

# A Case of NSAID Induced Collagenous Colitis

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## INTRODUCTION

Collagenous colitis is a disorder of chronic watery diarrhea. The pathogenesis of this condition is unclear, but has 2 main histologic forms. It is characterized by normal appearance of the colon on colonoscopy but abnormal histology. It is more likely to occur in elderly women and smokers and has been associated with certain medications such as NSAIDs, PPIs, Antipsychotics. Our case report demonstrates the importance of medication reconciliation when working patients up for diarrhea, and supports the fact that medications, such as those mentioned above can cause recurrence of symptoms, even after treatment.

## CASE PRESENTATION

A 68 year old female patient with a PMH notable for hypertension, GERD, and asthma was diagnosed with diarrhea-predominant IBS in 2015 treated with Rifaximin in the past. In 2015, she began to have 4-6 episodes of brown watery diarrhea daily, from a normal baseline. She underwent colonoscopy at the time, which was normal. She was treated with a 10 day course of Rifaximin with resolution of symptoms. 3 years later, she began to have diarrhea and abdominal cramping for which she made dietary changes with no improvement. She completed another 10 day course of Rifaximin with persistent symptoms. She was admitted to LHMC for weakness and diarrhea because of her inability to tolerate oral intake. Colonoscopy on 11/28 demonstrated ulceration in the hepatic and splenic flexures concerning for ischemic injury versus inflammatory bowel disease. Biopsies were consistent with collagenous colitis although there was neutrophilic cystitis concerning for a superimposed drug induced or infectious process. She was started on Budesonide with improvement in her symptoms before she returned 2 weeks later with diarrhea. Medication reconciliation demonstrated patient had been placed on Omeprazole and Aspirin. This was discontinued however her symptoms persisted and she underwent repeat colonoscopy. Biopsies were consistent with Collagenous colitis.

## Images

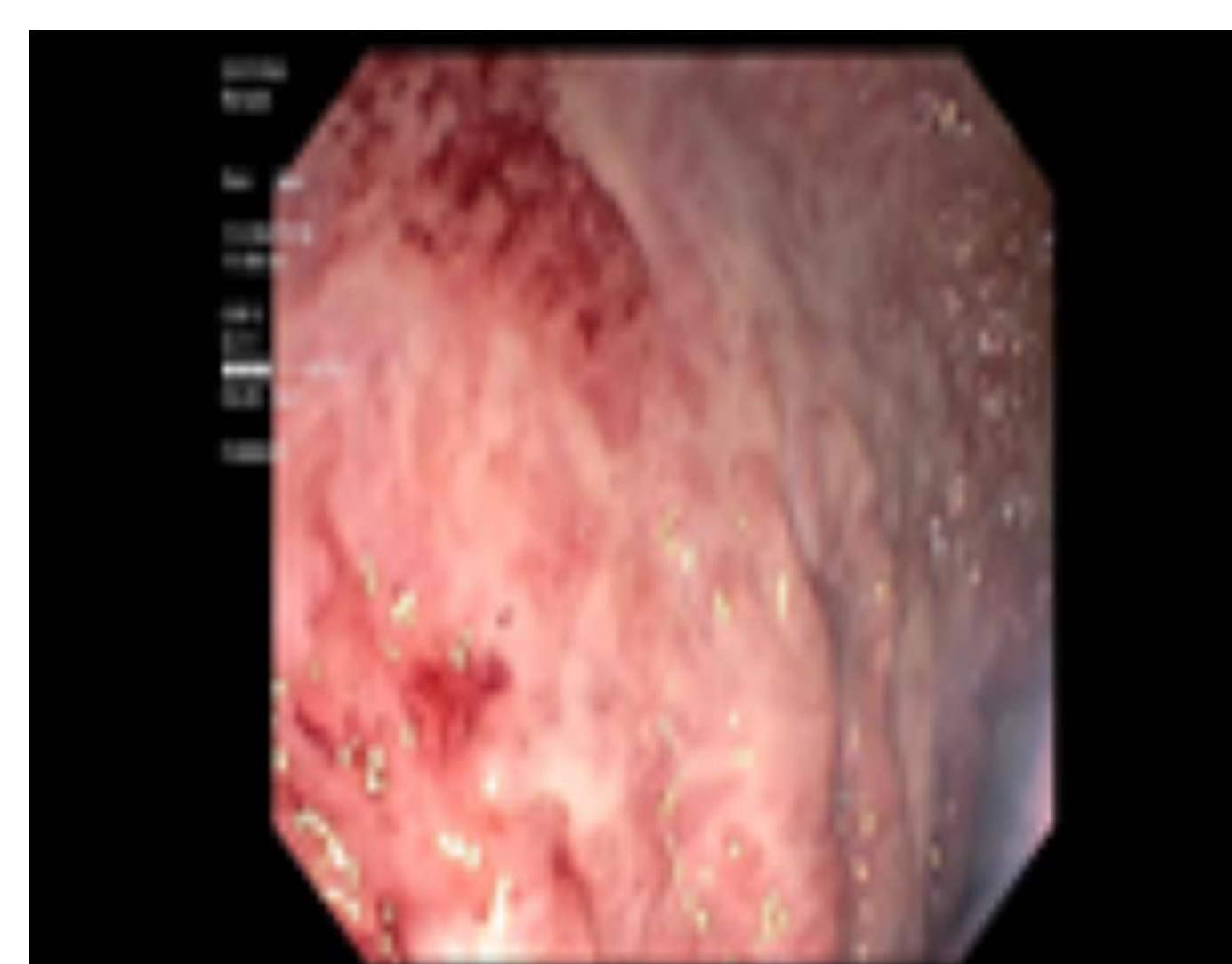


Image [1]: First colonoscopy demonstrating ulcerated mucosa and decreased vascularity

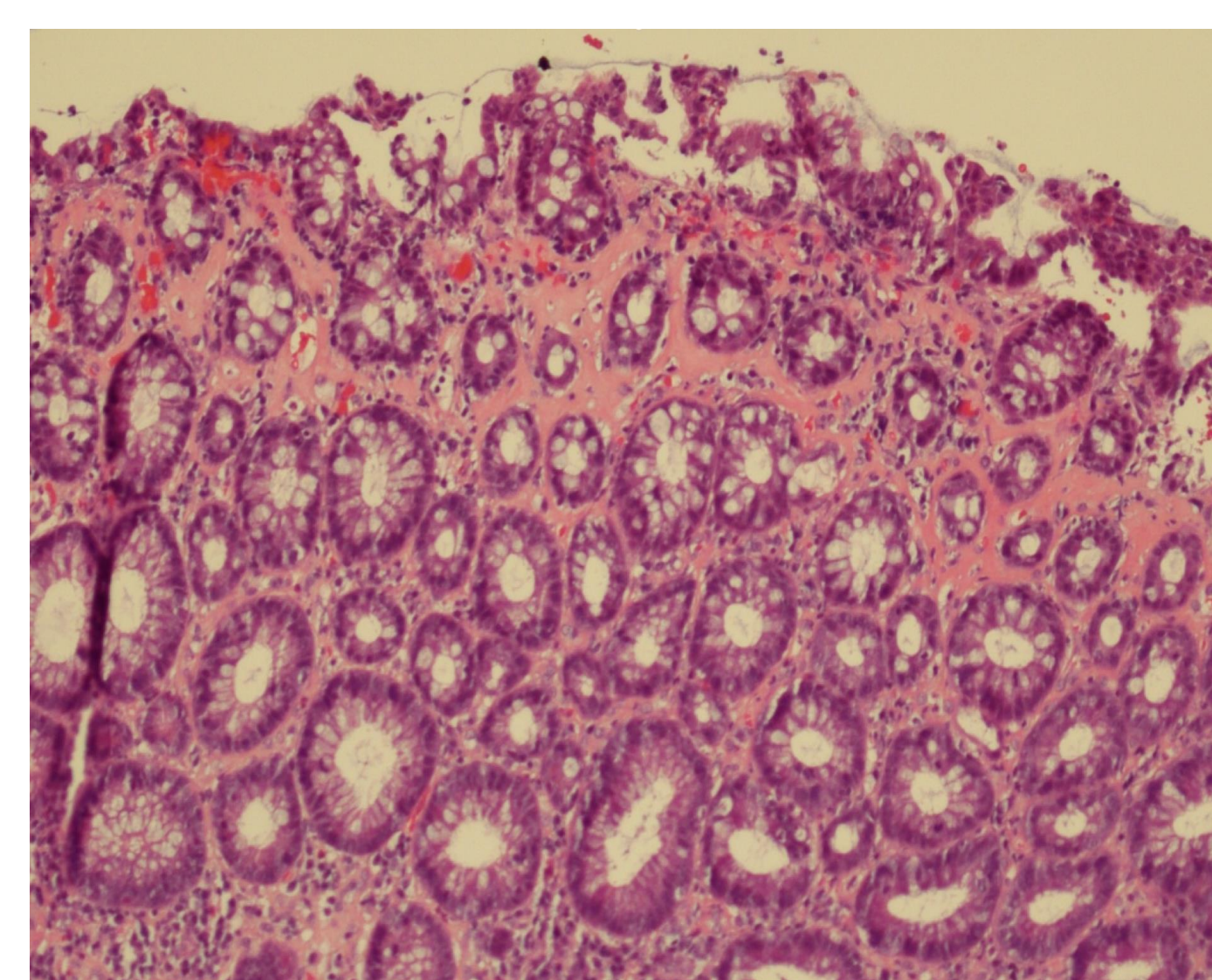


Image [3]: Histology demonstrating increased intra-epithelial lymphocytes

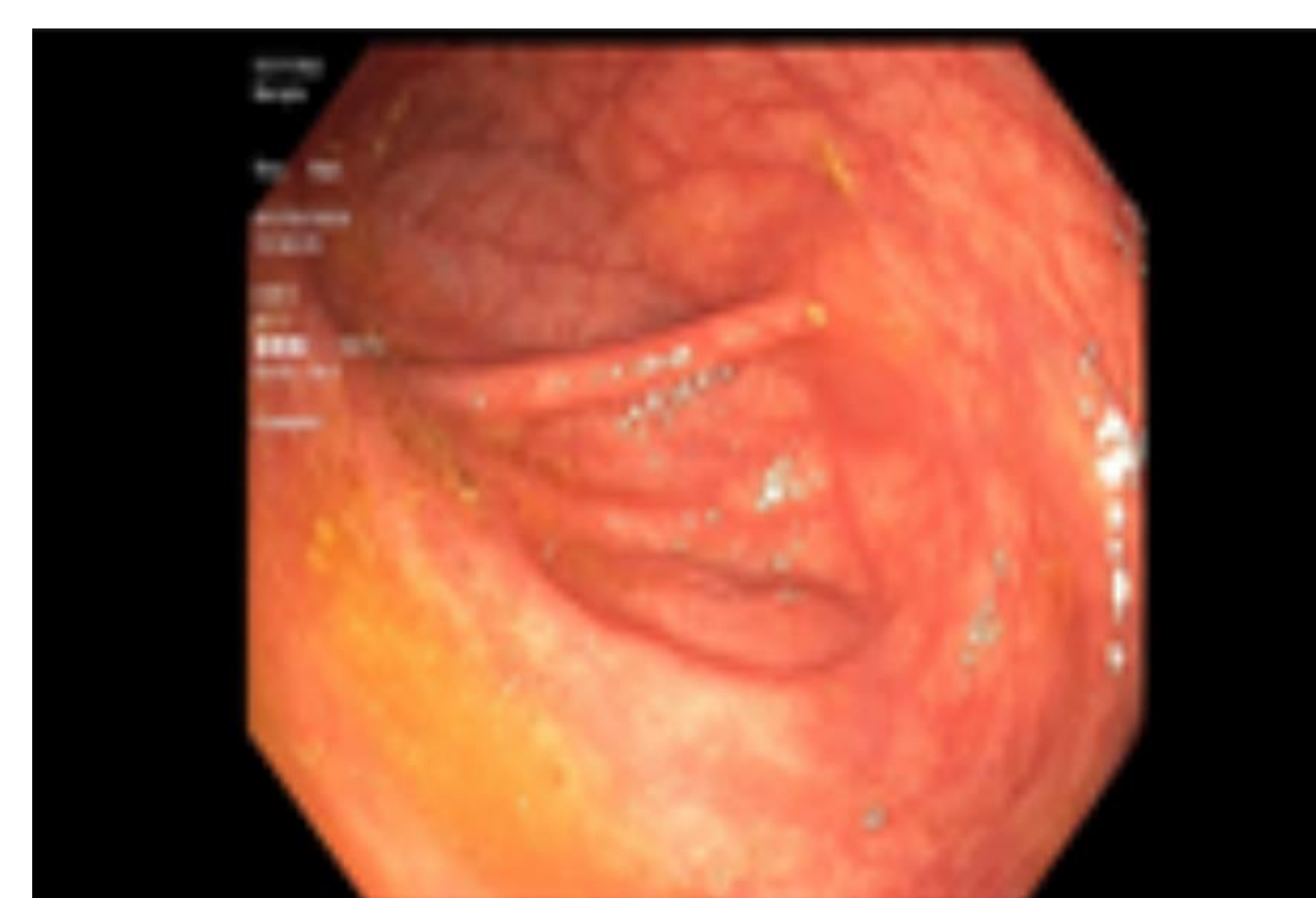


Image [2]: Second colonoscopy demonstrating mild erythema and vascular pattern decreased mucosa

## Discussion

- Collagenous colitis is a chronic inflammatory disease of colon
- Pathogenesis unclear, likely multifactorial in genetically predisposed individual
- Medications (Aspirin, NSAID, PPIs, Ranitidine, Sertraline) and smoking are considered triggering factors for flares of microscopic colitis
- Female predisposition, with mean age at diagnosis of 65 years
- Typically present with insidious onset of chronic watery non bloody diarrhea
- Treatment includes avoiding triggering medications and for patients with active disease, Budesonide is recommended
- Budesonide is given 9 mg per day for 6-8 weeks
- If Patient is in clinical remission taper dose over 4 weeks then discontinue drug
- If no response to Budesonide, concomitant therapy with Cholestyramine or a trial of bismuth subsalicylate is recommended
- Surgery is reserved for patients refractory to medical therapy

## Conclusion

Collagenous colitis has been associated with multiple medication classes, including medications that this patient was on. She had been treated with Budesonide with resolution of her symptoms, however re-initiation of both PPI and Aspirin may have caused recurrence of her symptoms. Our case highlights the importance of vigorous history, chart and medication review when investigating a patient with diarrhea of unknown etiology.