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 attain remission.

PART 4

Putting It All Together

by Wayne Persky

The Current State of MC Treatment

The official medical treatment policies for microscopic colitis (MC) have remained frustratingly stagnant over the past two decades. Unlike the significant advances seen in treating Crohn's disease and ulcerative colitis, MC patients face essentially the same treatment options today as they did 15-20 years ago. This lack of progress stems from several factors: the disease's misleading reputation as "benign" (despite significantly impacting quality of life), limited commercial incentive for pharmaceutical development, and the fact that initial treatment with budesonide works well enough for many patients—at least temporarily.

Budesonide remains the cornerstone

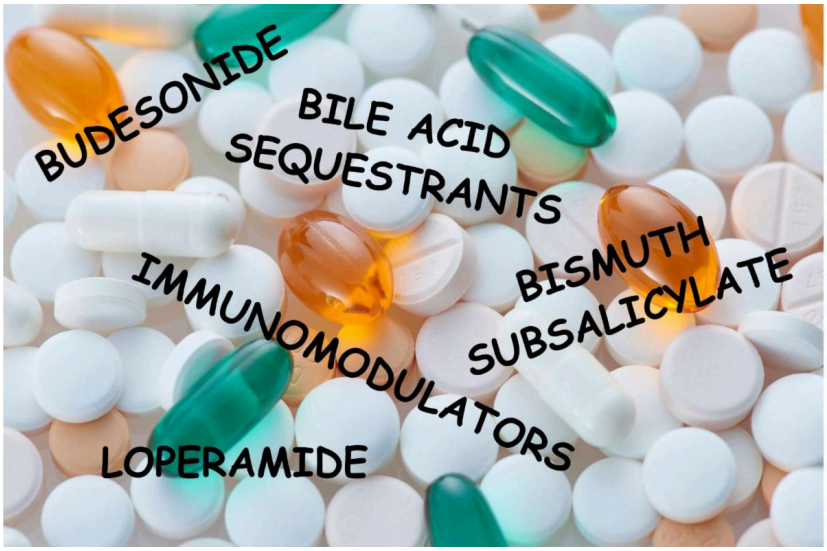
of medical treatments for MC. This corticosteroid works by suppressing inflammation, primarily by reducing mast cell activity. The standard protocol involves:

- An initial treatment of 9 mg daily for 6-8 weeks
- A success rate of 70-80% achieve remission initially
- But the catch is that 40-80% relapse after stopping treatment

For those who relapse, maintenance strategies involve lower doses (3-6 mg daily, or 3 mg every other day), which can keep 70-80% of patients in remission. However, long-term budesonide use requires monitoring for potential adverse side effects on bone density, glucose metabolism, and eye health (cataracts).

> **Not much progress in the past 10 years.**

> **Budesonide remains the frontline treatment.**



Supporting medications include:

- Bile acid sequestrants (cholestyramine, colesevelam, and colestipol) for the approximately two-thirds of MC patients with concurrent bile acid malabsorption
- Loperamide for managing urgency and reducing bowel frequency
- Bismuth subsalicylate, although Dr. Kenneth Fine (who pioneered its use for MC) no longer recommends it due to accumulation risks and potential neurological complications

For refractory cases, immunomodulators (azathioprine, 6-MP) or biologics (anti-TNF agents, vedolizumab) may be tried, though evidence remains limited. Surgery is extremely rare and reserved only for severe, treatment-resistant cases.

Why Nearly Half of Patients Struggle.

A landmark 2025 European study (PRO-MC collaboration) revealed sobering statistics from 5-year follow-up data:

- Only 6% remained symptom-free without treatment
- 54% achieved remission after initial treatment
- 33% relapsed after remission
- 7% had chronic active disease requiring continuous therapy

Combined, nearly 40% of MC patients face ongoing or relapsing symptoms, despite available medications. This reality underscores why alternative treatment approaches are essential.

The Dietary Solution for the 40%

For the significant portion of patients who can't achieve stable remission with medications, or who prefer not to take lifelong drugs, dietary modification offers a proven path to remission. However, this approach requires patience, as intestinal healing proceeds slowly, often taking months or even years.

How Food Sensitivities Develop:

MC causes intestinal inflammation that breaks down the tight junctions between epithelial cells, creating "leaky gut." This allows incompletely digested protein peptides to enter the bloodstream, where the immune system recognizes them as foreign invaders and produces antibodies against them. Subsequent exposure to these proteins triggers inflammatory responses that perpetuate the disease.

The Most Common Food Sensitivities:

Based on patient data, the "Big 4" food sensitivities affecting the most MC patients are:

1. Gluten (nearly universal)
2. Casein (over two-thirds of patients)
3. Soy (over half of patients)
4. Eggs (over half of patients, specifically egg white/albumin)

Additional sensitivities to almonds, cashews, walnuts, beef, chicken, pork, corn, rice, and nightshades are somewhat common but typically less problematic. It's important to note that a negative celiac test does NOT rule out gluten sensitivity. Many gastroenterologists mistakenly tell MC patients they can eat gluten based solely on negative celiac screening—this is incorrect, as non-celiac gluten sensitivity cannot be officially diagnosed but is extremely common in MC.

The Two-Phase Dietary Approach:

Phase 1: Elimination Diet (Achieving Remission)

- **Safe proteins**, such as turkey, quail, duck, goose, lamb, venison, rabbit, shellfish (shrimp, crab, lobster, clams, mussels)
- **Safe vegetables**: Carrots, squash, green beans, kohlrabi, rutabagas, turnips, parsnips, sweet potatoes, yams

During recovery, avoid:

- All "Big 4" foods (gluten, dairy, soy, eggs)
- High-fiber foods
- Raw foods and salads
- Fruits (high fructose, fiber, and citric acid)
- Spicy foods, onions, hot peppers
- Cruciferous vegetables if gas is problematic
- Restaurant dining (32% of "gluten-free" restaurant meals are cross-contaminated)

Phase 2: Careful Reintroduction (After Remission)
Once stable remission is achieved, test foods one at a time:

- Day 1: Small portion
- Day 2: Slightly larger portion (if no reaction)
- Day 3: Normal portion (if still no reaction)

If a reaction occurs at any point, eliminate that food and wait 1-2 weeks before testing another food.

Critical Success Factors:

1. **Don't rush. Healing takes time. Research shows chronic inflammation damages intestinal stem cells, dramatically slowing healing capacity.**
2. **Don't trust favorite foods in Phase 1. The foods you trust most are often the ones causing reactions.**
3. **Prioritize remission over nutrition. Worry about balanced nutrition after you're absorbing nutrients properly.**
4. **Be patient with yourself. Complete intestinal healing can take 5-10 years in older patients.**
5. **Accept that variety must come later. Stick with simple, safe foods during Phase 1, and add variety only after achieving remission.**

Combining Approaches for Faster Results:

Many patients find success using budesonide to achieve rapid initial remission (within days to a week) while simultaneously implementing dietary changes. Once the diet is established and working, budesonide can be tapered and discontinued, with the diet maintaining remission indefinitely, unless bile acid malabsorption requires ongoing management with bile acid sequestrants.

> **Dietary modifications can work.**

> **While each person is different, there are some common guidelines.**

The Path Forward

Despite the frustrating lack of pharmaceutical progress, MC patients have two viable paths to remission:

1. **The medical route works for approximately 60% of patients willing to accept long-term medication use, with its associated monitoring requirements and potential side effects.**
2. **The dietary route requires more effort and lifestyle adjustment but offers medication-free remission for most who commit to it, which is particularly important for the 40% who cannot achieve stable remission with drugs alone.**

The choice isn't always either/or. Many patients use medications strategically during flares while relying primarily on diet for long-term management. The key is understanding that MC, while challenging, is controllable—and that control is possible whether through medication, diet, or a combination of both approaches.

What matters most is not giving up hope and finding the approach that works for your individual situation, symptoms, and lifestyle. As thousands of MC patients have demonstrated, remission is achievable, and a return to normal life is possible.

Additional Alternative and Complementary Treatment Strategies:

Beyond the standard medical and dietary approaches, several evidence-based complementary treatments can support MC management. These aren't replacements for primary treatment but can address underlying deficiencies, reduce inflammation, and support healing — particularly for patients who struggle to achieve or maintain remission.

Essential Nutritional Support:

Restoring depleted magnesium reserves:
MC patients frequently develop magnesium deficiency due to chronic diarrhea, malabsorption, PPI use, and age-related decline. This deficiency exacerbates fatigue, muscle cramps, poor sleep, irregular motility, and reduces vitamin D absorption — all of which can worsen MC symptoms.

Key points:

- Choose magnesium glycinate or magnesium malate (magnesium oxide absorbs poorly at only 4%).
- Correcting deficiency often improves stool consistency, sleep quality, and inflammation tolerance.
- Standard serum magnesium tests are unreliable; RBC magnesium provides a more accurate assessment.
- Many patients require 300-400 mg daily of elemental magnesium.

Vitamin D Optimization:
Vitamin D functions as a critical regulator of immune tolerance, tight-junction integrity, T-regulatory cell function, and mucosal immunity. Research shows IBD patients (including those with MC) often have low vitamin D during flares, and improved levels correlate with reduced inflammation and better treatment response.

Important considerations:

- Many adults over 50 need 4,000-6,000 IU daily to maintain optimal levels.
- Target range for autoimmune control: 50-80 ng/mL (125-200 nmol/L).
- Vitamin D deficiency substantially slows intestinal healing.
- Adequate magnesium is required for proper vitamin D metabolism.

MC increases the risk of B12 deficiency more than most doctors realize.
Most GIs say, “MC affects the colon, not the ileum (where most B12 is absorbed), so B12 should be normal.” This is simply incorrect.

- B12 deficiency makes MC harder to control, more severe, and slower to heal.
- It also worsens MC related fatigue, brain fog, and weakness.
- B12 deficiency worsens MC by disrupting mucosal repair.

Microscopic colitis is fundamentally a mucosal barrier injury plus immune activation problem. If B12 is low, the gut lining cannot repair itself properly, which leads to:

- longer or more frequent flares
- impaired response to diet changes
- persistent inflammation

- slower recovery even with budesonide

This is one reason some MC patients say, “I improved but can’t seem to get all the way back to normal.” B12 deficiency can make MC worse in many additional ways, but a detailed discussion of that information takes up a lot of space, and since this article is very long already, if you would like to read all the details of how B12 deficiency can negatively affect MC, you can read those details on the Microscopic Colitis Foundation website at the following link:

https://www.microscopiccolitisfoundation.org/important-nutrients.html

Addressing Concurrent Autoimmune Conditions

Thyroid Disorders (Especially Hashimoto's):
MC has one of the strongest autoimmune-overlap profiles with Hashimoto's thyroiditis. Hypothyroidism slows gut motility and intestinal repair, and poor thyroid control often means poor MC control—flares of one autoimmune condition frequently destabilize the other.

Recommended screening includes:
- TSH, Free T4, Free T3
- TPO antibodies
- Reverse T3 if symptoms persist despite normal TSH

Proper thyroid management often significantly improves stool stability and immune balance in MC patients.

Optimizing Bile Acid Management:
Many patients who "fail" budesonide or dietary approaches actually have untreated or undertreated bile acid malabsorption (BAM). Since BAM affects approximately two-thirds of MC patients, more aggressive management can be crucial.

Enhanced BAM management strategies:
- Combine bile acid sequestrants with a low-fat diet (even 5-10 grams of fat can trigger symptoms in severe BAM)
- Take cholestyramine, colesevelam, or colestipol at least 4 hours before, or 2 hours after eating
- Recognize that BAM may be secondary to inflammation and can improve as healing progresses
- Start with low doses and increase gradually to minimize side effects

Targeted Probiotic and Postbiotic Support:
Not all probiotics help MC—some may worsen symptoms. However, specific strains show consistent benefit in research and patient experience:

Most supportive evidence:
- *Bifidobacterium infantis* 35624 (brand name: Align)
- *Lactobacillus plantarum* 299v
- *Saccharomyces boulardii* (especially helpful for antibiotic-triggered or post-infectious MC)

Postbiotic approaches:
- Butyrate supplementation (oral or enema form) supports colonocyte health.
- Heat-killed Lactobacillus strains that reduce mucosal inflammation without colonization risks.

Note that these are not cures, but properly selected strains may reduce inflammation, improve barrier integrity, and support the healing process.

Managing Histamine-Related Flares

Many MC patients unknowingly flare from histamine overload due to gut dysbiosis, impaired DAO (diamine oxidase) enzyme production, DAO-blocking medications, or consumption of high-histamine foods.

Symptoms suggesting histamine involvement:

- Sudden watery diarrhea after certain meals (high histamine meals)
- Excessive gas and bloating
- Facial flushing or skin itching
- Sleep disturbances
- Vertigo or lightheadedness

Management options:

- Trial of low-histamine diet (typically 2-4 weeks)
- DAO enzyme supplements taken before meals
- Avoiding histamine-liberating foods (citrus, tomatoes, spinach, aged/fermented foods, alcohol)
- Reviewing medications that inhibit DAO activity
- See additional suggestions in the next section

Antihistamines and Mast-Cell Stabilization

Growing evidence shows that mast-cell activation plays a key role in microscopic colitis. Mast cells release histamine, tryptase, TNF-α, interleukins (IL-6, IL-13), and other inflammatory mediators. These substances worsen intestinal permeability, stimulate chloride secretion (causing watery diarrhea), and perpetuate immune system activation.

Many MC patients (especially those whose symptoms are triggered by foods, stress, or medications) show a clinical pattern identical to histamine intolerance or mast-cell–driven inflammation. This is why antihistamines can significantly reduce flare frequency and severity for a subset of patients.

Types of Antihistamines That May Help MC Patients:

H1-antihistamines (H1-receptor antagonists):

These reduce symptoms such as diarrhea urgency, cramping, gas, bloating, sleep disturbances, and anxiety (histamine is a neurotransmitter). The best options are:

- Cetirizine (Zyrtec)
- Fexofenadine (Allegra)
- Loratadine (Claritin)
- Diphenhydramine (Benadryl) — for short-term or nighttime use only

H2-antihistamines (H2-receptor antagonists):

These reduce histamine-driven gastric secretion and can improve upper-GI irritation, esophageal hypersensitivity, and post-meal urgency. Common H2 blockers include:

- cimetidine (Tagamet)
- Famotidine (Pepcid) — preferred
- Nizatidine (Axid)
- Ranitidine (Zantac) was also a common example, but it has been withdrawn from the U.S. market due to concerns over contamination by a carcinogen)

Patients often tolerate combined H1 + H2 therapy well, similar to protocols used in mast-cell activation disorders.

Mast-Cell Stabilizers

These reduce histamine release, not just histamine action. Options include:

Cromolyn Sodium (Gastrocrom)

- Blocks mast-cell degranulation
- Reduces histamine release
- Has helped many MC patients with food-triggered flares
- Must be taken with meals
- Prescription only
- Very safe long-term

Quercetin (natural flavonoid)

- Over-the-counter mast-cell stabilizer
- Reduces IL-6 and TNF-α
- Helps many with histamine-driven symptoms
- Works synergistically with vitamin C

Vitamin C

- Helps degrade histamine
- Supports mast-cell stability

Boswellia

- Anti-inflammatory with mast-cell–stabilizing properties
- Evidence of benefit in UC, anecdotal benefit in MC

The above treatment options are particularly effective in patients with:

- Food-triggered flares
- Stress-triggered flares
- Seasonal/warm-weather worsening
- "Allergic diarrhea" patterns
- Coexisting histamine intolerance
- High IgE levels or atopic history

Why Antihistamines Work for MC

They target MC at one of its upstream root mechanisms:

Mast cells drive inflammation.
Budesonide works largely by suppressing mast cells. Antihistamines and mast-cell stabilizers accomplish this more selectively.

MC often behaves like mast-cell activation disorders.
Many MC flare triggers mirror mast cell activation syndrome (MCAS) triggers, including alcohol, aged foods, fermented foods, stress, infections, NSAIDs, heat or exercise, and high-histamine foods.

Histamine increases intestinal permeability.
Blocking histamine helps the gut barrier reset and reduces diarrhea.

Coexisting histamine intolerance is common.
Especially in patients with low DAO enzyme activity, SIBO, dysbiosis, or long-term PPI use.

This helps explain why an elimination diet works.
Reducing the histamine load dramatically reduces mucosal immune activation.

When Antihistamines Are Most Useful:
Antihistamine therapy is particularly helpful for MC patients whose symptoms flare in response to foods, stress, medication changes, or seasonal allergies—patterns that strongly suggest mast-cell involvement.

Relapses that occur when a budesonide treatment is ended often occur because of a mast cell population rebound — especially when a budesonide treatment is ended abruptly, or too soon. Taking a daily antihistamine for a couple of weeks when ending a budesonide treatment can often prevent a relapse of MC symptoms.

Evidence-Based Anti-inflammatory Supplements

While anti-inflammatory supplements cannot replace primary treatment, certain compounds show promise as supporting therapy:

- **Boswellia serrata** demonstrated effectiveness comparable to mesalamine in some ulcerative colitis studies due to its relatively strong mast-cell stabilizing properties (as noted above)
- **Curcumin** (turmeric extract) is a potent NF-κB inhibitor that enhances tight-junction proteins — (An **NF-κB inhibitor** is a substance that blocks the signaling pathway of the transcription factor Nuclear Factor-κB (NF-_B), preventing it from entering the nucleus and activating genes involved in inflammation, cell survival, and immunity
- **Quercetin** is a natural mast-cell stabilizer that reduces inflammatory cytokines (IL-6, TNF-α) implicated in MC
- **Omega-3 fatty acids** support mucosal healing and reduce systemic inflammation (typical dose: 2-3 grams EPA/DHA daily)
- **Zinc carnosine** improves mucosal repair and reduces intestinal permeability

These supplements work best as part of a comprehensive treatment plan, not as standalone solutions.

Stress Reduction and Autonomic Nervous System Balance

MC flares frequently correlate with major stress events, poor sleep, and autonomic imbalance. Stress triggers mast-cell activation, and cortisol dysregulation worsens inflammation — research shows strong

connections between trauma/chronic stress and inflammatory conditions.

Evidence-supported stress-reduction approaches:

- Meditation and mindfulness practices (shown to lower inflammatory cytokines)
- Heart rate variability (HRV) training
- Vagal nerve stimulation through natural methods: slow deep breathing, humming, singing, cold exposure
- Adequate sleep (7-9 hours nightly)
- Regular gentle exercise as tolerated

Comprehensive Medication Review

For some patients, MC can enter remission simply by eliminating triggering medications. A thorough medication review should be standard practice.

Most common drug triggers:

- Proton pump inhibitors (PPIs) have some of the strongest associations with MC.
- NSAIDs can trigger or worsen MC.
- SSRIs and SNRIs are well-documented MC triggers.
- Statins, ticlopidine, and beta-blockers are less common, but documented triggers.
- Metformin can cause osmotic diarrhea mimicking or worsening MC.

Work with prescribing physicians to find medically safe alternatives, as discontinuing the offending medication may resolve MC entirely in some cases.

Post-Infectious and Antibiotic-Associated MC

A significant subset of patients develops MC following infections or antibiotic exposure — triggers include *C. difficile*, norovirus, COVID-19, food poisoning, or broad-spectrum antibiotic courses.

These cases often benefit from:

- Short-term budesonide (6-8 weeks) to break the inflammatory cycle
- *Saccharomyces boulardii* probiotic (particularly after *C. diff* or antibiotic exposure)
- More aggressive attention to dietary triggers post-infection
- Enhanced magnesium and vitamin D support during recovery

Emerging and Experimental Approaches

While still under investigation, several promising therapies are under study:

- **Fecal microbiota transplantation (FMT):** Limited studies suggest potential benefit for MC, particularly in cases with severe dysbiosis or recurrent C. difficile. Data remains minimal (and sometimes inconsistent), and this should be considered experimental.
- **Targeted biologic pathways:** Research into IL-22 modulators, JAK inhibitors, and oncostatin-M (OSM) pathway blockers may eventually produce targeted therapies specifically for MC, though these remain in research stages.
- **Microbiome-based precision therapy:** Early-stage research into customized microbiome interventions shows conceptual promise but requires much more study.

Integrating Complementary Approaches:

These alternative treatments work best when thoughtfully integrated with primary medical or dietary management. The goal is to:

1. Correct underlying deficiencies (magnesium, vitamin D) that impair healing.
2. Address concurrent conditions (thyroid dysfunction, BAM) that worsen MC.
3. Support immune regulation through appropriate supplements and stress management.
4. Eliminate contributing factors (trigger medications, histamine overload).
5. Enhance healing capacity through targeted nutritional and probiotic support.

Remember that what works for one patient may not work for another. These complementary approaches should be introduced systematically, one at a time, so you can assess their individual effectiveness. Always discuss significant supplement additions or medication changes with your healthcare provider, particularly if you're taking other medications or have additional health conditions.

In conclusion, the key is building a personalized, multi-faceted approach that addresses your unique situation — combining the treatments that work best for you while avoiding the trap of trying everything at once, which makes it impossible to determine what's actually helping.

Check Out Wayne's Blog

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.

How the Gut Modulates the Development of Inflammation

How Do Gastroenterologists View Elimination Diets?

How Common Is "White Coat Syndrome"?

Avoiding Dangerous Medications

Announcing Our New App: "Search the MC Forum Using AI"

The MC Discussion and Support Forum has been in existance for 20 years, and has accumulated around 211,000 posts on a host of topics. It is a terrific source of information, news articles, research, and lifestyle help.

Use AI to search this database for answers to your questions about living with MC.

Download for Android phones:
https://play.google.com/store/apps/details?id=com.mcf.searchapp

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*** The availability of the iPhone app in England and Europe was delayed because of extra time needed for approval. If you couldn't download earlier, try again.

We would appreciate getting feedback about your experiences, and any suggestions for improvement.

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