Community HealthPathways Wales Collaboration

Diarrhoea in Adults

Lead Region Page: CV (lead), Wales (host). No followers yet.

Red flags

- Significant dehydration
- Significant acute renal impairment or electrolyte abnormality
- Chronic disease at risk of de-compensating, e.g. diabetes, chronic renal, or cardiac disease

Background

About diarrhoea in adults

About diarrhoea in adults

- Diarrhoea is loose, watery stools occurring more than 3 times in 1 day or more frequently than normal for the patient.
- Acute diarrhoea lasts less than 14 days. If acute, it is usually attributed to gastroenteritis (bacterial or viral) and commonly clears without any intervention. In this case it may be accompanied by vomiting and colicky abdominal pain.
- Persistent diarrhoea lasts more than 14 days and less than 4 weeks.
- Chronic diarrhoea lasts more than 4 weeks – any symptoms for more than 4 weeks suggests non-effective aetiology and merits further investigation.
- Complications of diarrhoea include:
    - Short-term – dehydration, renal impairment and acute kidney injury, especially in the young and old, and in less-developed countries.
    - Long-term – quality of life and consider important conditions, e.g. inflammatory bowel disease, coeliac disease, and bowel cancer.

Assessment

1. History – Ask about:
    - history of diarrhoea.

History of diarrhoea

- Onset, duration, and severity
- Last bowel motion
- Nocturnal diarrhoea and blood
- Frequency and consistency of motions:
    - It may be normal to open bowels up to 3 times a day
    - The Bristol Stool Chart is useful for determining consistency
- Presence of alternating diarrhoea
- Recent change in bowel habit
- Rectal bleeding and nature of bleeding, e.g. bright red, dark red, mixed with stool
- Lumps
- Abdominal or rectal pain, bloating, nausea, or vomiting
- Tenesmus, urgency, and incontinence (consider overflow)
- Perceived relationship to foods
- Other family members who have or have had diarrhoea
- Unexplained weight loss over the last 6 months

- other contributing features.

Other contributing features

- Surgical history, e.g cholecystectomy, (bile acid diarrhoea), small bowel surgery, resections of the small bowel (malabsorption and bacterial overgrowth), previous pancreatic disease
- Medical conditions, e.g.:
    - History of hyperthyroidism, portal hypertension
    - Recent *Clostridium difficile* infections
    - Family history of inflammatory bowel disease (IBD) or coeliac disease
    - Lactose intolerance
- Medication use:
    - Use and dose of laxatives or loperamide
    - Medications, e.g. magnesium, antacids, metformin, proton pump inhibitors (PPI), antibiotics, nicotine gum, amphetamines, anti-hypertensives (e.g. ACE inhibitors, DPP4-inhibitors (gliptins), theophylline), non-steroidal anti-inflammatory drugs (NSAIDs)

- Lifestyle:
    - Excess alcohol intake
    - Sexual health – in particular men who have sex with men, to consider enteric sexually transmitted infections
    - Artificial sweeteners (including diet soft drinks and chewing gum), caffeine, stimulant (illicit) drugs
    - Diet and lifestyle, travel history, change in caffeine intake, change in drinking water
    - Food additives, e.g. sorbitol

2. Consider:

- causes.

Causes

- Infection:
    - Viral, e.g. norovirus – most common
    - Bacterial, e.g. *Campylobacter jejuni*, *Shigella species*, *Escherichia coli* and *Clostridium difficile* – especially in patients who are older, immunocompromised, or who have been in hospital
    - Parasitic, e.g. *Cryptosporidium*, *Giardia*, *Entamoeba histolytica*, and *Cyclospora*

Protozoan or bacteria infections may cause diarrhoea of 14 days or more.

- Irritable bowel syndrome (IBS) – diarrhoea predominant
- Bile salt diarrhoea (post cholecystectomy)
- Diet
- Diverticulitis
- Large or small bowel cancer
- Inflammatory bowel disease (IBD) or extra-intestinal manifestations of IBD, e.g. uveitis, skin rashes (erythema nodosum), pyoderma gangrenosum, arthralgia.
- Coeliac disease
- HIV, enteric sexually transmitted infections
- Ischaemic colitis
- Microscopic and collagenous colitis
- Small bowel bacterial overgrowth
- Lactose intolerance

- Liver or pancreatic disease
- Exocrine pancreatic insufficiency
- Malabsorption syndromes
- Post-abdominal surgery
- Gastrointestinal neuroendocrine tumours

- impact of diarrhoea on absorption and effectiveness of medications, e.g. oral contraceptive pill and immunosuppressants.

3. Perform an examination:

- Measure temperature, blood pressure, pulse rate.
- Assess hydration.
- Calculate body mass index (BMI).

Body mass index (BMI)

Body mass index = kg/m^2 (weight divided by height squared)

NHS has an online calculator.

- Less than 18.5 – underweight
- 18.5 to 24.9 – healthy or normal weight
- 25 to 29.9 – overweight
- Over 30 – obese

For black African, African-Caribbean, and Asian groups:

- Less than 18.5 – underweight
- 18.5 to 22.9 – healthy or normal weight
- 23 to 27.5 – overweight
- Over 27.5 – obese

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- Examine generally for signs of other systemic illness.
- Inspect the abdomen for surgical scars, palpate for masses and focal tenderness in left or right iliac fossa, auscultate to assess presence and character of bowel sounds, and inspect for signs of other systemic illness.
- Where appropriate, consider examination of perineum and rectum, including a digital rectal examination (DRE) to inspect for anal rectal tone, lumps, fissures, and evidence of bleeding.

- If clinically indicated, consider bimanual pelvic examination.

4. Consider arranging investigations.

Investigations

Investigations are not routinely required for a patient with acute diarrhoea, as most episodes are self-limited. Reserve investigations for patients with severe dehydration, persistent fever, bloody stool, immunosuppression, chronic diarrhoea, or concern of a secondary cause. [1]

In acute diarrhoea, send a stool sample for faecal microbial investigation (molecular enteric) and *Clostridium difficile* PCR (if recent antibiotics) if:

- bloody diarrhoea.
- the patient has had antibiotics, proton pump inhibitor, or been in hospital.
- foreign travel (request cysts ova and parasites on the form with the place of travel).
- the patient has been to an at-risk area or *Amoebae*, *Giardia*, or *Cryptosporidium* are suspected.
- needed to exclude infective diarrhoea in a patient with exacerbation of inflammatory bowel disease.
- a public health recommendation.

Management

1. Arrange emergency assessment if:
    - severe dehydration or shock.
    - signs of sepsis.
2. If the patient is at risk, consider requesting acute or same-day general medicine assessment if clinically indicated.

At risk

- Elderly patient
- Systemically unwell
- Blood in diarrhoea
- Abdominal pain and tenderness
- Immunocompromised
- Pregnant patient
- Postoperative patient
- Chronic renal or cardiac failure

- Patient with diabetes

3. If suspected inflammatory bowel disease, follow the Inflammatory Bowel Disease (IBD) pathway.
4. If acute diarrhoea, treat initially using simple measures.

Simple measures

- Treat nausea and vomiting
- Isolate the patient if appropriate
- Advise the patient to:
    - maximise clear fluid intake.
    - avoid caffeine and alcohol.
    - avoid solids.
    - consider taking over-the-counter medications from pharmacies for symptomatic relief of acute diarrhoea:
        - oral electrolyte replacement, e.g. over-the-counter oral rehydration salts (Dioralyte).
        - loperamide – can be used for symptomatic relief of acute diarrhoea if diarrhoea needs to be stopped for a few hours.
    - maintain good hand and food hygiene.
- Consider holding medications which can cause acute kidney injury. See also:
    - Diabetes Continuing Care for patients with diabetes
    - NHS Nottinghamshire Area Prescribing Committee – Medicines and Dehydration: Sick Day Rules

5. If chronic diarrhoea:
    - Arrange FIT test – see Suspected Colorectal Cancer pathway.
    - Arrange:
        - FBC, ferritin, electrolytes and renal function, LFT, thyroid-stimulating hormone (TSH), ferritin, CRP, ESR, B_{12}, folate, coeliac serology. If concerns of ovarian cancer, consider CA125.
        - Stool tests – microscopy, culture, and sensitivities (MCS), ova, cysts, and parasites (OCP), PCR, *Clostridium difficile* toxin, giardia antigen.
        - HIV serology – consider HIV testing as chronic unexplained diarrhoea is an indicator condition for HIV.

Indicator condition for HIV

An indicator condition is any medical condition associated with an undiagnosed HIV seroprevalence of 1 per 1000 or higher. [2] HIV testing is recommended and could avoid HIV-associated complications, and reduce morbidity and mortality. See the Human Immunodeficiency Virus (HIV) pathway.

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- If inflammatory bowel disease is suspected, arrange faecal calprotectin – this reduces the need for endoscopy.
- Do not arrange carcinoembryonic antigen (CEA).

Carcinoembryonic antigen (CEA)

- CEA is a tumour marker for monitoring disease progression.
- It cannot be relied on for diagnosis inclusion or exclusion.

- Review results.

Review results

- If positive *Clostridium difficile* infection, seek microbiology advice and see microguide. Consider undertaking a root cause analysis for *C. difficile*.

Root cause analysis for *Clostridium difficile*

Email the completed root cause analysis (RCA) form to Louise.Thomas8@wales.nhs.uk.

The Primary, Community and Intermediate Care (PCIC) governance team will send it to infection prevention and control.

- Ensure all investigations are complete and review medications. If all tests results are negative:
  - consider a stool bulking agent for 4 weeks, e.g. Fybogel.
  - arrange a review appointment.
- Request urgent suspected cancer colorectal surgery assessment if:
  - a positive FIT result.
  - the patient meets the criteria for referral without waiting for FIT results.
  - gastrointestinal (GI) symptoms other than rectal bleeding, and suspicion of colorectal cancer based on clinical judgement.
- If after 4 weeks of stool-bulking agent and diarrhoea is still present with:
  - no concerning features (e.g. strong family history of gastrointestinal cancer, weight loss), request routine gastroenterology assessment.

- alarm symptoms, request urgent suspected cancer or urgent gastroenterology assessment, depending on level of clinical concern.

- If suspected colorectal cancer, follow the Suspected Colorectal Cancer pathway.

6. If faecal incontinence rather than diarrhoea, follow the Faecal Incontinence pathway.

Request

- Arrange emergency assessment if:
  - severe dehydration or shock.
  - signs of sepsis.
- If the patient is at risk, consider requesting acute or same-day general medicine assessment if clinically indicated.
- Request urgent suspected cancer colorectal surgery assessment if:
  - a positive FIT result.
  - the patient meets the criteria for referral without waiting for FIT results.

    Urgent suspected cancer criteria for referral without waiting for FIT results

    - Abdominal mass
    - Rectal mass
    - Anal mass or ulceration
    - Abdominal pain with obstructive symptoms
    - Iron deficiency anaemia in men and postmenopausal women
  - gastrointestinal (GI) symptoms other than rectal bleeding, and suspicion of colorectal cancer based on clinical judgement.
- If after 4 weeks of stool bulking agent and diarrhoea is still present with:
  - no concerning features, request routine gastroenterology assessment.
  - alarm symptoms, request urgent suspected cancer or urgent gastroenterology assessment, depending on level of clinical concern.
- If positive *Clostridium difficile* infection, seek microbiology advice.

Information

For health professionals

Further information

- British Society of Gastroenterology – Guidelines for the Investigation of Chronic Diarrhoea in Adults: British Society of Gastroenterology, 3rd Edition
- NICE Clinical Knowledge Summaries (CKS) – Diarrhoea: Adult's Assessment

For patients

NHS – Diarrhoea and Vomiting

SEND FEEDBACK

SOURCES

References

1. Barr, Wendy, Smith, Andrew. Acute Diarrhea in Adults. [place unknown]: American Family Physician; 2014.

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2. HIV Testing Guidelines. Letchworth (UK): British HIV Association; 2020.

PAGE INFORMATION

Last Updated: 29 September 2023

Last Reviewed: 29 September 2023

Keywords: ——

Topic ID: 986800