Microscopic Colitis Foundation

Newsletter Archive

Wayne's Blog

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We feel that it will be helpful to provide an overall summary of the various treatments for microscopic colitis (MC), and their reported effectiveness. Gathering this important information together in a comprehensive series of articles will hopefully give patients a basic understanding of the various treatment options, and how they might work together to achieve improvement of symptoms and remission.

PART 1

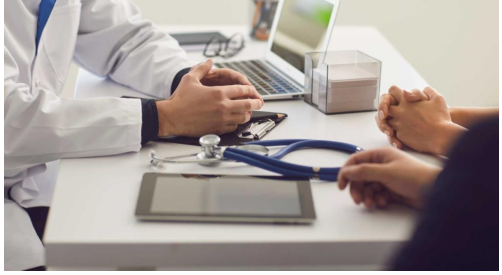
Has the Medical Treatment of MC Improved during the Last Decade or Two?

by Wayne Persky

When we look at how treatments for Crohn's and colitis have changed during the past couple of decades, we find that numerous new drugs have been approved, and patients are being treated with these drugs, so that many IBD patients are experiencing improved treatment results.

But when we look at how treatments have changed for microscopic colitis (MC), it's difficult to locate any significant treatment

writing home about.



> **The standard of care for MC is largely unchanged from 10 years ago.**

> **But advances in understanding the disease have occurred.**

So what has changed, and what has not changed?

1. The standard of care is largely unchanged.

- Budesonide (a corticosteroid acting locally in the colon) remains the only proven, guideline-recommended first-line therapy for active MC. It induces remission in the majority of patients but relapse rates are very high once the drug is discontinued.
- Symptomatic relief with anti-diarrheal agents (like loperamide), bile acid binders (cholestyramine, colesevelam), or bismuth subsalicylate is still commonly used, just as it was 10–15 years ago.
- Dietary modification and trigger avoidance (NSAIDs, PPIs, SSRIs, gluten, lactose, high-fat foods, alcohol) are still widely recommended as supportive approaches, but not part of formal drug guidelines.

2. There have been advances in understanding.

- Research has expanded into immune pathways, including the roles of Th17 cells, IL-22, and oncostatin M (OSM), all of which may sustain chronic gut inflammation.
- Studies have highlighted the importance of the gut microbiome and how antibiotics, PPIs, and other medications alter it, possibly triggering or worsening MC.
- Recognition of overlap with celiac disease, bile acid malabsorption, and mast cell activation has grown, but these insights haven't yet translated into new official therapies.

3. Emerging and Off-Label Treatments:

- Biologics (anti-TNF agents, vedolizumab, ustekinumab) have been tried in severe, refractory cases, but provided no strong evidence base yet. These are rarely used outside of research or highly refractory disease because MC usually responds to budesonide.
- Methotrexate, azathioprine, 6-MP are sometimes used off-label in budesonide-dependent or refractory MC, but with variable success and more side effects.
- Mast cell–targeted therapies (for example, ketotifen, cromolyn sodium, quercetin) have been investigated in small studies or case reports, but are not yet used in standard practice.
- fecal microbiota transplantation (FMT) remains only anecdotal and case-level evidence so far.

4. What has NOT improved?

- No new FDA- or EMA-approved drugs specifically for MC in the past decade.
- High relapse rate problem remains unsolved — many patients relapse after budesonide is stopped.

- Long-term management strategies are still trial-and-error, often requiring a mix of diet, trigger avoidance, and repeated steroid courses.

5. What's on the horizon?

- Ongoing research into cytokine inhibitors (IL-22, OSM, JAK-STAT pathways) could one day produce targeted biologics for MC.
- Better recognition of medication-induced MC may help reduce incidence by avoiding unnecessary NSAIDs, PPIs, SSRIs, and certain antibiotics.
- Interest is growing in microbiome-directed therapies and nutritional interventions, but these are still in exploratory stages.

The harsh reality: There has been precious little real-world progress.

- Most patients still require long-term medication to prevent relapse.
- Quality of life remains significantly impacted for many patients.
- The condition remains "invisible" and poorly understood by healthcare providers and society.
- No cure exists - only symptom management.
- Treatment failure rates haven't dramatically improved.

Why has progress in the treatment of MC stalled?

MC is one of the most common causes of chronic watery diarrhea, especially in older adults. Yet, unlike Crohn's disease and ulcerative colitis, treatment options for MC have barely advanced in the past 20 years. Budesonide remains the only consistently effective first-line therapy, and no new drug has been approved specifically for MC. A recent landmark European study, the PRO-MC collaboration, helps explain why progress has been so limited (Verhaegh et al,, 2025)[1].

In the study:

Researchers followed over 400 newly diagnosed MC patients across Europe, with 220 completing a full five-year follow-up. The long-term outcomes broke down into four distinct groups:

- 6% had a dormant course, remaining symptom-free.
- 54% achieved remission after initial treatment.
- 33% relapsed after remission.
- 7% had chronic active disease requiring continuous therapy.

Taken together, nearly 40% of patients lived with relapsing or ongoing symptoms over the five-year period. These individuals experienced reduced quality of life and often needed long-term budesonide to control symptoms. Importantly, the first year after diagnosis predicted the long-term course. If a patient relapsed early, they were very likely to continue struggling with relapsing or chronic disease.

> **After 5 years, about 60% of MC patients were in remission after initial treatment.**

> **But that leaves 40% still struggling.**

Medical therapies for MC have barely advanced because:

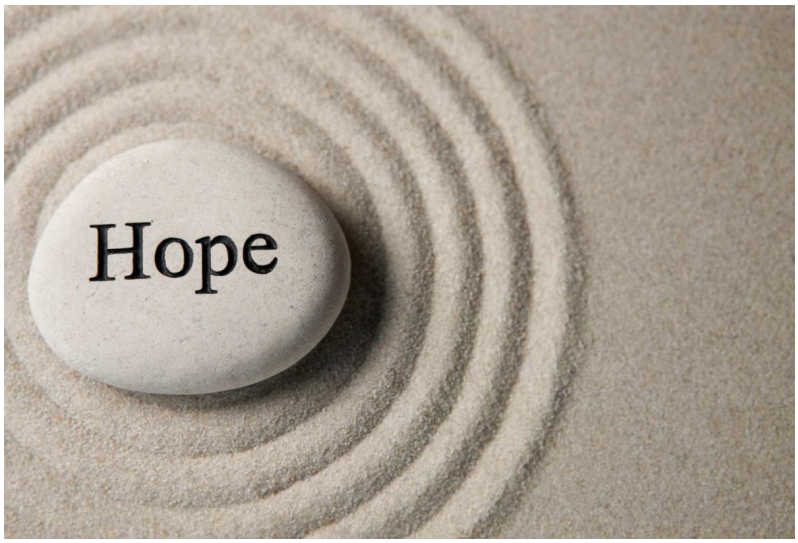
1. Most patients respond (at least initially) to budesonide. With more than half achieving remission after treatment, the drug is considered “good enough.” This success rate reduces urgency for pharmaceutical companies to invest in developing costly alternatives.
2. The disease course looks stable after year one.

Since the first year strongly predicts the long-term pattern, researchers can identify patients likely to relapse early. But this also creates a sense of therapeutic resignation because clinicians often assume that budesonide dependency is inevitable in these patients rather than exploring innovative options.

3.Relapses are not life-threatening. Unlike Crohn’s or ulcerative colitis, MC rarely causes hospitalization, surgery, or life-threatening complications. Its “benign” reputation means it attracts less research funding and fewer drug development efforts, despite the real suffering caused by chronic diarrhea and impaired quality of life.

4. There's limited commercial incentive. Because MC is common in older adults, many physicians still manage it with generic budesonide, anti-diarrheals, or bile acid binders. The market for expensive biologics or novel therapies is perceived as small compared to Crohn’s or ulcerative colitis, where treatment urgency and costs are higher.

Consequently, the net result of these realities is therapeutic stagnation. Patients with relapsing or chronic MC remain stuck on long-term budesonide, often cycling through flares and remissions without better options. Meanwhile, the impact on quality of life, including urgency, fatigue, malnutrition, and social isolation, remains underappreciated by both researchers and clinicians.



Maybe this study will inspire some treatment progress.

The PRO-MC study highlights a critical truth — MC is not always a mild, self-limiting disease. Nearly half of

patients face years of relapses or chronic activity. Recognizing this should shift the mindset from “good enough” to "urgent need for innovation".

- Research into immune pathways (IL-22, oncostatin M, mast cell activation) and the gut microbiome may provide new targets for therapy.
- Greater awareness of the predictive value of the first year could encourage earlier, more aggressive intervention in high-risk patients.

- A stronger patient voice emphasizing quality of life may push the medical community to prioritize MC alongside other inflammatory bowel diseases.

At least we can hope that improvement may be forthcoming. One thing MC patients who are successful in controlling their disease learn early on, is to never give up hope.

And for MC patients who can't achieve remission using medical treatments:

Although this article discusses changes (or the lack of changes) in medical treatments for MC, remember that the 40% of MC patients who are unable to achieve stable remission with medical treatments can explore nonmedical treatment options such as those described by the Microscopic Colitis Foundation.

Look for Part 2 in the next Newsletter
"A Closer Look at Medications Used to Treat MC"

References

1. Verhaegh, B. P. M., Münch, A., Guagnozzi, D., Wildt, S., Cebula, W., Pedersen, N., . . European Microscopic Colitis Group [EMCG]. (2025). The long-term disease course of microscopic colitis: a European prospective incident cohort study. Journal of Crohns & Colitis, 19(7). jjaf110. Retrieved from https://pubmed.ncbi.nlm.nih.gov/40583189/

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He posts a new blog about once a week. Here are the titles of the most recent. Click the button at the top of the newsletter to access.

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USING THE KETOGENIC DIET TO REDUCE INFLAMMATION

PROPER IMMUNE SYSTEM FUNTION REQUIRES GOOD KIDNEY FUNCTION

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