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Foundation News

The Microscopic Colitis Foundation continues to gather names of those interested in local support groups. Currently, individuals are spread out across the United States as well as in a few countries abroad. In addition to working towards establishing local support groups, the foundation will be featured in USA Today. Be on the lookout for the article in the upcoming Digestive Wellness publication!



**For your financial
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Microscopic Colitis
Foundation**

Why Don't I Have Any Energy?

Lack of energy is very common with microscopic colitis. It can be caused by several issues that are commonly associated with the disease.

- The immune system consumes a lot of energy dealing with the disease.
- Nutrient deficiencies can reduce available energy.
- Iron deficiency anemia can dramatically drain energy.

Why the disease itself depletes energy.

Healing is controlled by the immune system, and energy is consumed by the healing process. But when healing cannot proceed normally, it cannot reach completion in a timely manner. This results in a chronic condition of wasted energy. When MC is active,



new inflammation is being continuously regenerated by elevated antibody levels. Even after the food has been withdrawn from the diet, these antibody levels may remain elevated because of the half-life of the respective antibodies involved, or they may be elevated because of cross-contamination in the diet or undiscovered reactive foods in the diet that contribute new antibodies. But if the foods causing the inflammation are completely withdrawn from the diet, then their associated antibody levels will begin to decline, and eventually they will return to normal (unreactive) levels.

However there is another delay involved. Even when the antibody levels decline, the T cells that are triggered in response to the antibodies (T cells are the primary local cause of most of the inflammation in the intestines) tend to take a relatively long time to return to a normal population. As long as T cell populations are above normal levels, some degree of inflammation will remain, because inflammation is the first stage in the healing process. So as long as T cell populations remain elevated, there will be a continuing energy drain.

But the main cause of slow healing is intestinal damage caused by gluten, because the anti-gliadin antibodies resulting from exposure to gluten have a 120-day half-life. If a patient's anti-gliadin antibody level is unusually high when gluten is removed from the diet, it can take multiple years for the level to decay to normal. That can be easily verified by an IgA-based stool test such as those offered by EneroLab. The antibodies triggered by most other inflammatory foods have only about a 6-day half-life, so those antibody levels decay much, much faster than anti-gliadin antibodies, after those foods are withdrawn from the diet.

Nutrient deficiencies can reduce available energy.

Slow healing can also be amplified by deficiencies of vitamin D or magnesium. The immune system cannot function normally with a vitamin D deficiency because the active form of vitamin D is used by the immune system to suppress inflammation. And magnesium is an essential ingredient in the completion of many vital chemical processes that are necessary for the normal operation of the human body.

The malabsorption problem associated with MC causes a significant loss of energy by preventing normal absorption of nutrients in food. Malabsorption occurs not only because of the direct effects of the inflammation to limit absorption, but the rapid transit that commonly occurs when the disease is active does not allow sufficient time for normal absorption due to the short exposure time.

And finally, when MC is active digestion will usually be incomplete, so that many of the nutrients will not even be available in a form that can be absorbed. This occurs because the inflammation prevents the production of normal quantities of the enzymes needed to properly digest food. The digestion of carbohydrates is especially compromised.

Iron deficiency can severely limit energy, and can be difficult to correct.

Testing one's ferritin level is a good way to test for iron deficiency. There may not be enough iron in one's diet, resulting in iron deficiency anemia. Roughly 70 percent of the iron in the human body is in the form of a complex metalloprotein known as hemoglobin in red blood cells. Hemoglobin is used to transport oxygen into cells and red blood cells also

carry carbon dioxide out. So this basically determines the limits of energy production available to the body.

But if the number of red blood cells is below normal, this can cause anemia because not enough red blood cells are available to utilize the available iron.. Both vitamins B-12 and B-9 (folate) are necessary for the production of red blood cells (red blood cells are produced in bone marrow), so a deficiency of either vitamin can lower red blood cell numbers, resulting in anemia.

Boosting vitamin B-12 and folate levels is a relatively simple supplementation process. But boosting iron levels can be tricky because virtually all iron supplements tend to have adverse effects on the digestive system. Consequently, increasing one's iron level must be done slowly, so the process may take months to years to complete, in some cases.

In many cases, a combination of these problems may be present, so it's no wonder that low energy is a common complaint among MC patients. Some of these issues may be self-correcting as digestion improves and healing occurs, while others may require special attention. In particular, iron deficiency may require separate treatment.

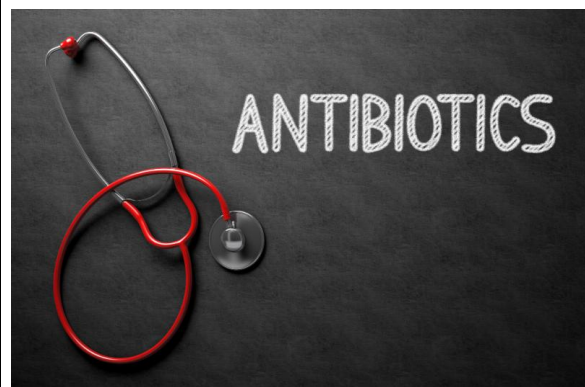
Did You Know That IBDs Are Regional Diseases?

Studies of medical statistics show that Crohn's disease and ulcerative colitis (UC) are typically found in the same geographic areas. And interestingly, microscopic colitis (MC) tends to be most common in areas where Crohn's and UC are seldom found.

In the United States for example, Crohn's and UC patients tend to be concentrated in the Northeast or North Central areas, and they are somewhat rare in some of the southern states. The distribution of MC patients is almost the opposite. MC is common in the Southwestern states, including California, and in other states across the South, especially Georgia and Florida.

The lack of correlation between the distribution of MC and the other IBDs suggests that the risk factors for the development of MC differ significantly from the risk factors for Crohn's disease and UC.

The Antibiotic Dilemma



For microscopic colitis patients, antibiotics present a dilemma. We know that most antibiotics can trigger an MC flare, and yet occasionally one of our doctors may tell us that we need to use an antibiotic in order to resolve an infection, which under some circumstances might possibly turn into a life-threatening situation if we fail to take that advice.

Of course it would be expecting too much to expect to find research that specifically addresses the use of any antibiotics (experimental or otherwise) to treat MC. But one or two decades ago, the use of various antibiotics to treat Crohn's disease

Eating When Traveling



Traveling during a flare-up can cause considerable anxiety and many Microscopic Colitis sufferers worry about eating while traveling. However, with prior planning, mealtime can be a positive experience while traveling. There are many ways that one can prepare beforehand to ensure gut-friendly meals.

- Before traveling, research restaurants in the nearby vicinity to your hotel. Many food establishments publish a menu online and are very happy to accommodate any special food requirements. In addition, call ahead to confirm that the restaurant can meet your needs.
- Create a written plan of food establishments for breakfast, lunch and dinner. Be sure to have a few back-ups.
- Pack and bring a carry-on with non-perishable snacks such as rice crackers and gluten-free pretzels. Semi-liquids like nut butters can be brought by packing in checked bags.
- If possible, book an efficiency room that offers the option to cook your own food rather than eating out for meals.
- Eat plain foods. Ask restaurants to cook your food in only olive oil and withhold spices, sauces and condiments. This allows you to control any added ingredients that can cause a flare-up.
- Do not try new foods. Although it may be tempting to eat Cajun food while visiting New Orleans, it can be a recipe

was studied. [Researchers compared](#) the effectiveness of different antibiotic treatment regimens and found that certain combinations of clarithromycin or azithromycin, rifabutin, and certain other therapeutic agents showed efficacy rates in the range of 58-82 % of Crohn's disease patients in some studies.

But these treatment regimens were mostly designed to treat Mycobacterium avium paratuberculosis (MAP) infections. MAP bacteria are responsible for the highly contagious disease known as Johne's disease in ruminants, including cattle and sheep. The symptoms of Johne's disease in ruminants are very similar to the symptoms of Crohn's disease in humans.

But that line of research has produced inconsistent results, and it has lost favor over the years. Researchers seem to have at least temporarily given up on trying to find a bacterial infection link with IBDs. And in this article we are more interested in using antibiotics for other reasons, and using them without triggering an MC flare.

According to the [Mayo Clinic](#), almost all antibiotics can cause antibiotic-associated diarrhea. But the types most commonly involved seem to be the cephalosporins, including cefixime and cefpodoxime and the penicillins, including amoxicillin and ampicillin.

And there are indeed studies that show that increased use of antibiotics is associated with a higher risk of developing IBD. Many authorities believe that the increased risk is due to the effects that antibiotics have on gut bacteria. [One study showed](#) that people who used the most antibiotic treatments had as much as a 50 % higher risk of developing Crohn's disease within 2 to 5 years.

For years, the fluoroquinolones, and particularly ciprofloxacin were thought to be MC-friendly. That is to say, they do not usually trigger an MC reaction. In fact, they almost always bring temporary remission for as long as they are used and

for disaster and not worth the possible aftermath.

Finding Support for MC



Microscopic Colitis can be a difficult and debilitating disease. Many individuals feel lonely and unsupported while trying to get symptoms under control. Although finding support can seem like a daunting task, it is crucial for maintaining emotional well-being.

- **Online Forum** Register for the online discussion forum [here](#). Even if you do not post, it can be comforting to read other's stories and know that you are now alone in your journey to achieving remission.
- **Facebook** Search and join online groups specifically for Microscopic Colitis. Facebook groups help to connect with others also suffering from the same condition when a face-to-face support group is not possible.
- **Local Support Groups** Ask your GI if he or she is aware of any local Inflammatory Bowel Disease (IBD) support groups. Also check local hospitals for possible support groups.
- **Read books on dealing with a chronic illness** It is surprising how much a book can impact and lift the spirit. Try books by Toni Bernhard such as *How to Live Well with Chronic Pain and Illness: A Mindful Guide*.

Did you know?

Donations to the Microscopic Colitis

possibly a few days longer. But unfortunately they have been found to carry serious risks of causing other health issues.

Over the years, the FDA has continued to add black box warnings to this class of drugs, ranging from the risk of tendonitis and torn ligaments, to tinnitus and even peripheral neuropathy. In fact, [the FDA](#) has gone so far as to say:

Because the risk of these serious side effects generally outweighs the benefits for patients with acute bacterial sinusitis, acute exacerbation of chronic bronchitis and uncomplicated urinary tract infections, the FDA has determined that fluoroquinolones should be reserved for use in patients with these conditions who have no alternative treatment options. For some serious bacterial infections, including anthrax, plague and bacterial pneumonia among others, the benefits of fluoroquinolones outweigh the risks and it is appropriate for them to remain available as a therapeutic option.

Antibiotic-associated diarrhea is not a risk that's specific to MC patients. The truth is, most people who use certain antibiotics are at risk of diarrhea as a side effect. But of course diarrhea as a side effect tends to be more concerning for IBD patients than for other patients because of the risk of a relapse of the disease.

[The Cleveland Clinic](#) offers some suggestions for preventing diarrhea while taking an antibiotic. What do they recommend? The use of a probiotic of course. But interestingly, they also note that people who have gastrointestinal issues should be especially careful with their diet while taking an antibiotic. For MC patients this might be taken to mean that it might be helpful to go back to a simple, basic recovery diet while taking an antibiotic, including limiting the intake of sugar, fiber, spices, and any other food ingredients that might cause inflammation,

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irritation, or other problems when MC is active. The goal of course is to prevent MC from becoming active. So it seems logical that adopting a recovery diet might be helpful for preventing a flare of the disease in response to antibiotic-induced diarrhea.

The bottom line is that unfortunately, there are no easy answers because the only class of antibiotics that once was thought to be safe for MC patients has been found to carry far too many serious side effect risks to be considered a safe antibiotic. Like all the others, it should be used only when a broad-spectrum antibiotic is definitely needed and no better option is available.

So perhaps the best course of action is to use an antibiotic only when it is really necessary. And if an antibiotic is necessary, adjusting one's diet to a form that minimizes the chances of inflammation or irritation should be helpful. And unless probiotics have already been previously found to cause an adverse reaction, adding a good probiotic to the treatment regimen and continuing to take it for at least 2 weeks past the end of the antibiotic treatment program may also be beneficial.

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