watery diarrhea

There are no reliable blood or fecal biomarkers, including fecal calprotectin



Need a colonoscopy with biopsies!

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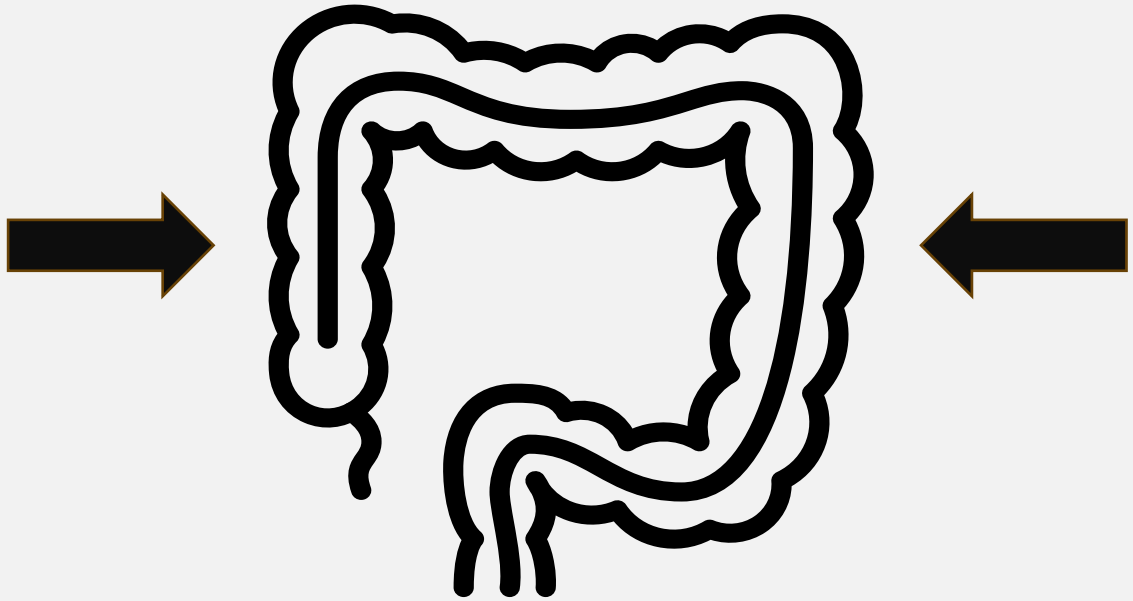
To make a diagnosis

Colon mucosa often normal, macroscopic findings ~17%

Need ≥2 biopsies from right and ≥2 biopsies left colon



Rectum is low yield, don't biopsy

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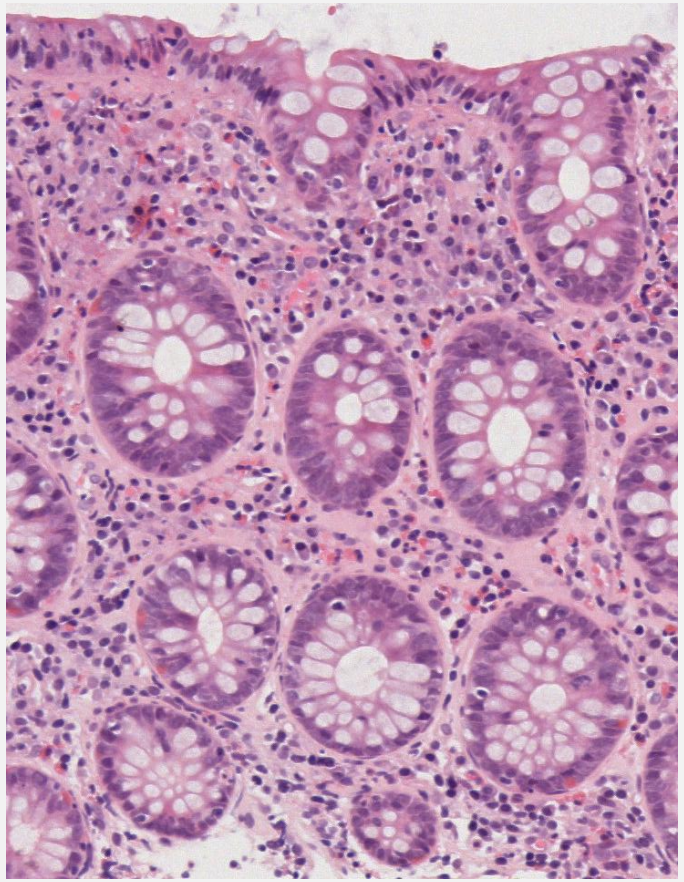
Lymphocytic colitis

Normal

LC: >20 IEL per 100 surface epithelial cells



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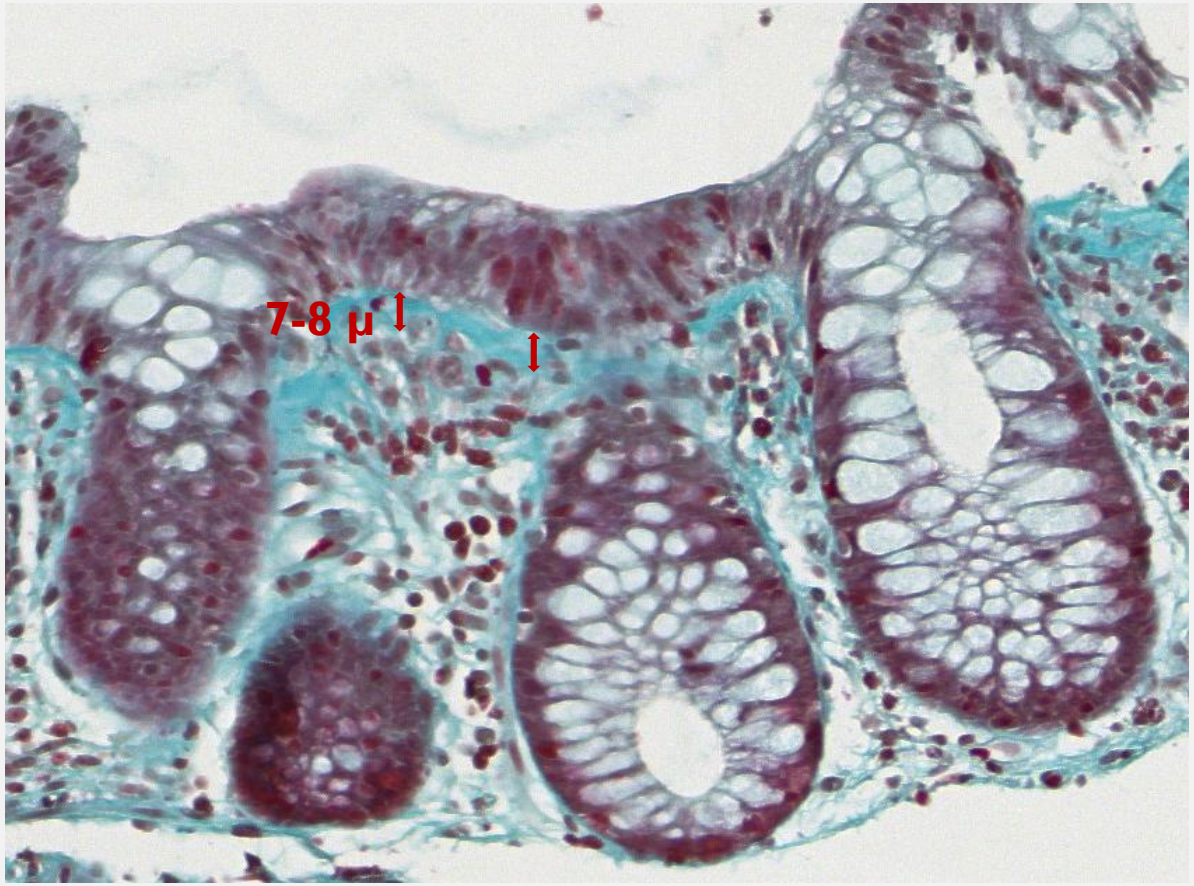
Collagenous colitis

Normal

CC: thickened subepithelial collagen band (>10 µm)



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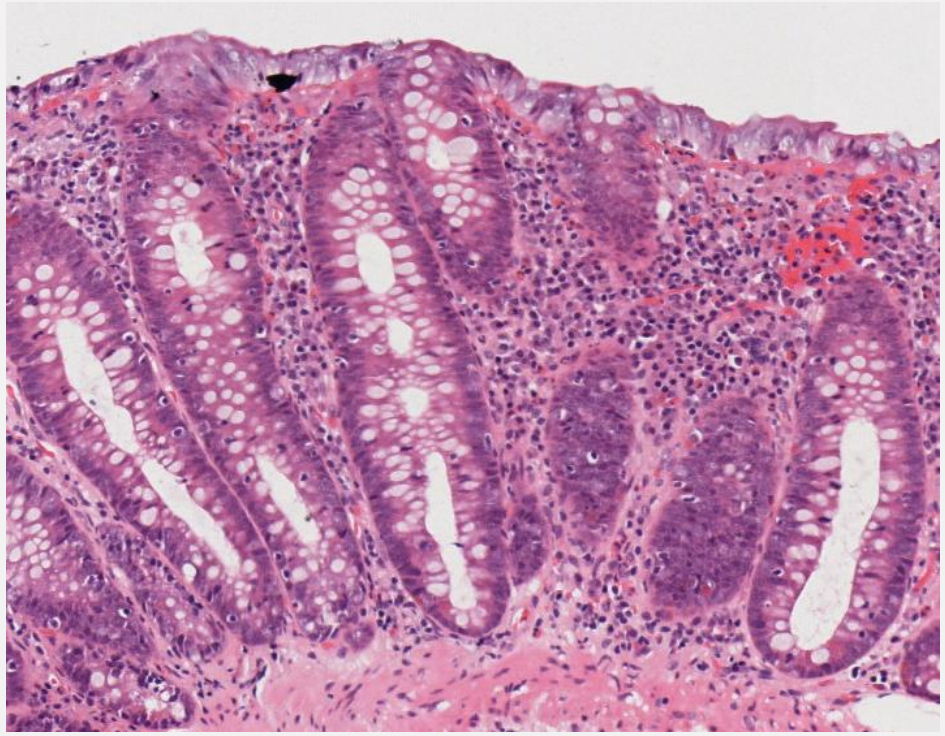
Incomplete microscopic colitis

Either IELs or a thickened subepithelial collagen band

that does not meet thresholds for classic diagnosis



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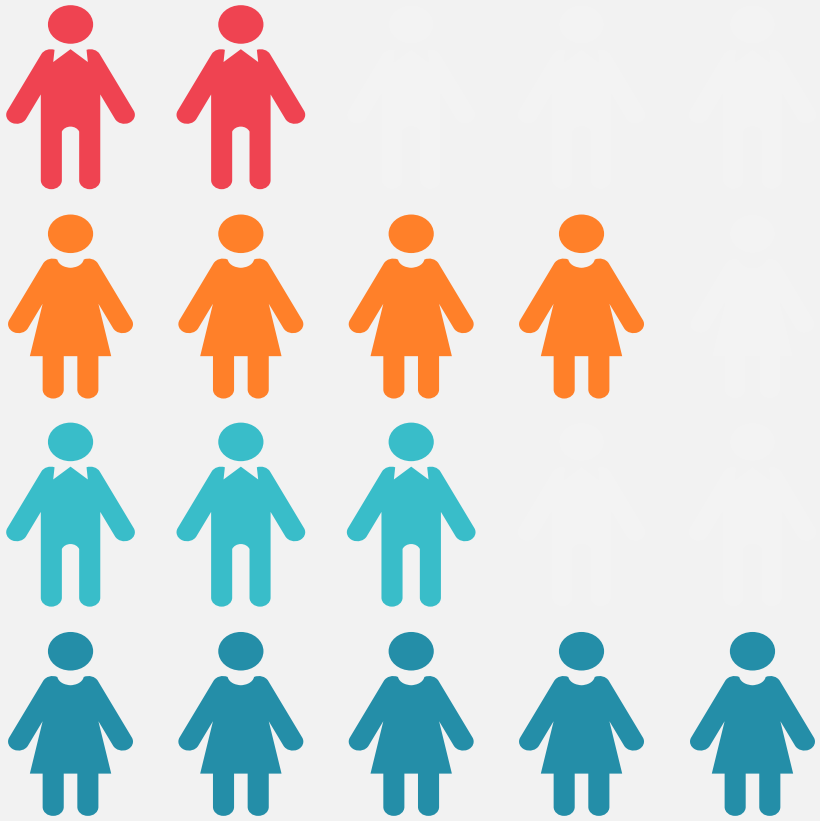
Risk factors

Older age

Female sex

Any race/ethnicity



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Risk factors

Alcohol use and smoking

History of GI infections (C *difficile*, Norovirus, *Campylobacter*)

Autoimmune diseases:

- ~7% patients with celiac disease diagnosed with microscopic colitis
- T1D, IBD, RA, MS, Graves disease

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Risk factors – medications??

Many medications (NSAIDS, PPI, SSRIs) associated with MC

- Recent studies using colonoscopy or chronic diarrhea controls have challenged these observations
- “Clinicians should carefully balance the intended benefits of these medication classes against the low likelihood of a causal relationship with microscopic colitis” - Annals of Internal Medicine 2025

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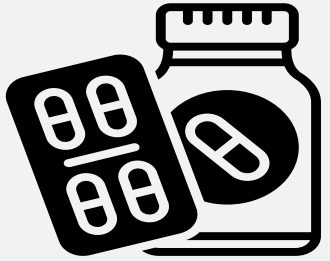

ICI – microscopic colitis

Immune checkpoint inhibitors can induce a type of MC that may be more severe than sporadic MC and may require different treatment

Box 1 | **Approved immune checkpoint inhibitors according to cancer type**

Anti-CTLA-4 antibodies
- Ipilimumab
  - Colorectal cancer[a]
  - Melanoma
  - Renal cell carcinoma[a]

Anti-PD-1 antibodies
- Nivolumab
  - Bladder cancer
  - Colorectal cancer
  - Head and neck cancer
  - Hepatocellular carcinoma
  - Hodgkin lymphoma
  - Melanoma
  - Non-small-cell lung cancer
  - Renal cell carcinoma
- Pembrolizumab
  - Bladder cancer
  - Cervical cancer
  - Gastro-oesophageal junction cancers
  - Head and neck cancer
  - Hepatocellular carcinoma
  - Hodgkin lymphoma
  - Merkel cell carcinoma
  - Metastatic solid tumours classified as microsatellite instability high or deficient mismatch repair
  - Non-small-cell lung cancer
  - Primary mediastinal large B cell lymphoma
  - Stomach cancer
- Cemiplimab
  - Cutaneous squamous cell carcinoma

Anti-PD-L1 antibodies
- Atezolizumab
  - Bladder cancer
  - Breast cancer
  - Non-small-cell lung cancer
- Avelumab
  - Bladder cancer
  - Merkel cell carcinoma
- Durvalumab
  - Bladder cancer
  - Non-small-cell lung cancer

[a]In combination with nivolumab.

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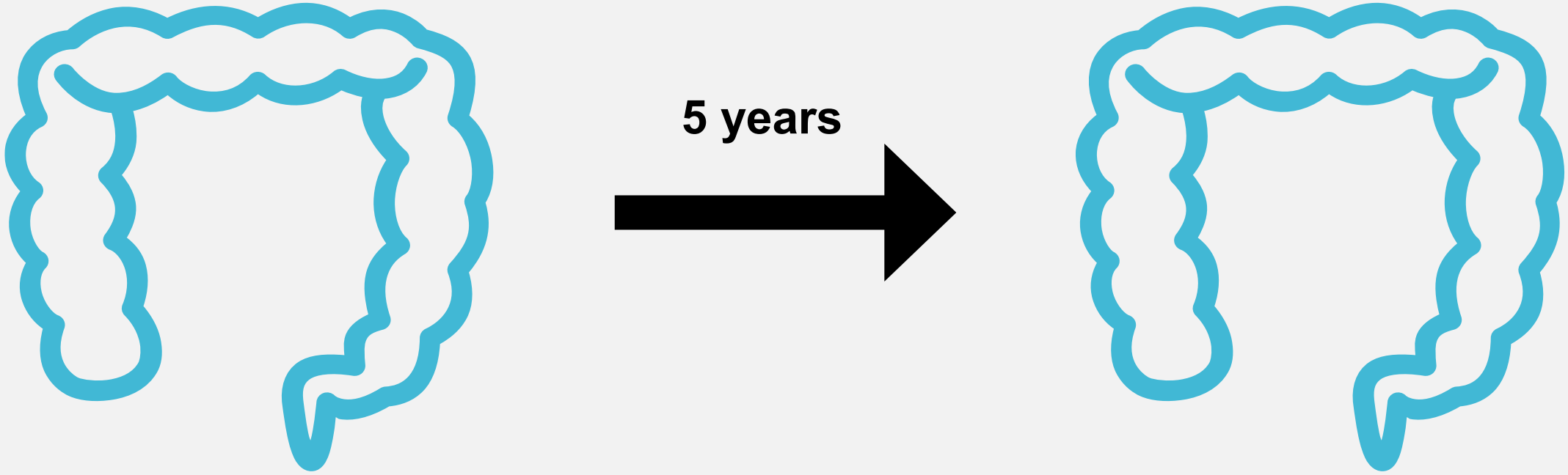
Microscopic colitis can be chronic



New diagnosis

40% relapsing/chronic disease

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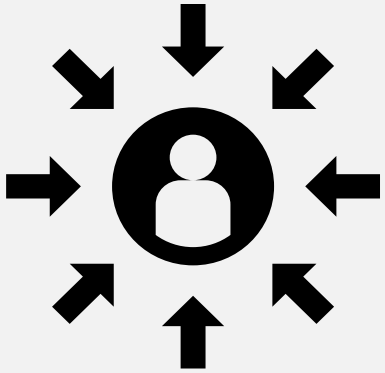
Management

Management does not differ by microscopic colitis subtype

Treatment response should be patient-centered and symptom-based

- Clinical remission defined as <3 BMs and <1 watery BM per day
- Routine confirmation of histologic response is not necessary



Close outpatient follow-up essential to assess symptom burden and treatment response

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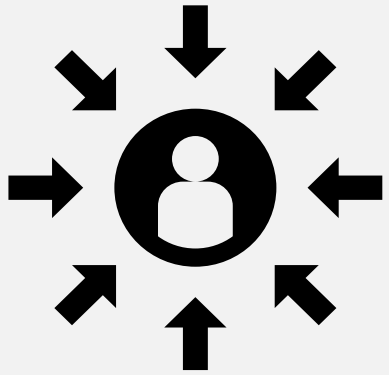
Budesonide is 1st line therapy

Active symptoms: budesonide 9 mg daily for 8 weeks

- After standard induction course, some experts taper budesonide over weeks to months, while other discontinue without taper
- Symptom recurrence after budesonide discontinuation is common, occuring in approximately 50-80% of cases



If mild symptoms, patient may prefer antidiarrheal

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Many patients require maintenance!

Consider maintenance therapy if clinical relapse after 2 courses of budesonide 9 mg daily

- Taper budesonide to maintain symptom remission
- +/- Loperamide
- +/- Bile acid sequestrants

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Many options for maintenance

- Monotherapy budesonide 3-6mg daily
- Monotherapy loperamide or bile acid sequestrant
- Combination budesonide 3-6mg daily + bile acid sequestrant +/- loperamide

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Budesonide Failure

- Clinical activity despite budesonide 9mg
- Clinical activity despite budesonide maintenance treatment +/- adjuvant
- Unacceptable side effects from budesonide

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Budesonide Failure

- Determine smoking status, as smoking may reduce treatment response
- Reassess the diagnosis of microscopic colitis and rule out alternative causes of diarrhea
- Refer to IBD center for consideration of advanced therapy (e.g., anti-TNF agents, vedolizumab, or JAK inhibitors)

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What not to do

Mesalamine is no more effective than placebo

Systemic corticosteroids provide limited to no benefit

Maintenance therapy with bismuth subsalicylate is not recommended

- Risks include salicylate toxicity (nausea, vomiting, abdominal pain, tinnitus) and bismuth-related encephalopathy

Don’t do it.

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Case

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- Diarrhea improved on budesonide; not on maintenance therapy
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Take home points

- Consider microscopic colitis in adults presenting with chronic watery diarrhea
- Medications have a low probability of a causal relationship with microscopic colitis
- Budesonide is 1st line therapy; maintenance treatment often required
- Close outpatient follow-up is essential to assess symptom burden and treatment response

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CME/MOC Question:

A 72-year-old woman with biopsy-proven microscopic colitis achieves complete symptom resolution after an 8-week course of budesonide 9 mg daily. Two weeks after discontinuation, she develops recurrent watery diarrhea. Which of the following statements regarding management is most accurate?

A. Relapse after budesonide discontinuation is rare and suggests an alternative diagnosis
B. Maintenance therapy with mesalamine should be initiated
C. Systemic corticosteroids are preferred for recurrent disease
D. Recurrence after stopping budesonide is common, and low-dose budesonide maintenance may be required
E. Histologic remission must be confirmed before restarting therapy

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CME/MOC Answer:

Correct Answer: D. Recurrence after stopping budesonide is common, and low-dose budesonide maintenance may be required

Explanation: Relapse occurs in approximately 50–80% of patients after discontinuation of budesonide. Many patients require maintenance therapy with the lowest effective dose to control symptoms. Mesalamine and systemic corticosteroids have limited benefit, and routine histologic confirmation of remission is not required. Management should be symptom-based.

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