A Tale of Two Colitides
Noelle Provenzano DO, Lindsey Foker DO, Paul Belser MD, Yogesh Govil MD

Introduction
Inflammatory bowel disease (IBD) and microscopic colitis are two distinct subgroups within the larger group of colitides. The occurrence of microscopic colitis (MC) in patients with IBD is rare, with few cases previously reported. We report a case of a patient presenting with concurrent collagenous colitis (CC) and ulcerative colitis (UC).

Clinical Vignette
The patient is a 76-year-old male with a history of anemia, hyperlipidemia, and UC, who presented to the gastroenterologist with frequent loose stools. He reported 6-8 non-bloody bowel movements a day without abdominal pain. He was originally diagnosed with UC in 2019 after presenting with bloody diarrhea. His colonoscopy in 2019 showed generalized diffuse inflammation of the colon and rectal mucosa consistent with UC. Biopsies of colon in 2019 showed changes of active chronic colitis including cryptitis, crypt abscess formation, increased lamina propria lymphocytes, plasma cells and background glandular architectural distortion. (Figure 1,2) He was treated with oral and rectal 5-ASA with resolution of his symptoms. He was continued on oral 5-ASA as maintenance therapy. A surveillance colonoscopy with repeat biopsies done in 2020 showed normal mucosa and no pathological changes of active UC.

Given his prior history, his current presentation was initially thought to be due to a flare up of UC. He was started on oral prednisone and he underwent a flexible sigmoidoscopy. While the sigmoid colon mucosa looked grossly normal, the biopsies revealed a changed histology. The biopsies demonstrated glandular architectural distortion, Paneth cell metaplasia, and mildly increased lamina propria lymphocytes/plasma cells consistent with quiescent chronic colitis. However, with trichrome stain there was mild surface epithelial attenuation and a mildly thickened, irregular subepithelial collagen band which was suggestive of collagenous colitis. (Figure 3) Upon further review of his biopsies from 2019 there was evidence of intraepithelial lymphocytes and a thickened irregular subepithelial collagenous band indicating there was collagenous colitis with concurrent UC. (Figure 4) After his biopsy results from 2021, prednisone and oral 5-ASA were discontinued and he was started on oral budesonide 9mg daily with resolution of his symptoms.

Discussion
Although onset of CC in patients with UC has been reported occasionally, no concurrent CC and UC case was found in literature review. Why and how CC develops in existing UC is not known. It is possible that CC development in UC patients could occur either due to an ongoing aberrant or exaggerated healing due to an imbalance between inflammatory pathways vs mucosal healing pathways. Once UC is controlled with treatment the CC could manifest. Although these are likely random associations of two different disorders, our case highlights that MC should be considered in the patient with UC with new-onset diarreha after successful treatment, especially in those cases with complete mucosal healing.

FIGURE 1,2
2019 40x (left) 100x (right) H&E stain from the left colon demonstrating UC

FIGURE 4
2019 10X trichrome stain from the right colon with UC and CC

FIGURE 3
2021 100x Masson Trichrome stain of Sigmoid colon showing mildly thickened subepithelial collagen band, irregular at its base, with entrapped small capillary vessels and RBCs. Focal surface epithelial attenuation/damage is noted as is mild background glandular architectural distortion from the quiescent IBD.

Provenzn@Einstein.edu