Pseudo-pseudomembranous collagenous colitis


Microscopic colitis has been divided into three types (Warren BF, et al. Histopathology 2002;40:374-8), all characterised by watery diarrhoea and minimal mucosal changes at colonoscopy, associated with an increase in lamina propria lymphocytes and minimal crypt architectural distortion. Of the three types, lymphocytic colitis also has an increase in intraepithelial lymphocytes, collagenous colitis has a subepithelial collagen band, and microscopic colitis not otherwise specified has neither. A form with giant cells has also been described and types may evolve from one to another (very rarely to ulcerative colitis) in the same patient. Now, along comes another variant—pseudomembranous collagenous colitis—and the question arises as to whether or not it is a true bill. This case series of 10 patients describes collagenous colitis with pseudomembranes (neutrophils, fibrin, and debris). Cases were gleaned from pathology records of distinguished pathology departments in Seattle and Connecticut over a 10 year period. Only one case was associated with Clostridium difficile toxin but results were unavailable in 4/10 cases. Very limited clinical and colonoscopic data are available. Those that are provided describe visible mucosal changes in 7/8 patients (including ulcers in five cases) but no long term follow up data on any patient. In five cases the duration of diarrhoea was eight weeks or less. Well established types of inflammatory bowel disease, including non-steroidal anti-inflammatory drug colopathy, or even Crohn’s disease or ulcerative colitis, may present with little or no crypt architectural distortion in the early stages of illness although none features a subepithelial collagen band.

The case for a new entity is not entirely convincing but an open mind is appropriate. More careful correlation between histological and clinical data is necessary before the diagnosis of pseudomembranous collagenous colitis is introduced into the medical lexicon.

Adding a new dimension to ultrasonography


The search for accurate non-invasive methods of imaging in suspected biliary obstruction goes on, and both endoscopic ultrasound and magnetic resonance cholangiopancreatography (MRCP) have their advocates. Transcutaneous ultrasonography has limited sensitivity yet its availability, safety, and low cost make it attractive for this purpose. Recent advances in ultrasound, in which digitised multislice images are acquired and reconstructed into a three dimensional volume that can be manipulated, have made it possible to generate three dimensional ultrasound cholangiograms. The authors prospectively evaluated the ability of this technique, compared with direct cholangiography (endoscopic retrograde cholangiopancreatography (ERCP)/percutaneous transhepatic cholangiogram (PTC)) and MRCP, to detect and characterise biliary obstruction in 40 patients. Experienced operators, who were blinded to the results of the other tests, evaluated images for technical adequacy, presence and level of obstruction, and suspected cause of any stricture. Compared with two dimensional ultrasound, three dimensional analysis improved the assessment of biliary anatomy in seven of 40 patients. Three dimensional ultrasound however visualised the peripapillary region less well (80%) than MRCP (95%) and direct cholangiography (100%) but was superior at demonstrating the gall bladder and biliary tree proximal to a stricture. All techniques were highly sensitive for detection of biliary obstruction (100%) and each diagnosed the likely cause in 90-95% of cases. Three dimensional ultrasound detected the correct level of obstruction in 92% of cases compared with 95% for MRCP and 90% for ERCP/PTC. There was little discussion of the learning curve or length of time it takes to generate these high quality images but the non-invasiveness, absence of ionising radiation, and availability of ultrasound make this new technique a promising one. So, be prepared for many more years of happy debate over the optimum method of imaging the biliary tree in patients with malignant biliary obstruction.

Virtual colonoscopy for screening: accurate, acceptable, but affordable?


Virtual colonoscopy for colorectal cancer screening sounds attractive—non-invasive, no sedation, and no collection of stool. However, a full bowel preparation is needed and so far its sensitivity and specificity for lesions measuring <10 mm diameter have suggested it is not accurate enough to be used for screening. The study by Pickhardt et al, the largest to date, involves 1233 average risk asymptomatic adults in three centres who underwent virtual colonoscopy followed by a same day conventional colonoscopy. Multidetector computed tomography scans were used to generate fast high resolution images, and water soluble and barium contrast materials were used to tag residual fluid and stool to enable the software to electronically cleanse the fly through images. The results were impressive, with the virtual examination being as accurate as conventional colonoscopy for polyps of 6 mm or larger; in fact, some lesions detected were missed on conventional colonoscopy. In addition, scans took only 1.4 minutes to perform and 20 minutes to read compared with 32 minutes for colonoscopy and another 64 minutes in recovery. Acceptability, perhaps the greatest remaining obstacle to screening, was better than for conventional colonoscopy even though sedation was given for the latter.

Clearly, the place of virtual colonoscopy will depend greatly on what proportion of examinations need to be followed by a conventional colonoscopy and polypectomy. Nevertheless, virtual colonoscopy is now looking sufficiently promising for the AGA to have set up a task force to report at this year’s DDW.