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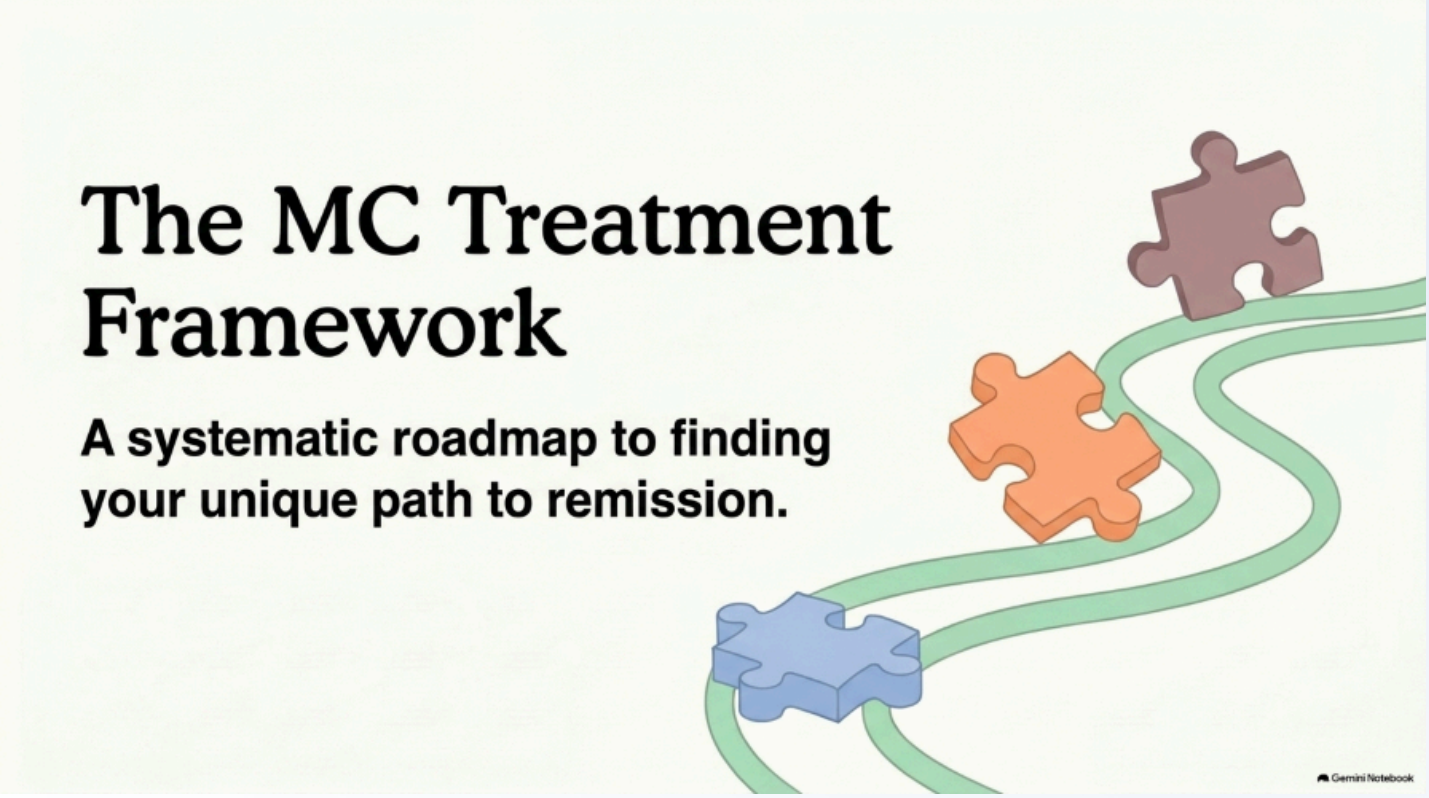


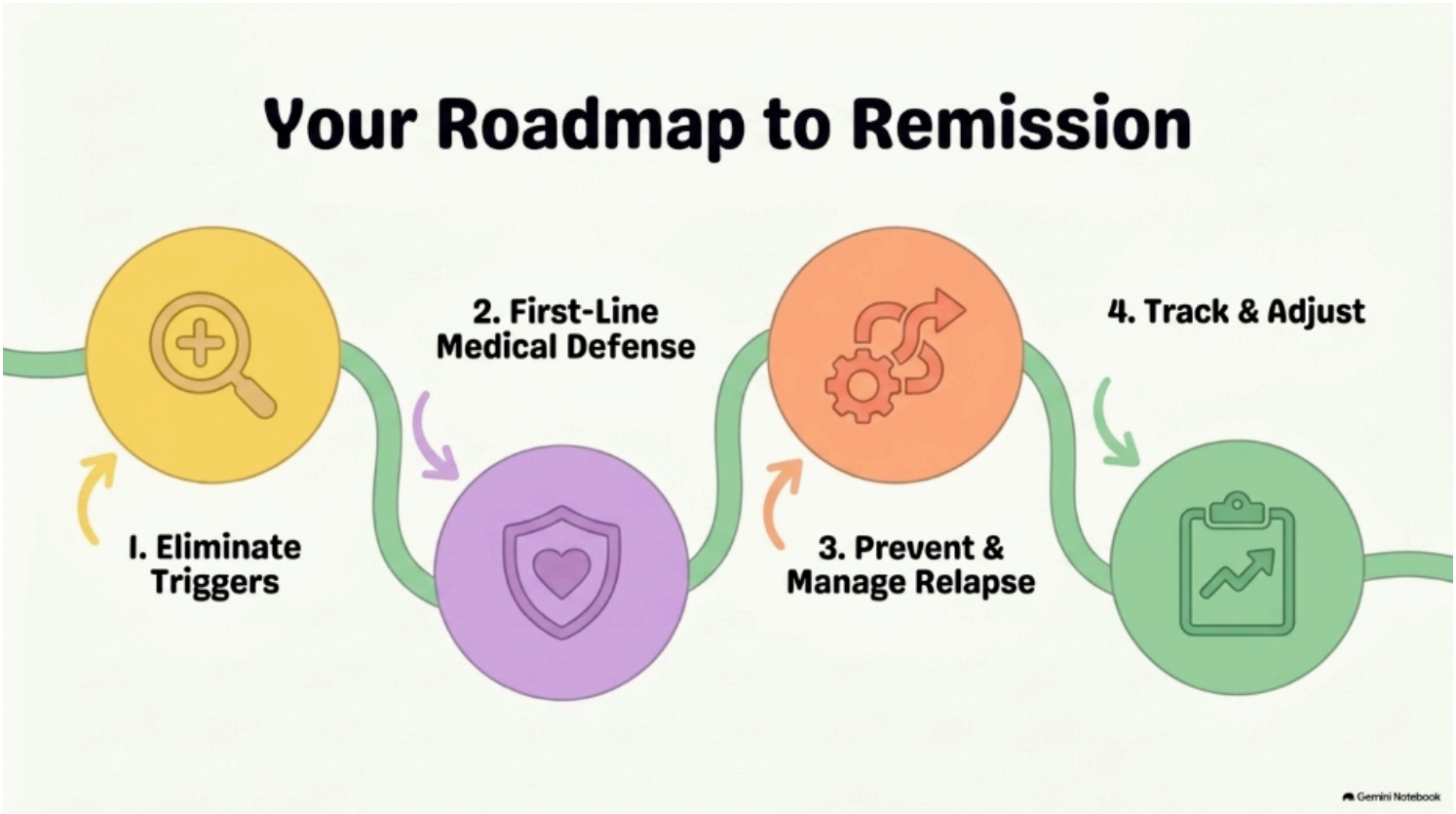
Newly Diagnosed MC Patients' Treatment Framework

by Wayne Persky

Because we're all different, there's no single correct treatment plan, but choosing an optimal treatment plan, and modifying it as needed, will bring remission with a minimum of setbacks and confusion.

One of the first questions newly diagnosed microscopic colitis (MC) patients ask is “What's the best treatment?” It's a reasonable question, and the honest answer is that there isn't one universally correct plan. MC presents differently from patient to patient, triggers vary considerably, and responses to both medications and dietary changes are highly individual. What reliably helps one person may be ineffective or poorly tolerated by another. That's not a failure of medicine — it's a feature of a complex autoimmune disease in which the specific combination of contributing factors differs from person to person.

What does exist is a reasonably clear evidence-based framework — a logical sequence of steps that gives each patient the best opportunity to identify what works for their specific situation. That framework is the focus of this article.



Several medication classes are well-documented MC triggers. Proton pump inhibitors (PPIs) such as omeprazole, pantoprazole, and lansoprazole are among the most commonly implicated. They appear in a disproportionate number of MC cases, and discontinuation sometimes produces remission without any other treatment. Non-steroidal anti-inflammatory drugs (NSAIDs) including ibuprofen, naproxen, and aspirin are also consistently associated with MC onset and flares. Selective serotonin reuptake inhibitors (SSRIs), including antidepressants such as sertraline, paroxetine, and fluoxetine, appear in the literature as possible triggers in some patients, though the association is less consistent than with PPIs and NSAIDs. Statins, immune checkpoint inhibitors used in cancer treatment, and certain blood pressure medications have also been associated with MC in case reports and observational studies (Westbrook, and Garber, 2024).[1]

Ideally, a newly diagnosed MC patient should bring a complete medication list to the gastroenterologist at a diagnosis followup appointment, and specifically ask whether any current medications are known MC triggers. If a PPI or NSAID is being taken for a condition that might be managed another way, discussing alternatives is worthwhile before adding MC medications on top of a potential ongoing trigger.

Address diet at the same time as medication, not as an afterthought.

The dietary triggers most consistently associated with MC include gluten, dairy, soy, and eggs — with gluten being the most reliably documented across the largest number of patients. Many MC patients are also sensitive to other specific foods including certain additives, artificial sweeteners, alcohol, caffeine, and significant amounts of fiber, though these vary considerably between individuals.

If your gastroenterologist doesn't recognize that the inflammation associated with MC is typically connected with certain food sensitivities, you might benefit from switching to a gastroenterologist who does. The critical point for newly diagnosed patients is that dietary management and medical treatment work best together, not sequentially. A patient who achieves remission with budesonide but continues consuming gluten or other triggers is suppressing inflammation medically while continuing to provoke it with almost every meal. When the medication is tapered, the underlying inflammation driven by dietary triggers reasserts itself, which is one of the most common reasons why MC patients relapse after a budesonide treatment is ended. Research consistently finds that relapse after budesonide tapering affects

40% to 80% of patients, and unaddressed dietary triggers are a significant contributor to that rate (Taelman et al., 2026).[2]

The most systematic approach is to eliminate the most common triggers (gluten, dairy, and soy) completely and simultaneously at diagnosis, rather than eliminating them one at a time over months. This gives the gut the cleanest possible environment in which to respond to treatment, and it avoids the prolonged trial-and-error period that partial elimination produces. Foods can be tested and reintroduced one at a time after stable remission has been achieved, with enough time between reintroduction tests to identify reactions clearly.

The proper way to test foods:

To test foods before adding them back into your diet, eat a small portion the first day. If there's no adverse reaction, then the second day eat a slightly larger portion. If there's no reaction, eat a normal size portion the third day, If there's still no reaction, that food can probably be safely added back into your diet. If symptoms develop at any point during the test, stop testing that food and consider it to be off limits.

Budesonide is the appropriate first-line medical treatment for most patients:

Oral budesonide is the only medication for MC supported by strong, disease-specific randomized controlled trial evidence, and it's the first-line recommendation of both the American Gastroenterological Association and the European guidelines (Nguyen, Smalley, Vege, and, Carrasco-Labra, 2016; Miehlke et al., 2021).[3,4] It works by suppressing colonic inflammation locally, with relatively limited systemic absorption, which gives it a more favorable safety profile than systemic corticosteroids such as prednisone.

The standard starting dose is 9 mg daily, typically continued for 6 to 8 weeks. Patients treated with 9 mg budesonide daily are more than twice as likely to achieve clinical remission compared to no treatment, with most responders seeing meaningful improvement within the first two weeks.[3] After initiation, the dose is tapered — typically from 9 mg to 6 mg to 3 mg over several weeks — with the goal of finding the lowest dose that maintains remission, or discontinuing entirely if remission is stable.

Although a few MC patients may need long-term budesonide therapy, most will not (especially if the proper diet changes are made). The medical literature shows that approximately one third of patients maintain remission after tapering off budesonide entirely. But note that this finding is based on research conducted on patients who made no documented diet changes before starting the treatment. Because of that, experience shows that MC patients who make the proper diet changes before starting a budesonide treatment will be much more likely to remain in remission, especially if they extend the dose tapering when ending the budesonide treatment. For those who relapse during or after tapering — which the evidence suggests is the majority (at least, for those who do not change their diets) — maintenance therapy at the lowest effective dose is appropriate, typically 3 to 6 mg daily, with reassessment after 6 to 12 months.

Relapse after tapering is common, and usually manageable.

A large retrospective study of 239 MC patients found that 54.8% of budesonide responders eventually relapsed — with 44.6% relapsing during the tapering process itself, and the remaining 55.3% relapsing shortly after treatment ended.[2] Younger patients were more likely to relapse than older ones, though the study didn't examine why.

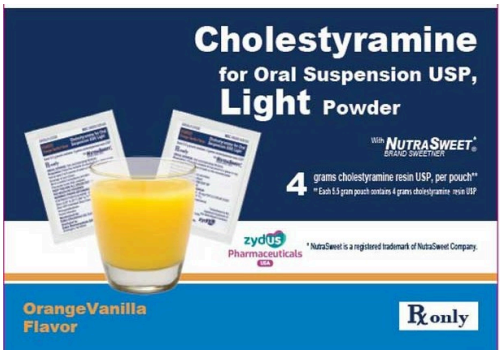
Importantly, like most budesonide trials, this study did not control for dietary management, meaning the relapse rates it reports reflect patients who were largely continuing their normal diets, and may not represent what's achievable when dietary trigger elimination is combined with treatment from the beginning.

Relapse after budesonide tapering should not be interpreted as treatment failure. It's more accurately understood as an indicator that the underlying drivers of inflammation have not been fully addressed. The appropriate response is to investigate what those drivers are, whether dietary triggers remain in place, whether a trigger medication is still being taken, whether stress or sleep disruption is contributing through the gut-brain axis, rather than simply restarting the same budesonide course indefinitely without addressing the root cause.

For patients who relapse repeatedly or who cannot taper below a higher dose without symptoms returning, the descriptive term used is budesonide-dependent MC. This warrants a more thorough investigation of ongoing triggers, and in many cases, referral to a gastroenterologist with specific IBD expertise.

The next steps to take when budesonide isn't enough.

For patients in whom budesonide is ineffective, not tolerated, or insufficient for long-term management, several options exist, although the evidence base for most of them is not as well studied as for budesonide (as is usually the case for MC).



Cholestyramine, a bile acid sequestrant, is worth considering early, particularly for patients who have had their gallbladder removed, have had ileal surgery, or whose diarrhea has characteristics more specific to bile acid malabsorption — a yellow or bright green watery stool, symptoms that are triggered or significantly worsened by fatty meals, and urgency that tends to occur within an hour or two of eating rather than being distributed throughout the day. A trial of cholestyramine is sometimes used diagnostically — if symptoms improve substantially within a few days of starting it, bile acid malabsorption is likely a significant contributor.

Cholestyramine is inexpensive, non-systemic, and can be effective in this subgroup without the immunosuppressive effects of budesonide. Cholestyramine can also be used concurrently with budesonide, as there are no known interactions.

Bismuth salicylate and mesalamine are sometimes used as alternatives or additional treatments when budesonide isn't feasible, though the evidence for both is considerably weaker than for budesonide, and the American Gastroenterological Association guidelines suggest them only when budesonide cannot be used.

For patients who have genuinely failed budesonide despite adequate dietary management and trigger elimination, the most promising options based on current real-world evidence are the advanced therapies discussed in detail in a separate article in this series, particularly JAK inhibitors, which produced the highest response and remission rates in the largest real-world MC study to date, and vedolizumab, which offers a favorable safety profile for older patients with comorbidities (Verstockt et al., 2026).[5] These options require referral to a center with IBD specialty expertise.

Monitoring and adjusting over time:

MC is not a static disease. Symptom patterns change, new triggers emerge, medications change, and stress levels fluctuate — all of which can shift the disease's activity. The treatment approach that achieves remission at diagnosis may need adjustment over time, and patients who are doing well have often arrived at their current regimen through a process of systematic observation and adjustment rather than a single correct decision at diagnosis.

Keeping a detailed symptom and food diary is one of the most practically useful things a newly diagnosed patient can do. Recording what was eaten, what medications were taken, stool frequency and consistency, and any significant stressors gives both the patient and their physician the information needed to identify patterns that would otherwise be invisible. This is especially important during the dietary elimination and

reintroduction process, where the difference between a clear reaction and a coincidental bad day can be genuinely difficult to determine without written records.

Regular follow-ups with the gastroenterologist matter — not just during active flares but during remission, to monitor for medication side effects, assess bone density in patients on long-term budesonide, and reassess whether the current regimen still fits the current situation.

The role of patient community experience:

The Microscopic Colitis Foundation (MCF) forum has accumulated practical knowledge about what actually works for real MC patients, that the published clinical literature cannot fully capture, because it reflects the lived experience of thousands of patients over many years, including patients who have tried multiple approaches and can describe specifically what helped and what didn't.

Newly diagnosed patients who engage with that community often compress the learning curve substantially, and are able to develop effective dietary strategies and medication management approaches that might otherwise take years of trial and error to discover independently, or with a knowledgeable gastroenterologist. It's a complement to that relationship — one that provides the kind of practical, disease-specific information that a physician seeing a patient for 20 minutes every few months simply cannot provide.

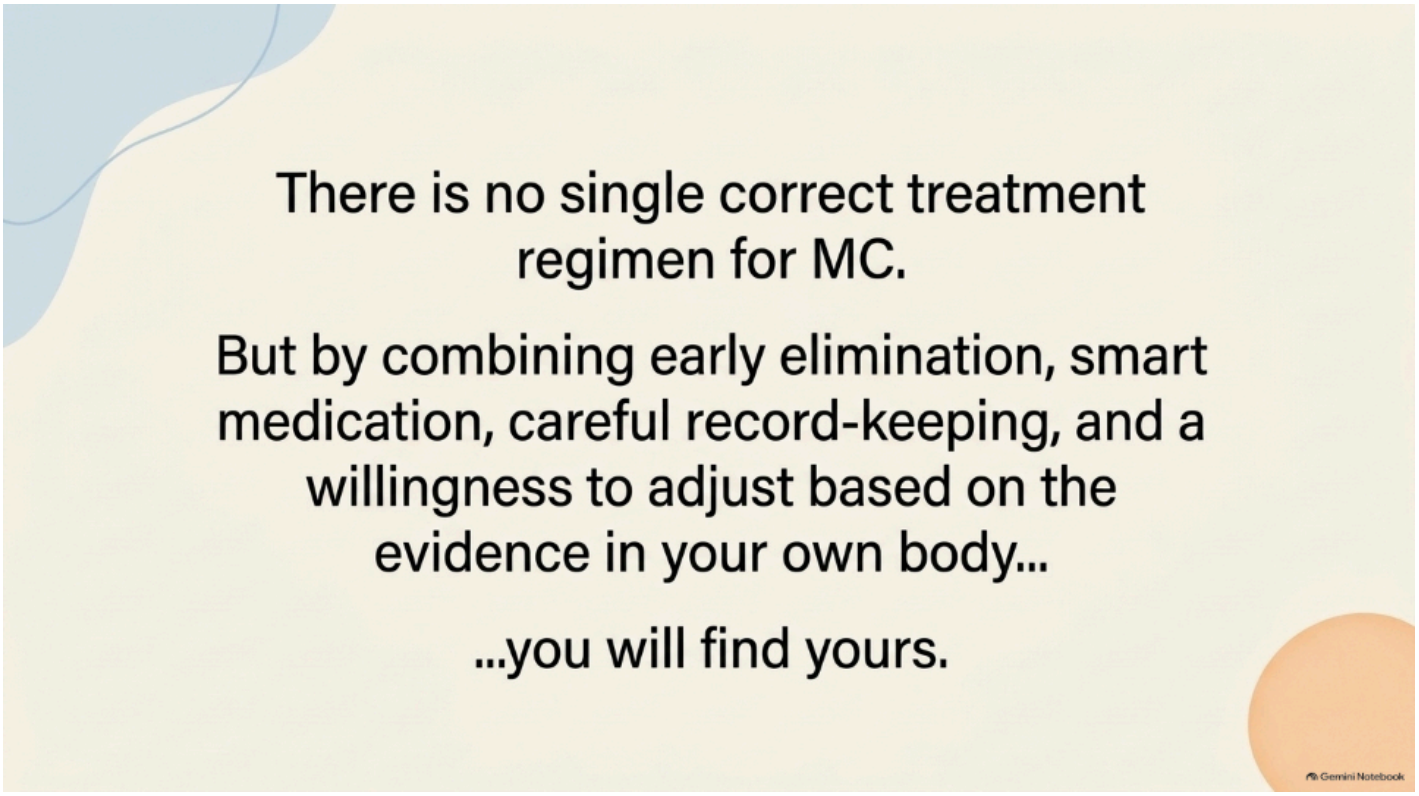
The MCF website contains a huge amount of data, including current and back issues of newsletters, blog articles, and links to a discussion and support forum containing over two decades of shared experiences posted by members living with MC. To simplify searching through all that data to answer questions about living with MC, the MCF offers a free smartphone and iPad app that can be searched by AI. The app can be downloaded at the following links:

iPhone Version: https://apps.apple.com/us/app/search-the-mc-forum-using-ai/id6753160674

Android Version; https://play.google.com/store/apps/details?id=com.mcf.searchapp

The bottom line:

There's no single correct treatment regimen for MC, but there is a logical sequence for identifying and eliminating trigger medications, and addressing dietary triggers completely and early in the treatment. If budesonide is used as a first-line treatment, it should be at an adequate dose for an adequate duration. The cause of any relapse should be investigated, and when standard approaches are insufficient, consider escalating to specialist care. Within that framework, the specific combination that works best will be different for each patient, which is why systematic observation, careful record-keeping, and a willingness to adjust based on what the evidence in your own body is showing you are among the most important tools available.



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Guidance in Lifestyle Habits This Fall, According to Traditional Chinese Medicine

by Shannon Freedom

During the three months of autumn, everything in nature reaches its peak of maturity. The crops ripen, and the harvest takes place. The energy of the heavens becomes cooler, and the weather follows suit. The winds begin to blow. This marks a period of change, when the yang, or active, phase shifts into its opposite, the yin, or passive, phase. One should go to bed at sunset and wake at dawn. Just as the autumn weather becomes harsher, the emotional atmosphere can also become more difficult. Therefore, it is essential to remain tranquil and at peace, avoiding feelings of sadness and depression so that the transition into winter can occur smoothly.

This is the season to collect one's spirit and energy, develop greater focus, and avoid letting desires become excessive. One should keep the energy of the lungs strong, pure, and calm. This involves practicing breathing exercises to strengthen lung qi. (Qi is defined as the vital energy or functional activity that helps the body maintain balance. Healthy lung qi is associated with processing loss, establishing boundaries, and letting go of what is no longer needed.)

Additionally, one should avoid smoking and excessive grief, which is the emotion associated with the lungs.

Following these practices helps prevent kidney or digestive difficulties during the winter. If this natural rhythm is disregarded, the lungs may be harmed, potentially leading to diarrhea with undigested food during winter. This weakens the body's ability to store energy during the winter season.

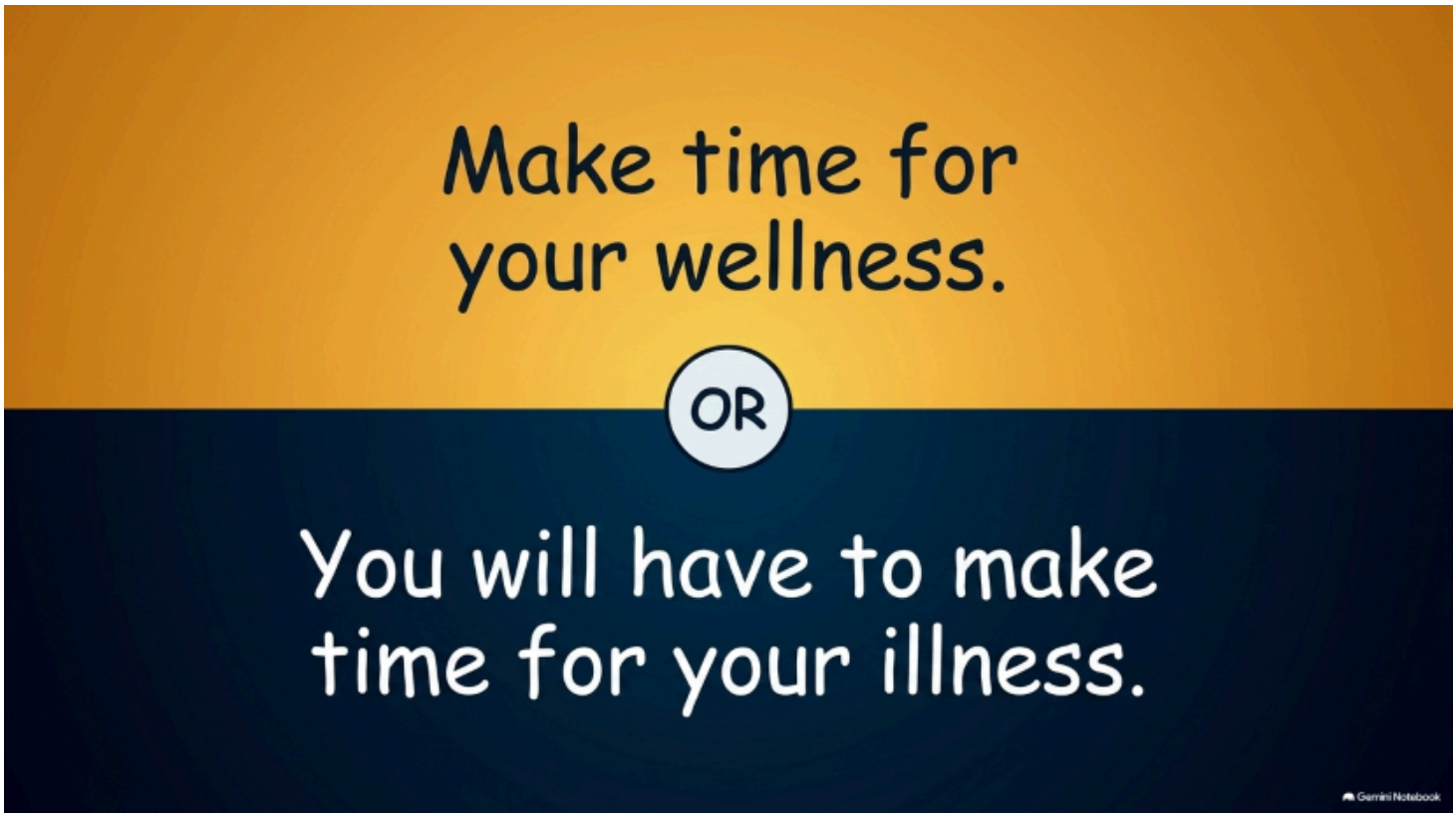
2 Minute Meditation:

Emotions can last about 90 seconds unless reinforced by a thought. Try this meditation for an emotional reset.

- Sit down and observe your breath. This is concentration.
- When your thoughts invade and you notice, this is awareness.
- When you come back to your breathing, this is letting go.
- Whatever happens you grow. Just do it.

Your concentration will grow, your awareness will grow, and so will the power of letting go.
You Always Win.

This 2 minute meditation can be used as a tool any time we feel stirred up, to recenter ourselves. Give ourselves permission to take care of our bodies for 2 minutes despite any external or work related pressures. A guilt free rest break.



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The Calcium Fixation

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