Other Colitis, Not IBD: Colitis Potpourri

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Overview

• Microscopic colitis
• Diverticulitis
• Ischemic Colitis
Microscopic Colitis

• Characterized by
  – Chronic watery diarrhea
  – Normal appearance of colonic mucosa
  – Abnormal histopathology

• Higher incidence of autoimmune disorders
  – Examples: arthritis and celiac disease

• Association with certain medications
  – NSAIDs, PPIs, sertraline, ticlopidine, acarbose and statins
Microscopic colitis

- Collagenous colitis
  - More frequent in women
  - Peak incidence 5th decade

- Lymphocytic colitis
  - Men and women affected equally
  - Peak incidence 5th decade
Histopathology

Collagenous colitis

Thickened collagen layer

Lymphocytic colitis

Increased lymphocytes
Treatment

• Varies based upon symptoms and severity

• Diet and lifestyle changes
  – Limit caffeine, dairy and fatty meals
  – Stop NSAIDs (or other possible offenders)

• Medications
  – Peptobismol, lomotil or loperamide
  – 5ASAs
  – Steroids
  – Immunosuppressives
Peptobismol

- K Fine, Gastro 1998; 114:29-36
  - 13 patient with MC (CC and LC)
  - Peptobismol tablets 262 mg 8 tablets daily x 8 weeks, open labeled
  - 12 patients completed the study
  - 11 patients had resolution of symptoms
  - Average time to improvement 2 weeks
Mesalamine

- 64 Italian pts with MC
  - Mesalazine alone x 6 months
  - Mesalazine + cholestyramine x 6 months
- 54 patients had resolution of symptoms
- Clinical remission and histological remission
  - 85% lymphocytic colitis
  - 91% collagenous colitis
- 13% relapsed

Calabrese C, J Gastro Hepato 2007;22:809-814
20 CC pts
Budesonide 9/6/3 mg vs placebo
8 weeks
BM 6.2 bm/d to 1.9 bm/d (p<.01)
8 relapsed in 8 weeks

Bonderup O, gut 2003;52:248-251
Immunosuppressives

• Azathioprine 75 mg or 6MP 50 mg po q day
  – 6 patients
  – CC and LC patient steroid dependent
    • 2 attempt to taper completely off steroids
  – 3.5 months average time to completely taper off steroids

Vennamaneni S, AJG 2001;96:2798-2799
Immunosuppressives

• Methotrexate
  – 19 patients with microscopic colitis
  – 5 mg/week given orally and increased 2.5 mg increments
  – Median dose 7.5 – 10 mg every week
  – Complete response 74% of patients

Riddell J, J Gastro Hepat 2007;22:1589-1593
Boswellia Serrata Extract

31 MC pts
BSE 400 mg tid vs placebo
6 week duration
CR <3 BMs/d
No change in histology

Probiotics

29 MC pts
L. Acidophilus & B. animalis vs placebo
12 week
Prim endpt >50% in BMs
Sec endpt imp stool freq, histo, pain

P=0.635

Wildt S, IBS 2006;12:395
Treatment Algorithm

Antidiarrheals
- Bismuth subsalicylates
- Mesalamine+cholesytramine
- Budesonide

Biologics
- AZA/6MP/MTX

Surgery
Diverticulitis

• Asymptomatic diverticulosis is common
  – Incidence increases with age (<5% before age 40 and >65% by age 85)
  – 15-20% develop diverticulitis

• Disease of the elderly
  – 20% of diverticulitis <50 years

• Men and women affected equally
Diverticulitis

• Pathophysiology
  – Inflammation of one or more of the diverticula
  – Pathogenesis is unclear
    • Obstruction of the diverticulum opening
    • Distension of diverticula with vascular compromise
    • Subsequent micro or macro perforation

– Complications
  • Fistula formation, abscess formation, narrowing of lumen with subsequent stricture formation
Clinical presentation

• Abdominal pain
• Change in bowel habits
• Nausea and vomiting
• Constipation
• Diarrhea
• Flatulence
• Bloating

* Diverticulitis should not present as lower GI Bleeding
Diagnosis

- Lower abdominal tenderness with fever
- Leukocytosis
- CT abnormalities
  - Pericolic fat stranding
  - Colonic diverticula
  - Bowel wall thickening
  - Abscess
CT “diverticulitis”
Treatment

- Mild
  - Clear liquid diet
  - 7 to 10 days oral broad spectrum antibiotics
    - Ciprofloxacin and metronidazole
    - Trimethoprim-sulfamethoxazole and metronidazole
    - Amoxicillin/clavulanic acid
  - Advance diet 2 to 3 days once symptoms improve
Inpatient Treatment

- Bowel rest and IVFs
- Broad spectrum antibiotics
  - Piperacillin/tazobactam, Ampicillin/sulbactam, Ticaricillin/clavulanic acid, Imipenem or Tigecycline (pen allergy)
  - Metronidazole + quinolone or 3rd gen cephalosporin
- Repeat CT if no clinical improvement after 2 to 3 days
Indications for surgery

• Free-air
• Peritonitis
• Uncontrolled sepsis
• Pelvic abscess (>4 cm unable to aspirate)
• Obstruction
• Failing medical therapy
• Fistula formation
Ischemic Colitis

• Most common form of intestinal ischemia
  – Accounts for 1 in 1000 hospitalizations
  – Usually seen in the elderly
  – Spectrum of disease
    • Transient self-limited ischemia (mucosa and submucosa)
    • Acute fulminant ischemia with transmural infarction
  – First described as caused by ligation of IMA during aortic surgery or colon resection

• Acute self-limited compromise in intestinal blood flow
Colon Blood Supply

[Diagram showing the blood supply to the colon with labels for Superior mesenteric artery and Inferior mesenteric artery]
Conditions that predispose to IC

- Cardiac failure
- Shock
- Strenuous physical activity
- Arterial thrombus
- Hypercoagulable states
- Vasculitis
- Iatrogenic surgical causes
- Sickle cell disease
- Hemodialysis
- TTP
- Aortic dissection
Medications associated with IC

- Antihypertensives
- Cocaine
- Diuretics
- NSAIDs
- Digoxin
- esotrogen
- Oral contraceptives
- Vasopressin
- Pseudoephedrine
- Alosetron
- Danazol
- Sumatriptans
- Amphetamines
Clinical presentation

• Acute onset of abdominal pain and tenderness
• Urge to defecate
• Passage of bright red or maroon blood
  – Blood loss is usually minimal
• Anorexia, nausea, vomiting and abdominal distension is common
• 15% will have peritoneal signs
Computed Tomography

Thickened bowel wall

Pneumatosis suggest transmural ischemia or infarction
Colonoscopy

Mild
petechial hemorrhages
pale, edematous mucosa
segmental inflammation

Severe
cyanotic, dusky or black mucosa
pseudomembranes
Histology

Edema
Distorted crypts
Inflammatory infiltrate
Granulation tissue
Intravascular platelet thrombi necrosis
Treatment

• Mild
  – Supportive care
  – Bowel rest
  – IVFs
  – Optimize cardiac function

• Moderate to severe
  – Broad spectrum antibiotics
  – NGT tube
  – Rectal tube
  – angiography
Management of colonic ischemia.

ELDER K et al. Cleveland Clinic Journal of Medicine
2009;76:401-409
Thank you