Microscopic colitis: Report of two cases of collagenous colitis

WONG Yuen Sze Sivia, TANG Wai Lun Victor
Department of Clinical Pathology, Pamela Youde Nethersole Eastern Hospital

Introduction

Microscopic colitis is a relatively common yet under-recognized chronic inflammatory bowel disease. It causes watery non-bloody diarrhea, leading to urgency and ultimately fecal incontinence, which can have a great impact on the quality of life. Epidemiologic studies show a comparable incidence and prevalence between microscopic colitis and inflammatory bowel disease (Crohn's disease and ulcerative colitis). Studies have also revealed an increase in risk of incidence of inflammatory bowel disease among patients with microscopic colitis.

Case 1

A 59 years old male presented with watery diarrhea. Colonoscopy showed no colitis changes.

Microscopic examination shows patchy but significant increase in subepithelial and sometimes pericryptal collagen deposition. The lamina propria has minimal mixed inflammatory infiltrate with no evidence of cryptal distortion, cryptitis, crypt abscess or malignancy. The overall features, together with the clinical history, are consistent with collagenous colitis. Patient was given 5-aminosalicylate and his symptom subsided.

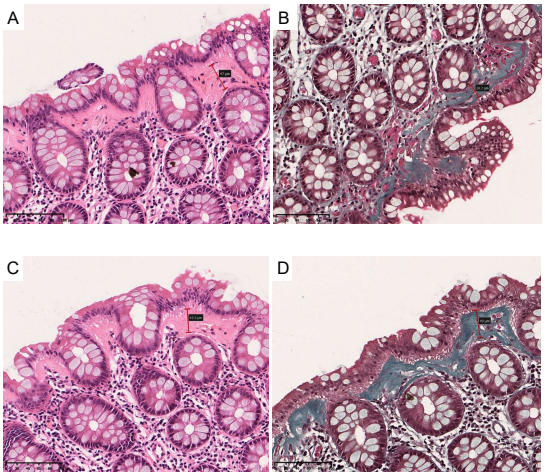

Figure 1. (A) Sigmoid, H&E stained (200X). (B) Sigmoid, Masson's Trichrome stained (200X). (C) Rectum, H&E stained (200X). (D) Rectum, Masson's Trichrome stained (200X).

Treatment

The primary aim of treatment is to achieve clinical remission and to improve patient's quality of life. Budesonide is the first-line therapy for active disease, with response rates greater than 80% and can be used as induction and maintenance therapy. It can be re-administered in case of relapse. Immunomodulators such as azathioprine or mercaptopurine can be used as alternatives. Immunosuppressive agents such as infliximab can be considered in patients with severe symptoms who are refractory or intolerant to budesonide.

Case 2

A 64 years old female presented with change of bowel habit, with bowel opening up to 9 times per day with watery stool. Clinically and radiologically were suggestive of protein losing enteropathy. Stool culture showed no pathogen. Colonoscopy showed normal looking terminal ileum and no mucosal lesion in colon.

Microscopic examination shows colonic mucosa with subepithelial collagenous deposition, especially between crypts, as highlighted by Masson's trichrome stain. Small number of chronic inflammatory cells and blood vessels are entrapped in the thickened subepithelial collagen band. The stroma is infiltrated by moderate to marked chronic inflammatory cell infiltrate including plasma cells, lymphocytes and eosinophils. Rare neutrophilic activity is observed. There is no significant increase in number of intraepithelial lymphocytes. Surface epithelial damage with flattening of surface and epithelial detachment is observed. No significant pathology is seen in the terminal ileum.

Patient was given budesonide and symptoms subsided. Budesonide was stopped after 4 months and no relapse reported so far.

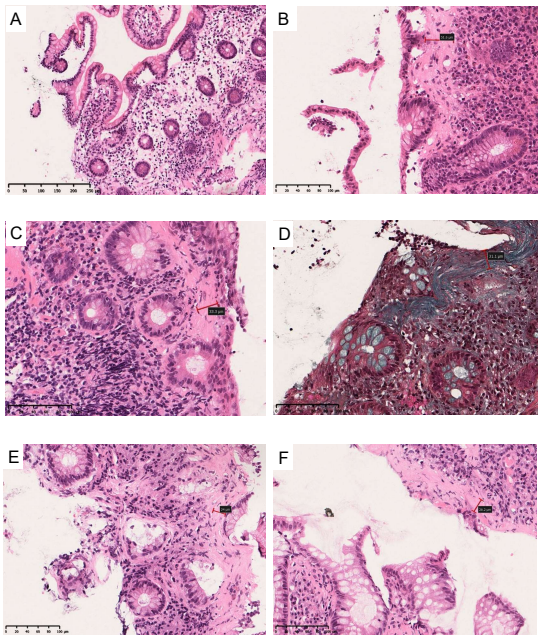

Figure 2. (A) Terminal ileum, H&E stained (50X). (B) Caecum, H&E stained (200X). (C) Transverse colon, H&E stained (200X). (D) Transverse colon, Masson's Trichrome stained (200X). (E) Sigmoid, H&E stained (200X). (F) Rectum, H&E stained (200X).

1. Münch A, Langner C. Microscopic colitis: clinical and pathologic perspectives. Clin Gastroenterol Hepatol. 2015 Feb;13(2):228-36.
2. Khalili H, Burke KE, Roelstraete B, Sachs MC, Olén O, Ludvigsson JF. Microscopic Colitis and Risk of Inflammatory Bowel Disease in a Nationwide Cohort Study. Gastroenterology. 2020 May;158(6):1574-1583.