PALCARE
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THE JIMMY S BILIMORIA FOUNDATION

PALLIATIVE CARE
GUIDELINES
FOR A HOME SETTING IN INDIA

DIARRHOEA

INTRODUCTION

Diarrhoea is defined as the passage of three or more unformed stools per day.
In patients with advanced cancer, diarrhoea is less common than constipation. Diarrhoea can be debilitating in patients with advanced disease because of loss of fluid and electrolytes, anxiety about soiling, and the effort of repeatedly going to the toilet. Inappropriate use of laxatives is the commonest cause of diarrhoea in patients with advanced cancer.

Steatorrhoea is the excretion of abnormal quantities of fat with the faeces owing to reduced absorption of fat by the intestine leading to the production of pale, bulky, offensive and loose stools.

Causes of diarrhoea:

Cancer related

- Cancer of rectum, colon, pancreas (islet cell), carcinoid tumours, oat-cell lung carcinoma, pheochromocytoma, medullary carcinoma of thyroid, gastrinoma, fistula
- Malignant intestinal obstruction
- Faecal impaction (overflow/spurious diarrhoea)
- Malignant hypercalcemia

Treatment related

- Drugs - laxatives, antibiotics, antacids, NSAIDs, iron preparations, disaccharide containing elixir
- Radiotherapy
- Chemotherapy
- Surgery - gastrectomy, ileal resection, colectomy

Concurrent disease

- Inflammatory bowel disease, hyperthyroidism, diabetes
- Diet - bran, fruits, spices and alcohol
- Infection - Clostridium difficile, Escherichia coli, Salmonella

ASSESSMENT

- Determine the underlying cause of diarrhoea, effectiveness of treatment and impact on quality of life for the patient and their family ***(refer to the Guideline - Symptom assessment)***
- Ask for history of past pattern of stools/frequency/presence of foul odour/blood/mucus/history of prior constipation
- Examination
  - Per rectal - to exclude faecal impaction
  - Abdomen - to exclude intestinal obstruction (distension, dilated bowel loops, visible peristalsis, bowel sounds)
  - Systemic - fever, dehydration
- Investigations as appropriate
  - X-ray Abdomen (erect) - to look for intestinal obstruction, impacted stools
  - Blood - Serum calcium, electrolytes, TSH

RECOMMENDATIONS

- It is important to distinguish diarrhoea and overflow (spurious) diarrhoea secondary to faecal impaction
- In general, a single medication should be used in the management of diarrhoea
- When using a combination of medications, avoid sub-therapeutic doses
- Loperamide is the first choice (once infection/ obstruction are ruled out)
- Codeine should be used when other medications are not effective
- Intractable diarrhoea may require subcutaneous infusion of octreotide (rarely)

MANAGEMENT

- **Specific treatment**
  - Medication induced
    - Laxatives - stop laxative and review
    - Antacids - stop antacids and review
    - Antibiotics - stop antibiotic and use metronidazole or vancomycin
    - NSAIDs - stop and review or change
  - Radiotherapy induced
    - Loperamide, diphenoxylate, cholestyramine, aspirin
  - Carcinoid Syndrome - Octreotide/Cyproheptadine
    - Octreotide - Start at 50mcg od or bd and a maximum of 1500 mcg/24 hours (occasionally higher) can be administered; depot or subcutaneous infusions can be considered
    - Cyproheptadine
  - Fat malabsorption - Pancreatin enzyme replacement with omeprazole
  - Zollinger Ellison Syndrome - Ranitidine

- Colectomy - Cholestyramine
- Fistula - Palliative surgery
- Bowel obstruction (***refer to the Guideline - Malignant bowel obstruction)***
- Faecal impaction and overflow diarrhoea ***(refer to the Guideline – Constipation)***
- Intestinal pseudo-obstruction - Corticosteroids
- Gastrinoma syndrome - Omeprazole
- Infection-Stool culture, appropriate antibiotics
    - C. Difficile diarrhoea - Metronidazole 400mg PO tid

- **Non-pharmacological measures - advise the carer to:**
    - Give oral hydration solution containing glucose, electrolytes, and water - ORS, fruit juices and soups
    - Avoid cold meals, milk, vegetables rich in fibre, fatty meat and fish, coffee, and alcohol
    - Use safe drinking water
    - Administer frequent, small, dry meals that are high in protein and low in carbohydrates; substances that prolong the absorption of carbohydrates, such as pectin, may be useful
    - Provide carbohydrates such as biscuits, bread and pasta
    - Consider rehydration with intravenous or subcutaneous fluids in the presence of clinical signs of dehydration (orthostatic hypotension, decreased skin turgor, and dry mouth - rarely necessary in palliative care population)
    - Encourage good sanitation and advise hand washing with soap

- **Pharmacological measures**
    - **Loperamide (1st line)**
        - Starting dose - 4mg PO stat
        - 2mg after each loose motion up to 5 times a day or 2mg qid
        - Increase up to 4mg qid
        - Maximum dose 16mg/24 hours
        - Loperamide is about 3 times more potent than diphenoxylate and 50 times more potent than codeine

    - **Other options**
        - **Diphenoxylate** - 2.5-5mg PO qid
        - **Codeine** - 10-60mg PO q4h

References

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