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Active microscopic colitis precipitated by fluoxetine

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Dear Editor,

We present the case of a 41-year-old woman with a history of gastric bypass for morbid obesity who consulted for abdominal pain, postprandial dizziness, and alternating bowel rhythm. She was assessed by Endocrinology and Gastroenterology and underwent a complete study, including endoscopy, with a diagnosis of dumping syndrome. The patient improved with hygienic-dietary measures and symptomatic treatment.

Subsequently, she was diagnosed with an adaptive disorder with anxiety and eating behavior disorder. Treatment was initiated with low-dose fluoxetine (20 mg daily), which was progressively increased to a dose of 120 mg daily, with better control of her psychiatric condition.

She was assessed again in the Gastroenterology Department for chronic watery diarrhea of 7 stools per day with abundant mucus but no bloody stools. Infectious etiology was ruled out. It was decided to perform a new colonoscopy with biopsies, which established the diagnosis of active microscopic colitis.

Microscopic colitis is a form of chronic and recurrent inflammatory bowel disease characterized by non-bloody, watery diarrhea, macroscopically normal colonic mucosa,

and characteristic histopathological findings.[1] Although the peak incidence is seen in women over 60 years old, it has also been described in younger patients.

The etiology of microscopic colitis is unknown, although it appears to be multifactorial. Some drugs have been described as triggers of colonic inflammation in predisposed individuals, while others may exacerbate microscopic colitis that evolves on its own.[2] Drugs associated with microscopic colitis include proton pump inhibitors, selective serotonin reuptake inhibitors, nonsteroidal anti-inflammatory drugs, and statins.[2,3]

The goal of treatment is to improve symptoms and quality of life for patients. In the absence of validated biomarkers, the impact on quality of life has been used as a surrogate marker of disease activity.[4]

Budesonide is the first-line treatment for both induction and maintenance therapy. It is considered safe due to its low bioavailability and systemic activity.[4,5]

In the present case, treatment with budesonide was initiated with excellent clinical response. Referral to Psychiatry was made to reduce the dose of fluoxetine or consider alternative treatments.

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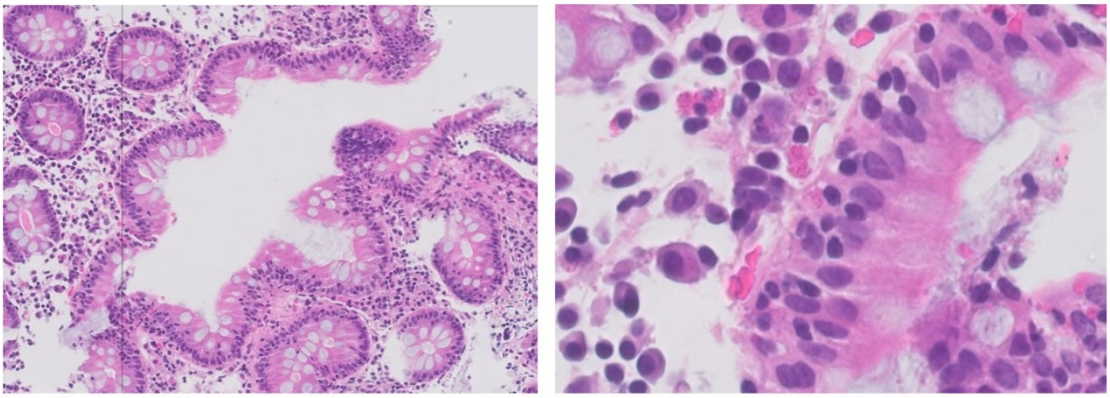

Figure 1. Histopathology of microscopic colitis with hematoxylin-eosin. Dense inflammatory infiltrate of plasma cells and lymphocytes in the lamina propria. In the glandular and surface epithelium there is intraepithelial lymphocytosis with a count of more than 20 lymphocytes per 100 enterocytes.