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• *LETTERS TO THE EDITOR* •

Is there an association of microscopic colitis and irritable bowel syndrome-A subgroup analysis of placebo-controlled trials

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TO THE EDITOR

With great interest we read the recent retrospectice study by Barta *et al* (1) dealing with the clinical presentation of patients with microscopic colitis. They investigated in a cohort of 53 patients with microscopic colitis (46 with collagenous colitis, 7 with lymphocytic colitis) the relationship between microscopic colitis and both constipation and diarrhea. One of their mean finding was that abdominal pain, diarrhea and constipation was a common symptom complex of patients with microscopic colitis, thus the face of microcopic colitis resembles the subgroups of irritable bowel syndrome (IBS).

Irritable bowel syndrome is highly prevalent disorder. Consensus diagnostic criteria (Rome II) based on symptoms have been established to aid the diagnosis of IBS. Microscopic colitis, encompassing collagenous and lymphocytic colitis, is diagnosed by histologic criteria. Since symptoms of microscopic colitis and both diarrhea predominant irritable bowel syndrome or functional diarrhea are similar, a considerable number of patients with micoscopic colitis may be misdiagnosed as IBS or functional diarrhea or a disease overlap could be present in a subgroup of patients.

We would like to confirm the data by Barta *et al*[1] presenting a subgroup analysis of placebo-controlled trials, in which we evaluate the possible symptom overlap between microscopic colitis and IBS. We aimed to assess the proportion of patients with histologically confirmed microscopic colitis who fulfill the Rom-II-criteria for IBS and functional diarrhea[2] .

We selected a large patient cohort with histologically confirmed symptomatic microscopic colitis, who participated in placebo-controlled trials of our group. Baseline gastrointestinal symptoms were assessed by standardized questionnaires and ascertained consistent with Rome-II-criteria (chronic abdominal pain and/or stool abnormalities for at least 12 wk in the preceding 12 mo, no alarm symptoms such as weight loss, no findings in the routine procedures including colonoscopy).

Eighty-two cases of microscopic colitis (74 collagenous, 8 lymphocytic) were included in this analysis. The mean age was 57 years (30-80). Seventy-three % were women. The mean stool frequency per day was 6 (range 3-15). The duration of symptoms prior to histological diagnosis of microscopic colitis ranged between 1 and 156 mo with a mean of 28 mo. Forty-seven patients (57.3%) had concomitant abdominal pain.

Twenty-three patients (28.1%) met the Rome-II-criteria for diarrhea-predominant IBS. Six patients (7.3%) fulfilled the criteria for functional diarrhea. If the criteria for duration of symptoms were excluded from our analysis, the corresponding rates were 65% and 13.4%, respectively These data clearly demonstrate that a considerable group of patients with microscopic colitis have diarrhea-predominant IBS- or functional diarrhea-like symptoms. Thus, patients with microscopic colitis could be misdiagnosed as IBS or functional diarrhea. Additionally, because of the high frequency of IBS, a disease overlap could be present in a subgroup of patients as it was shown between IBS and celiac disease[3]. We conclude that the clinical symptom-based criteria of IBS are not specific enough to rule out the diagnosis of microscopic colitis. Therefore, patients with diarrhea-predominance of IBS-like symptoms should undergo matrix biopsies from the entire colon to investigate for possible microscopic colitis especially biopsies from the right colon are of importance because the left colon sometimes is less involved.

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