JOLIMONT ENDOSCOPY

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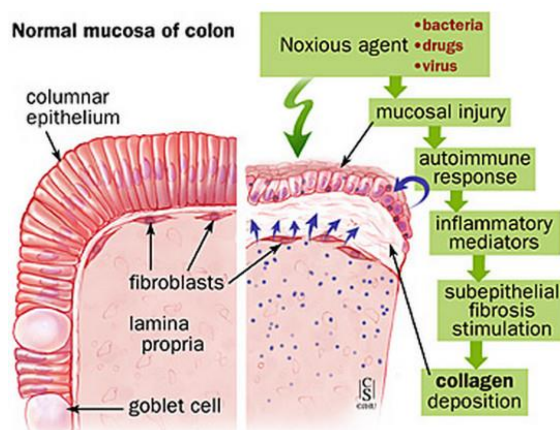
QUARTERLY NEWSLETTER
October 2016

# MICROSCOPIC COLITIS

Microscopic colitis is a chronic inflammatory disease of the colon that is characterized by chronic, watery diarrhea. Based on the histological features, microscopic colitis is divided into lymphocytic and collagenous colitis. This condition highlights the need for high quality endoscopy with multiple biopsies, as 40% of cases of collagenous colitis would be missed if only recto-sigmoid biopsies are taken. Biopsies should be obtained from the right side of the colon as the severity of histologic changes declines from the proximal (right) to the distal (left) colon.

The pathogenesis of microscopic colitis is unclear, but it is likely to be multifactorial, involving mucosal immune responses to luminal factors in a genetically predisposed individual. Microscopic colitis has been associated autoimmune conditions including coeliac disease, autoimmune thyroiditis, type 1 diabetes, and autoimmune arthritis. Medications and smoking have been implicated as being causative or triggering flares of microscopic colitis. The commonest medications that lead to microscopic colitis are NSAIDs, SSRIs and proton pump inhibitors. Microscopic colitis occurs more commonly in females usually over 50 years of age.




Patients with microscopic colitis typically present with insidious onset of chronic, non-bloody, watery diarrhea, but 40% of cases can occur with an acute onset. Bowels actions are generally between 5-10 per day including nocturnal symptoms in 50%. Other symptoms include faecal urgency (70%), abdominal pain (50%) and faecal incontinence (40%). Microscopic colitis should be suspected in a patient with chronic diarrhea with testing including stool cultures and a colonoscopy. Mucosal biopsy is the only way to establish the diagnosis of microscopic colitis and to exclude other inflammatory diseases. Collagenous colitis is classically characterised by a thickened colonic subepithelial collagen band and lymphocytic colitis is characterised by a high intraepithelial lymphocytic infiltrate (>20 per high power field).

Patients should be advised to avoid NSAIDs and, if possible, discontinue medications associated with microscopic colitis. Anti-diarrheals may be used alone in patients with mild diarrhea or in conjunction with other therapies, based on the severity of symptoms. For patients with microscopic colitis and active disease (≥3 stools daily or ≥1 watery stool daily), budesonide is started at 9 mg/day for four weeks. If the patient is in remission (<3 stools daily and no watery stools), the dose is tapered to 6 mg for four weeks, and then to 3 mg for another four weeks. If the symptoms are not controlled or if symptoms recur on tapering, the dose of 9 mg can be continued for longer periods before tapering budesonide.

Patients with recurrent symptoms after an initial response to budesonide can either be re-treated with budesonide as intermittent therapy or as continuous maintenance therapy at the lowest dose that maintains clinical remission. In the 10-20% of patients who are non-responders to budeonside, other options include combination budesonide and cholestyramine, as bile salt diarrhea is commonly also present due to mucosal inflammation, or other immunosuppressive agents such as azathioprine or anti-tumor necrosis factor (TNF) agents.

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**Men's Health**
Jolimont featured in a promotion during the recent EJ Whitten Legends game. Sports commentator Brian Taylor highlighted the need for men to take care of their health after his recent colonoscopy check-up here at Jolimont and his prostate check done at Australian Prostate Cancer Centre.
Please find link to video below -
**http://www.prostatecancerresearch.org.au/events/brian-taylor-tackles-mens-health/**

**GP Referrals**
As we are a stand alone facility we have guidelines for admissions to ensure the safety of our patients.
Patients with the following conditions will require a consultation with a specialist prior to any booking.
-Poorly controlled diabetes
-Significant cardiac /valvular disease
-Unstable or new onset of ischaemic heart disease/ cardiac Failure,
-Significant respiratory disease/COPD/asthma
-BMI over 40

Jolimont patients arrive close to the time of admission to minimize anxious time spent in the waiting room. IV sedation that is given for the procedure requires patients to have someone come and pick them up (anaesthetic guidelines say they are not to go home alone). The patient stay at Jolimont is generally less than 3 hours.

**Quest Apartments**
For patients requiring overnight stay before or after the procedure, Jolimont **Quest Apartments** (03) 9668 1200 , offer reduced rates and are situated within walking distance. Patients staying here will still need to be accompanied.

**Jolimont Online**
View the web site www.jolimont.com.au for further Information on services provided.

**Capsule Endoscopy /PILL CAM**
Is a well-established investigation for anaemia and is a simple outpatient procedure requiring no bowel prep or sedation.
**Referral Forms** designed to capture the information required to make booking for appropriate patients are available on the **web site** under the **GP tab.**

**Patient Centred Care**
Through consumer partnering we aim to
- Improve patient satisfaction and the quality of our services
- Encourage Change
- Increase consumer awareness
- Positively influence the ways our staff interact with patients.

**Quality Improvement Program**
Continuous Improvement is a systematic management approach to provide safe quality patient care with exceptionally high standards and improved patient care episodes. Monthly audits and surveys are reviewed, action plans created and then changes implemented.
Surveys and audits are conducted on a wide variety of topics including,
- Medication Safety
- Infection Control
- Medical Record Compliance
- Patient satisfaction