

## Overcoming Diagnostic Anchoring: Refractory Collagenous Colitis Masking Resectable Pancreatic Adenocarcinoma

S. Matseti<sup>1</sup>, E. Napier<sup>2</sup>, A. Tawfik<sup>3</sup>.

1. Internal Medicine Department, Altnagelvin Hospital, NHS Western Health and Social Care Trust, Glenshane Rd., Londonderry, Northern Ireland, United Kingdom.
2. Radiology Department, NHS Belfast Health and Social Care Trust, Grosvenor Rd, Belfast, Northern Ireland, United Kingdom.
3. Gastroenterology Department, Altnagelvin Hospital, NHS Western Health and Social Care Trust, Glenshane Rd., Londonderry, Northern Ireland, United Kingdom.

### Abstract

#### *Presentation*

We report an 80-year-old female with refractory Collagenous Colitis (CC) presenting with progressive weight loss and altered bowel habits over two years. Her symptoms were initially attributed to CC, creating a diagnostic anchor.

#### *Diagnosis*

Initial endoscopy and CT scan (January 2024) were inconclusive. Persistent constitutional symptoms prompted a repeat CT (September 2025), revealing a suspicious pancreatic head mass. Endoscopic Ultrasound (EUS) with fine needle biopsy (FNB) confirmed invasive ductal adenocarcinoma.

#### *Treatment*

A staging PET-CT scan confirmed localised disease. Following regional MDM review, the patient (ECOG status 1) was deemed fit for potentially curative-intent surgery (Whipple Procedure). However, she is currently reluctant to undergo the operation and has been provided time to consider her options.

#### *Discussion*

This case highlights anchoring bias. In established microscopic colitis, the development of persistent weight loss, new abdominal pain, or lack of response to standard therapy should prompt reconsideration of the diagnosis and early cross-sectional imaging.

## Introduction

Collagenous Colitis (CC) is a form of microscopic colitis characterised by a thickened sub-epithelial collagen band ( $>10\text{ }\mu\text{m}$ ) and chronic mucosal inflammation, typically leading to chronic watery diarrhoea, and is frequently diagnosed in middle-aged to older women<sup>1</sup>. Pancreatic Adenocarcinoma (PA) is a rare but devastatingly lethal malignancy, ranking as the fifth biggest cancer killer in the UK<sup>2</sup>. PA is notoriously difficult to diagnose early due to its deep anatomical location and its propensity to present with non-specific gastrointestinal symptoms such as diarrhoea, weight loss, or malabsorption, which can easily be mistaken for active colitis<sup>2,4</sup>. Diagnostic anchoring bias occurs when clinicians rely too heavily on an initial diagnosis to explain new or evolving symptoms. While diagnostic delay due to anchoring bias is well described, and pancreatic malignancy presenting with non-specific gastrointestinal symptoms is not uncommon, a presentation of PA in the context of presumed refractory CC has not been widely reported in the literature. This case uniquely demonstrates how an established chronic condition can mask a new, potentially curable malignancy.

## Case Report

An 80-year-old female with a 12-year history of histologically confirmed Collagenous Colitis (2012), managed on long-term oral budesonide<sup>5</sup>, presented with a two-year history of progressive weight loss and altered bowel habits. Her CC had failed to achieve clinical remission despite optimal medical management. Her weight loss and worsening non-bloody, watery diarrhoea were initially attributed to active CC complicated by malabsorption.

An initial workup included an upper gastrointestinal endoscopy (OGD) and a Computed Tomography (CT) scan in January 2024, which was largely unremarkable for sinister pathology. Due to the persistence of her constitutional symptoms, a repeat CT scan in September 2025 revealed a critical change: a suspicious pancreatic head mass. Biochemical tests showed an elevated CA 19-9 tumour marker (72 kU/L) alongside progressive anaemia and weight loss (Table 1).

An Endoscopic Ultrasound (EUS) with fine needle biopsy (FNB) confirmed invasive ductal adenocarcinoma. Histological demonstrated atypical biliary-type epithelium with nuclear pleomorphism, enlarged hyperchromatic nuclei, and occasional invasive neoplastic glands embedded in a fibromyxoid stroma.

A staging PET-CT scan demonstrated high Fluorodeoxyglucose (FDG) avidity in the mass but no evidence of distant metastasis, establishing resectability. Given her excellent functional status (ECOG Performance status 1), the regional Hepatopancreatobiliary MDM deemed her

fit for curative-intent surgery Pancreaticoduodenectomy (Whipple procedure). However, she is currently reluctant to undergo the operation and taking time to carefully consider her options.

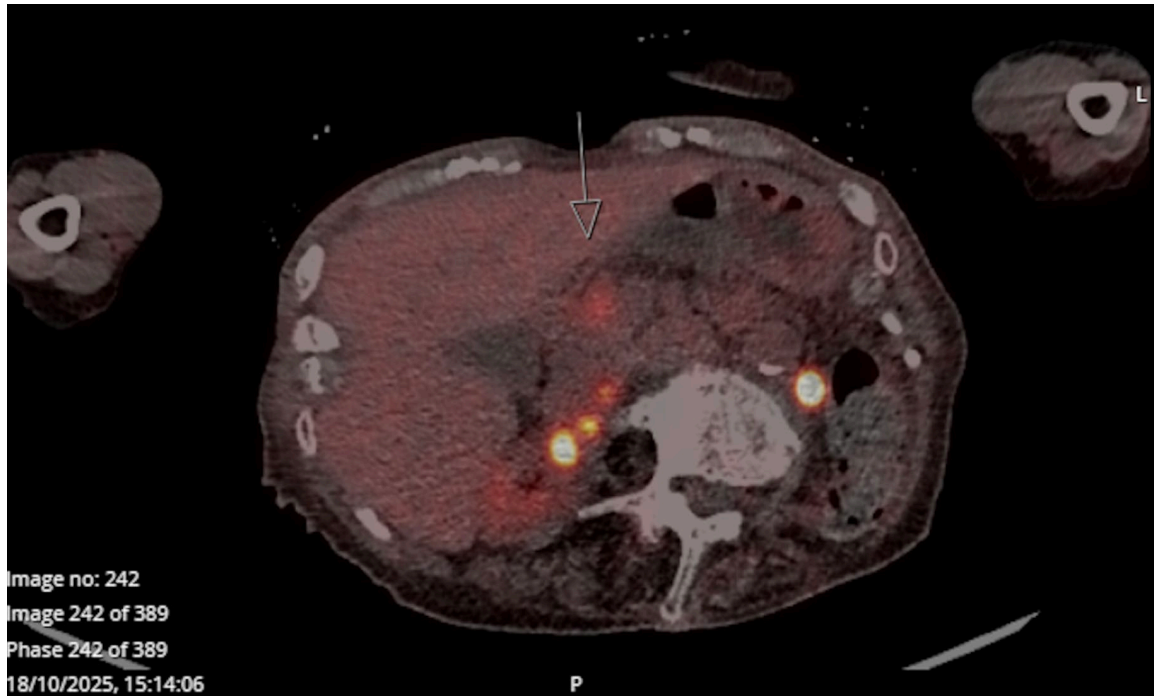


**Figure 1:** Axial view of the staging Positron Emission Tomography-Computed Tomography (PET-CT) scan in October 2025. The scan confirms high Fluorodeoxyglucose (FDG) avidity (indicated by the arrow/orange uptake) in the pancreatic head mass, consistent with the confirmed invasive ductal adenocarcinoma.

**Table 1:** Comparison of biochemical and clinical parameters between the initial workup and the time of PA diagnosis.

| Parameter                    | Initial Workup | Sept/Oct 2025 - Diagnosis | Clinical Relevance                     |
|------------------------------|----------------|---------------------------|----------------------------------------|
| Weight                       | 45.5kg         | 39kg                      | Significant progression of Weight loss |
| Haemoglobin                  | 119 g/dl       | 104 g/dl                  | Progression of anaemia                 |
| Faecal Elastase-1 (FE)       | —              | >800                      | Normal exocrine function               |
| CA 19-9 Tumour Marker        | —              | 72 kU/L                   | Elevated tumour marker                 |
| Ferritin                     | 21ug/L         | 26ug/L                    | Iron deficiency Anaemia (IDA)          |
| Serum Iron                   | 9umol/L        | 10umol/L                  | IDA                                    |
| Transferrin saturation Index | 20%            | 12%                       | IDA                                    |
| Vitamin B12                  | —              | 243ng/L                   | Malabsorption                          |
| Faecal Calprotectin          | 101ug/g        | 287ug/g                   | Ongoing intestinal inflammation        |

## Discussion

This case underscores the critical importance of maintaining a high index of suspicion for underlying malignancy, even with an established chronic gastrointestinal disease. The longstanding CC symptoms created a potent diagnostic anchor, causing the patient's constitutional decline to be persistently attributed to the refractory colitis. Microscopic colitis typically demonstrates high remission rates to standard therapies. For example, budesonide 9 mg daily induces remission in 80% of patients within eight weeks. Therefore, a prolonged lack of response should raise clinical suspicion for alternative pathologies. Crucially, in established microscopic colitis, the development of persistent weight loss, new abdominal pain, or a lack of response to standard therapy should prompt reconsideration of the diagnosis and early cross-sectional imaging. A low threshold for repeating investigations is warranted to prevent significant diagnostic delay. Early-stage PA lesions are challenging to detect, validating

the need for repeat imaging when symptoms inexplicably progress despite optimal medical therapy<sup>7</sup>.

**Declarations of Conflicts of Interest:**

None declared.

**Corresponding Author:**

Sai Matseti,  
Internal Medicine Department,  
Altnagelvin Hospital,  
NHS Western Health and Social Care Trust,  
Glenshane Rd.,  
Londonderry,  
Northern Ireland,  
United Kingdom.

**E-Mail:** [yamshikrishna0084@gmail.com](mailto:yamshikrishna0084@gmail.com)

**References:**

1. Pardi DS, et al. Clinical features of collagenous colitis. *Mayo Clin Proc.* 2007;82(6):708-718.
2. Pereira SP, et al. Early detection of pancreatic cancer. *Lancet Gastroenterol Hepatol.* 2020;5(7):698-710.
3. Tempero MA, et al. Pancreatic Adenocarcinoma, Version 2.2021. *JNCCN J Natl Compr Canc Netw.* 2021;19(4):439-457.
4. National Institute for Health and Care Excellence (NICE). Pancreatic cancer in adults: diagnosis and management (NG85). London: NICE; 2018. Available at: <https://www.nice.org.uk/guidance/ng85>.
5. Miehke S, et al. Low-dose budesonide for maintenance of clinical remission in collagenous colitis: a randomised, placebo-controlled, 12-month trial. *Gut.* 2016;65(1):47-53.
6. Apollos RJ, et al. Pre-diagnostic delays caused by gastrointestinal investigations do not affect outcomes in pancreatic cancer. *World J Gastroenterol.* 2018;24(34):3899–3907.
7. Khandelwal A, et al. Undetected pancreatic carcinoma: Retrospective analysis of missed findings at computed tomography. *Radiol Med.* 2017;122(12):909–916.
8. Miehke, S., et al. (2014) *World Journal of Gastroenterology*, 21(29), pp.8804-8810.