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Lymphocytic Colitis: The Diagnostic Challenge of Chronic Watery Diarrhea with Normal Endoscopic Findings

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SHORT COMMUNICATION

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A 69-year-old woman with a history of nasal polyposis, currently under treatment with fluticasone propionate, presented with a 3-month history of watery, non-bloody diarrhea. She reported weight loss with no other accompanying symptoms. She had no fever, vomiting, or recent travel history, and no other risk factors for infectious diarrhea. On examination, she showed signs of dehydration, with an otherwise unremarkable cardiopulmonary auscultation. The abdomen was soft, depressible, and non-tender on palpation, with no signs of peritoneal irritation. No visceromegaly was observed, and the neurological examination was strictly normal.

Blood test results were mostly normal, except for an elevated hematocrit of 52%. The biochemical profile showed mild renal impairment, with a creatinine level of 1.6 mg/dl. Metabolic acidosis was identified with a normal anion gap and hypokalemia, all findings consistent with prerenal acute renal failure due to marked dehydration. Liver function tests were normal. Autoimmune studies, including anti-transglutaminase IgA antibodies, were negative, as were stool studies for parasites and cultures.

An endoscopic study, including ileoscopy and colonoscopy, revealed no abnormalities. Serial biopsies were performed to rule out microscopic colitis, and the results were compatible with lymphocytic colitis (LC). This condition belongs to the family of microscopic colitides and is characterized by chronic watery, non-bloody diarrhea. It is more common in individuals over 50 years old and in females, with a female-to-male ratio ranging from 2.4:1 to 11:1. The diagnosis is based on histology, with examination of stepped biopsies from the colon. The colon appears normal on endoscopy, but histological inflammation is observed, including intraepithelial lymphocytes (IELs) >20/100 epithelial cells. Occasionally, it is drug-induced, and an autoimmune origin is also suggested.

European guidelines recommend discontinuing drugs with a suspected temporal relationship to the onset of symptoms, particularly proton pump inhibitors, nonsteroidal anti-inflammatory drugs, and tobacco use. Oral

budesonide is the first-line treatment, while drugs like azathioprine or TNF immunomodulators are indicated for refractory cases, with a response rate of 77% after 3-6 weeks of use.

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