NON-IBD COLITIS

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NON-IBD COLITIS

- MICROSCOPIC COLITIS
- ISCHEMIC COLITIS
- SEGMENTAL/DIVERTICULITIS
- RADIATION COLITIS
- DIVERSION COLITIS
- EOSINOPHILIC COLITIS
- BECHCET’S DISEASE
NON-IBD COLITIS

- ETIOPATHOGENESIS OFTEN OSCURE
- CHRONIC DIARRHEA
- ABD PAIN
- INTERMITTENT HEMATOCHEZIA
- LABORATORY DATA OFTEN NONSPECIFIC
- COLON EVAL AND BX ARE ESSENTIAL FOR DX
- PROGNOSIS AND RESPONSE TO RX VARIABLE
MICROSCOPIC COLITIS

- SUBTYPES: COLLAGENOUS & LYMPHOCYTIC
- UNKNOWN ETIOLOGY
- NORMAL COLONOSCOPY
- MUCOSAL INFLAMMATION
- REDUCED FLUID AND ELECTROLYTE ABSORPTION
- AGE >40 AND F>>M
- 10-15% CHRONIC DIARRHEA CASES
- INSIDIOUS ONSET, CONFUSED WITH IBS-D
MICROSCOPIC COLITIS

- SECRETORY DIARRHEA (LOW OSMOTIC GAP)
- MAY HAVE WBC’S IN STOOL
- DX: COLON BX’S → lymphocytes/plasma cells infiltrate

TREATMENT:
- ENTOCORT → PREDNISONE
- MESALAMINE: LC>>CC
- LOMOTIL (SPONT REMISSION CAN OCCUR)
- RELAPSES ARE COMMON
ISCHEMIC COLITIS

- MULTIFACTORIAL, VARIABLE PRESENTATION
- PATHOPHYSIOLOGY: DECREASED FLOW NOT ABLE TO MEET METABOLIC DEMAND OF COLON
- TRIGGERING EVENT OFTEN NOT ESTABLISHED
- 90% CASES OCCUR AGE > 60
- USUALLY MILD TRANSIENT DISEASE
- DX: IMAGING, COLONOSCOPY, HISTOLOGY
- MOST RESOLVE SPONT W/O COMPLICATIONS
ISCHEMIC COLITIS

- SMA $\rightarrow$ ASCENDING & TRANSVERSE COLON
- IMA $\rightarrow$ DESCENDING & SIGMOID
- INTERNAL ILIACS $\rightarrow$ RECTUM
- WATERSHED AREAS: SPLENIC FLEX & RECTOSIGMOID
- RECTAL ISCHEMIA RARE DUE TO DUAL SUPPLY FROM MESENTERIC AND ILIACS
- 5% POPULATION HAVE ABSENT COLLATERALS AT SPLENIC FLEXURE (ARTERY OF DRUMMOND)
- 50% POPULATION HAVE POORLY DEVELOPED VASA RECTA AT RIGHT COLON, LOW FLOW RISK
ISCHEMIC COLITIS

- 85% CASES NON-GANGREOUS, MILD COURSE
- 75% CASES OCCUR IN LEFT COLON
- SUDDEN ABD PAIN, DIARRHEA, URGENCY
- BLEEDING WITHIN 24 HRS
- LABS: LACTATE, LDH, CPK, AMYLASE NOT RELIABLE MARKERS, NORMAL IN MILD CASES
- IMAGING: THUMBPRINTING, DOUBLE HALO OR TARGET SIGN (EDEMA, SUBMUCOSAL BLEEDING)
THUMBPRINTING
DOUBLE HALO/TARGET SIGN
ISCHEMIC COLITIS

- Colonoscopy is gold standard for dx
- Most cases resolve spont, sx in 48 hrs
- Mild cases managed outpt w/ liquids and abx coverage
- 20% of acute cases may require surgery, with 60% mortality
- Resection is curative and recurrence is rare
SEGMENTAL/DIVERTICULITIS

- Rectal bleed with pain and diarrhea
- Tics common age >40 and M>F, 50% by age 50
- Low risk progression to diverticulitis
- Low fiber is main cause, nuts OK (JAMA’08)
- Most resolve spont within weeks and no recurrence
- Similarity to Crohn’s may lead to inaccurate dx
- Repeat colonoscopy reveals no residual inflammation (normal histology)
NUTS LINK TO DIVERTICULITIS?

- 47K MEN AGE 40-75 FOLLOWED FOR 18 YRS
- 27% EAT NUTS 2X/WK, 15% POPCORN 2X/WK
- PREVALENCE: 2.5% DIVERTICULITIS OR BLEED
- NUTS 2X/WK HAD 20% LOWER DIVERTICULITIS RISK THAN COHORTS
- POPCORN GROUP HAD 28% LOWER DIVERTICULITIS RISK

- JAMA 2008
RADIATION COLITIS

- INSIDIOUS ONSET 6mos – 5 yrs AFTER XRT
- MAJORITY OF ACUTE INJURY IS SELF LIMITED
- MOST RESPOND TO ANTI-DIARRHEAL AND REDUCED FAT & LACTOSE INTAKE
- OCTREOTIDE X 5 DAYS IF REFRACTORY
- CHRONIC XRT INJURY IS MAJOR CHALLENGE
- INTESTINAL INJURY TYPICALLY NOT HEAL
- CHRONIC INJURY IS PRECANCER CONDITION
- SURGERY CAN BE DIFFICULT, RESERVED FOR OBSTRUCTION, FISTULA, BLEEDING
RADIATION PROCTITIS

- CHRONIC INFLAM OF THE RECTUM
- 5-20% LATE SIDE EFFECT OF XRT (3-6mos)
- MUCOSAL ISCHEMIA, SUBMUCOSAL FIBROSIS
- CONSERVATIVE TX IDEAL, \textit{RESOLVE SPONT}
- VIT A/E/C ANTIOXIDANTS (50%)
- SUCRALFATE ENEMA (77%)
- HYPERBARIC O2 (32%)
- APC W/ CAUTION
- NEED PROSPECTIVE LARGER TRIALS
DIVERSION COLITIS

- HALLMARK: LYMPHOID FOLLICLE HYPERPLASIA
- DUE TO LACK OF SHORT CHAIN FA’S SUBSTRATE
- MOST ASYMP, BUT CAN PRESENT W/ BLEEDING, MUCOUS, TENESMUS
- OCCURS IN 90% CASES POST SURGERY
- TREATMENT: RESTORE STOOL FLOW CURATIVE
- CONSIDER MESALAMINE ENEMAS
EOSINOPHILIC COLITIS

- Obscure, rare and assoc with UGI tract segmental or diffuse
- Colon involvement usually confined to right colon
- Pain, bleeding, diarrhea, weight loss
- Food allergies noted in most pts
- 80% show peripheral eosinophilia
- Colo inconclusive, bx show eosinophils
- Food avoidance → steroids
**BEHCET’S DISEASE**

- GI INVOLVEMENT RARE: ULCERS IN TI/CECUM
- OFTEN HARD TO DISTINGUISH FROM IBD
- DX DEPENDS ON PRESENCE OF SYSTEMIC DZ
- TRIPLE COMPLEX: ORAL & GENITAL ULCERS, UVEITIS (DESCRIBED BY HULUSI BEHCET ‘37)
- ALSO SKIN LESIONS, ARTHRITIS, VASCULITIS
- CLUSTER ALONG ANCIENT “SILK ROAD”, MEDITERRANEAN TO ASIA, RARE IN U.S.
- TREATMENT: STEROIDS, IMURAN, REMICADE
CASE #1

- 59 Y/O REFERRED BY ENT FOR EVAL HOARSENESS THOUGHT TO BE FROM LPR.
- NO RESPONSE TO PPI BID
- LOOSE STOOLS SEVERAL TIMES/DAY FOR 1 YR
- NO RELATION TO PO, PAIN, BLOOD, WT LOSS
- NEG SCREEN COLO AGE 56 OSH
- CBC, CMP NL
DIAGNOSIS?
CASE #2

- 64 Y/O CERVICAL CA S/P CHEMO/XRT 2012
- REPORTS 2 WKS PAINLESS INT BRBPR, 4-5X/D
- HB 6.3 (BASELINE 8-9)
DIAGNOSIS?
THANK YOU