Microscopic Colitis Foundation

MICROSCOPIC COLITIS NEWSLETTER

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Some Insight into Using Medications to Treat Microscopic Colitis.

These days, when most people develop a health issue, they go to their doctor, get a diagnosis, and their doctor writes out a prescription for a medication to resolve their problem. Often, only a short-term treatment is needed, as in the case when an antibiotic is prescribed to treat an infection. But many health issues require continuing treatments, such as hypertension, or diabetes. Similarly, for many of us, microscopic colitis (MC) is an unrelenting problem, so it requires a continuing treatment. Unfortunately, unlike most other chronic syndromes, the most popular treatments prescribed to treat MC (the corticosteroids), are not generally practical for long-term use, despite the fact that they are so often prescribed to treat MC.

When they receive their diagnosis, a question on many MC patients' minds is, “Should I use a steroid such as budesonide to treat the disease, or is there a better choice?” Please note that all medical treatments for MC are temporary, that is, they are only effective as long as the prescribed drug is taken. Medical treatments do not provide a cure, because there is no known cure for MC. Note also, that there are no medications specifically labeled for treating MC. Because of this, all medications prescribed to treat MC are treatments that are labeled to treat Crohn's disease and ulcerative colitis, or some other health issue. Consequently, all medical treatments prescribed to treat MC, are off-label treatments.

The most popular treatment for MC appears to be Budesonide Controlled Release Capsules.
Budesonide is widely prescribed, and it's arguably the most effective medical treatment commonly prescribed for MC. But budesonide is a steroid (corticosteroid), so most gastroenterologists will only prescribe budesonide for several months, with possibly one or two prescription renewals. Some will allow longer-term use, but many MC patients would rather not do that, because of the long-term side effect risks. Published medical research shows that 85% of MC patients who benefit from budesonide, relapse after the treatment is ended. So on the second regimen of budesonide, some gastroenterologists will prescribe a transition to mesalamine, because it can be used on a long-term basis.

Because budesonide is a steroid, it cannot be stopped abruptly, unless the treatment has only been used for a relatively short period of time. Stopping abruptly after only a few months of use probably wouldn't cause any serious problems. But if budesonide has been used for 6 months or longer, ending the treatment too quickly can cause serious adrenal damage. That's why most doctors recommend a dose tapering schedule for ending the treatment, when they prescribe it.

Budesonide appears to suppress inflammation by suppressing mast cell numbers. It also helps to increase bile acid reabsorption in the terminal ileum. When a treatment is ended, mast cell populations rebound, and if the treatment is ended too quickly, mast cell populations tend to overshoot their normal population level, causing inflammation, and a relapse of symptoms. Because of that issue, even the tapering schedule recommended by gastroenterologists is often inadequate for properly ending a treatment. Their recommended tapering schedule will prevent possible adrenal damage, but often, it will not prevent a relapse of symptoms.

Properly tapering the dose when ending a treatment, is critical for preventing a relapse.
A common budesonide treatment regimen recommended by gastroenterologists is one month of taking 3 capsules (9 mg) daily, two weeks of taking 2 capsules (6 mg) daily, and two weeks of taking 1 capsule (3 mg) daily. We suggest that this tapering process should be carried much further, by taking 1 capsule every other day for a couple of weeks, followed by taking 1 capsule every third day for a couple of weeks, at the very least. Many MC patients find that it helps to carry this process even further, by taking 1 capsule every fourth day for a couple of weeks, then taking 1 capsule every fifth day for a couple of weeks, and some even carry it out to taking 1 capsule every sixth day for a couple of weeks or more.

The way budesonide is taken, is very important.
Budesonide supplements the cortisol that's naturally produced by the adrenal glands. Because cortisol levels normally peak first thing in the morning, budesonide should be taken first thing each morning. It can be safely taken on an empty stomach. The full treatment should be taken all at once, not spread out during the day. And it should be taken with enough water to ensure that it can be properly absorbed. Taking budesonide on some other schedule is not unsafe, but taking the full dose first thing each morning, maximizes the effectiveness of the treatment.

Corticosteroids lose effectiveness every time a treatment is restarted.
If budesonide treatments are ended and then restarted, please note that each time a budesonide treatment is restarted, the drug becomes slightly less effective, for most patients, and eventually, with repeated treatment cycles, it will no longer be effective. As long as the treatment is not completely stopped, budesonide will retain its effectiveness, even when taken at a very low rate, such as one 3 mg capsule every five or six days.

Regardless of our current treatment choice, if we find ourselves in a flare, and we need relatively quick relief from the symptoms of MC so that we can enjoy an important event, such as going on a cruise, a treatment regimen with budesonide is probably the fastest, most effective way for most of us to get to remission.

The long-term side effect risks of budesonide include osteoporosis, and various physiological, and sometimes neurological problems, but the risk of osteoporosis can be minimized by strictly avoiding gluten at all times, and taking enough supplemental vitamin D and magnesium to prevent any deficiencies.

Mesalamine is a non-steroidal, anti-inflammatory treatment option.
A treatment with mesalamine usually requires more time (compared with budesonide) before it becomes effective, and for some patients, it causes hair loss. For these reasons, together with the fact that it's not as effective as budesonide for most patients, mesalamine is not as popular for treating MC as it was before budesonide was approved by the FDA. And mesalamine-based drugs are derivatives of NSAIDS, so they may eventually cause some MC patients to begin to react against them.

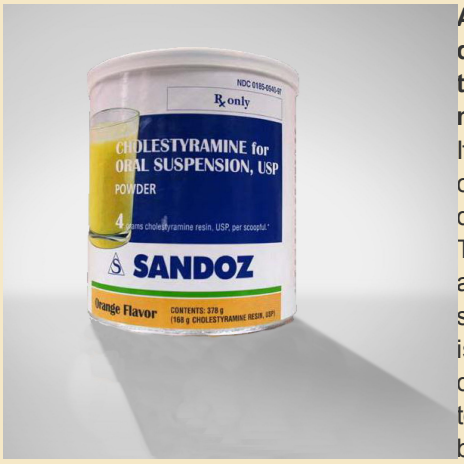
Another option for treating MC is known as the Pepto treatment.
Pepto-Bismol has mild antibiotic properties, and it leaves a soothing, protective coating over the lining of the intestines. The Pepto treatment was shown to be effective for over 90% of the patients in a treatment trial. However, this trial only involved thirteen patients, one of which dropped out before the trial was ended. The treatment consists of eight Pepto-Bismol tablets, or the liquid equivalent, daily, for eight weeks. For many MC patients, this treatment will bring remission in less than two weeks, but unless a gluten-free (GF) diet is followed, there may be a relapse of symptoms after the treatment is ended.

This treatment is no longer recommended by Dr. Kenneth Fine, the researcher who first developed it over 30 years ago, because of a slight risk that some people may experience a buildup of bismuth subsalicylate in their body, that can trigger neurological issues. Dr. Fine points out that the GF diet will bring remission in most cases, without the use of the Pepto-Bismol. The Pepto-Bismol merely shortens the time required to reach remission.

Imodium may be beneficial in many situations, before remission is attained.
Imodium, or the prescription generic form, loperamide, slows motility. It will not help to suppress the inflammation, but it will usually help to minimize the urgency, and delay the need for a trip to the bathroom, when a patient needs to leave home for shopping, or to run some other errands. It's a relatively safe medication, and it will not interact with other medications that are currently being taken. Up to eight capsules per day can be safely taken, if needed, but taking more than needed may cause constipation symptoms.

Lomotil is a prescription medication that works similarly to Imodium.
Although it's claimed to be more effective than Imodium, patient experience doesn't appear to bear that out, in actual usage. This medication is a combination of an antidiarrheal, diphenoxylate, and atropine. Diphenoxylate has narcotic attributes that tend to slow motility. Atropine is an anti-cholinergic that helps to dry up body fluids and slow motility. But because diphenoxylate has characteristics similar to opioids, it carries a significant addiction risk. Therefore, when ending a treatment, tapering the dose before stopping it completely, may be necessary in order to prevent withdrawal symptoms. Short, normal treatments probably won't require this precaution, but longer treatments, and higher doses, may require tapering the dose when ending a treatment.

Atropine is also an involuntary nervous system blocker.
An overdose of atropine tends to cause symptoms of agitation, dilated pupils, dry mucous membranes, dry skin, overactive bowel sounds, tachycardia, and possibly other generally-unpleasant symptoms. No more than four doses of Lomotil should be taken in any 24-hour period. Obviously, the atropine is added primarily to prevent patients from taking overdoses of diphenoxylate.



According to research, 40% of cases of diarrhea that are refractive to conventional treatments, are due to bile acid malabsorption (BAM).
If BAM is the problem, treatments with cholestyramine will usually resolve the diarrhea, if the optimal dose is used. Treatments using cholestyramine early on in an MC recovery program, usually will not be successful, due to unresolved food sensitivity issues. But if extensive efforts to control the diarrhea by carefully selected safe foods fails to resolve the diarrhea, and sufficient time has been allotted for healing, the remaining problem is often BAM.

The optimal dose of cholestyramine will have to be determined by trial and error, because too little will not provide control, while too much may cause cramps and constipation. And the timing of doses relative to meals will also influence its effectiveness.

Most MC patients seem to have the best success using the Sandoz brand of cholestyramine, but regardless of the brand you select, be sure you read the ingredient list and make sure that it doesn't contain any of your food sensitivities. Using packets, or sachets, is more convenient than loose powder, for most patients.

Finding the best dose may take time and effort, but the benefits are well worth the effort. Don't give up prematurely, because some MC patients have needed up to eight packets per day, in order to completely resolve the diarrhea. Be sure that you take all medications and supplements at least one or two hours before, or three of four hours after, taking the cholestyramine, so that it does not sequester them, causing you to lose their benefits.

Some MC treatments suppress the immune system.

Probably the two biggest issues with the use of most of the prescription drugs that are commonly prescribed to treat MC, are side effects, and their tendency to suppress the immune system after continued use. Most people will have a suppressed immune system after about a year of treatment with budesonide, for example. Other steroid treatments, such as prednisone, usually suppress the immune system much sooner, and have significantly worse side effects. Alternative treatments such as mesalamine, Pepto-Bismol, or any of the other anti-inflammatories that are not steroids, will not significantly suppress immune system function.

But budesonide has been given a free pass regarding COVID-19.
Despite the fact that it tends to suppress the immune system, researchers have concluded that budesonide does not increase the risk of complications, or disease severity, when treating COVID 19. In fact, some research has shown that budesonide may provide benefits during COVID 19 treatment. Of course, as is pointed out in the stated conclusions in virtually every research article, these results are only preliminary, and more research is needed.

Last-resort treatments include the immune system suppressants.
When nothing else works, the treatment of last resort is arguably the use of an immune system suppressant. For MC patients who are refractive to treatments with conventional anti-inflammatory medications, gastroenterologists are beginning to increasingly prescribe one of the so-called biologics. The drugs in this category are powerful immune system suppressants. Before the biologics were developed, gastroenterologists sometimes prescribed immune system suppressants of the type used after organ transplants, to prevent the patient's body from rejecting the transplanted organ. Imuran

(azathioprine) was popular for this use, and it (and other drugs in this class) were sometimes prescribed to MC patients who did not respond to conventional treatments.

Like all medical treatments for MC, an immune system suppressant will not always provide effective control of all MC symptoms, for all patients, although some MC patients are able to get good control with certain drugs. But be aware that all the drugs in this class significantly increase the patient's risk of many potential adverse events.

Suppressing one's immune system opens the door to the risk of infections, and various diseases, including cancer.
Currently, for example, immunocompromised patients are presumably in the riskiest category, regarding the odds of a fatal outcome after exposure to one of the coronavirus variants. And unfortunately, the vaccines typically provide relatively little protection against the COVID variants for patients who have a compromised immune system. But for patients who are diagnosed at a relatively young age, if medical treatments are the desired choice for controlling the symptoms of this disease, then the biologics appear to offer the best hope for providing long-term control.

Virtually all new treatments developed for treating IBDs appear to fall into this category.
Currently, the selection of treatment options available to provide immune system suppression specifically for IBD's, appears to be increasing faster than any other types of treatments. Many of these are used to treat a wide variety of autoimmune diseases. Most of the newly developed treatments are referred to as biologics. These are specially modified proteins that target various specific parts of the immune system that fuel inflammation. There are already many choices available to patients, and surely there are many more in development.

Biologics appear to be a permanent treatment choice, once selected.
Studies show that over half of all patients who stop using an anti-TNF biologic are unable to maintain remission for longer than two years, and that number decreases with time. And similar to using corticosteroids, when a treatment using a biologic is restarted, it will tend to be less effective, each time it's restarted. Some patients' immune systems even begin to produce antibodies against the drug, that may lead to adverse reactions against the drug. Because of these issues, it's generally recommended that once a treatment using a biologic is started, it should never be stopped.

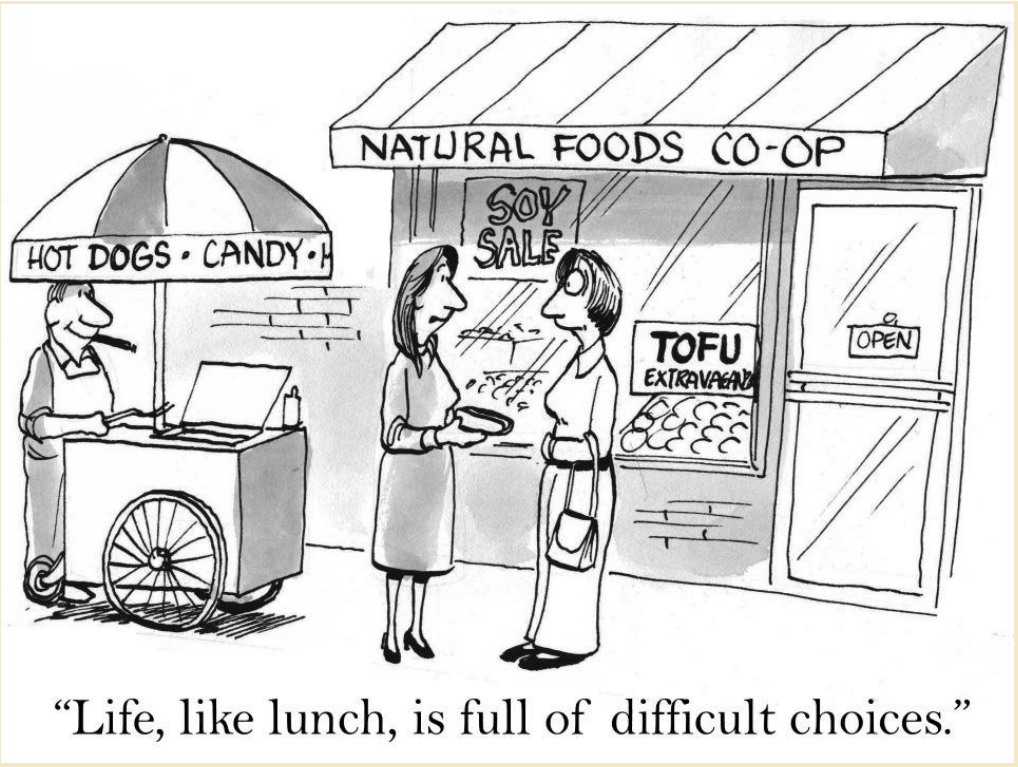
Choosing a treatment option such as this has such far-reaching implications, that it obviously requires careful consideration. But we're all in different circumstances, so it will have to be a personal decision based on our individual, unique lifestyle. Normally, the biggest issue with immune system function suppression is an increased risk of infection or disease. It could be argued that the benefits of the treatment outweigh the risks.

But today, we live in an increasingly hostile world environment.
With the world in a pandemic, that will probably last for years, maybe generations, that arguing point has lost much of its logical integrity. Choosing to use a drug that will suppress our immune system will obviously create a very serious risk of infection by many of the coronavirus variants. For many of us, that would be an unacceptable risk, because finding ourselves left virtually defenseless against a virus that has proven to be not only cruel and highly infectious, but deadly, has little appeal, to say the least.

The alternative to medications, and the safest way to control MC, is by making the appropriate diet changes.
There are no side effect risks associated with treating MC by using diet changes, and there are no long-term health risks associated with using this option. Few of us enjoy having to give up many of our favorite foods, but as is sometimes the case in life, when we're forced to make a choice between two evils, it behooves us to select the lessor of the two evils. For most of us, because this is a lifelong issue, the risk/reward ratio makes selecting treatment by diet a much better choice, than using medications. But this is a personal decision that each of us must make, because we're stuck with microscopic colitis for the rest of our lives, and each of us lives in our own particular set of unique circumstances.

As a closing thought, consider the digestive aid products, such as GlutenEase.
These are enzyme supplements, rather than medications, and there are several brand options on the market. They can be beneficial when eating at fast food restaurants, or any time we're eating someone else's cooking. They can be especially helpful for those of us who are using only diet changes to control our MC, and we plan to eat one or more meals away from home.

Most of these products claim that they will allow the user to “safely digest” gluten, and some of them include casein in that claim. Please don't assume that they will allow you to throw caution to the wind, and eat a normal meal that contains gluten and casein, without repercussions. You would be very disappointed. That said, taking a capsule before eating a meal that's claimed to be gluten-free and dairy free, should protect you if that meal happens to be cross contaminated with traces of gluten and casein. The products don't offer perfect protection, but if you do have any symptoms after a meal, they should be very minor. Note that these products typically won't protect against cross-contamination with soy, for those of us who are sensitive to soy.



"Life, like lunch, is full of difficult choices."