

**CONSENSUS  
GUIDE:**



**PRACTICAL GUIDANCE ON THE  
IDENTIFICATION AND MANAGEMENT  
OF SYMPTOMS OF GASTROINTESTINAL  
(GI) INTOLERANCE IN MALNOURISHED  
ADULTS IN THE COMMUNITY**

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## PRACTICAL GUIDANCE ON THE IDENTIFICATION AND MANAGEMENT OF SYMPTOMS OF GASTROINTESTINAL (GI) INTOLERANCE IN MALNOURISHED ADULTS IN THE COMMUNITY



### INITIAL ASSESSMENT

- What are the normal bowel habits for the patient?
- Have there been changes in bowel habit over the past 10–14 days?
- Is there any significant previous medical history that may predispose patient to GI intolerance? [e.g. irritable bowel syndrome (IBS), inflammatory bowel disease (IBD), pelvic radiation therapy]

### WHAT GI SYMPTOM(S) IS THE PATIENT EXPERIENCING?

- When do symptoms occur relative to eating / food intake?
- Are symptoms made worse or do they improve with eating?
- Frequency of symptoms (number of times per day, how long does symptom last, number of days per week?)

#### DIARRHOEA

- How do the stools appear (colour / type / volume)?\*
- Is there urgency?
- Is there pain?
- Is there blood or mucus?

**YES** to blood/mucus = **RED FLAG**

Diarrhoea may be considered severe if >4 times a day / urgent and risk of dehydration / malnutrition / affecting activities of daily living (everyday / specific aspects / mental health).

#### NAUSEA / VOMITING / REFLUX

- Determine appearance / frequency of vomiting
- Could nausea / vomiting / reflux have a non-food cause?
- Rule out constipation as a contributor to nausea
- Refer to physician for prescription of anti-emetic / antacid

**RED FLAG** concerns: constant nausea; significant weight loss (≥10% loss of body weight in 3–6 months); blood (fresh or ‘coffee ground’ appearance) and pain associated with symptoms.

\*Determine stool appearance using a validated tool (e.g. **Bristol Stool Chart** or **King’s Stool Chart**)

#### STEATORRHOEA

- How do the stools appear? (pale yellow / grey in colour; frothy; floating or oily?)<sup>^</sup>
- Is there incontinence / leakage / urgency / incomplete evacuation?
- Does the patient feel weak / fatigued?

**YES** to any of the above: consider specialist referral. View steatorrhoea as a **RED FLAG**

#### CONSTIPATION

Questions as for diarrhoea, plus:

- Is there tearing?
- Is there gas?
- Is there incomplete evacuation?

#### ABDOMINAL PAIN / CRAMPING

- Where is the pain located?
- Is the pain associated with flatulence / bloating?
- Is the patient constipated?
- Is pain relieved by: defaecation? pain killers?
- How severe is the pain?

#### BLOOD OR MUCUS

- Always a **RED FLAG**

#### OTHER SYMPTOMS

- Bloating, flatulence, incomplete evacuation

### ASSESS SYMPTOM SEVERITY, USING VALIDATED TOOLS WHERE APPROPRIATE

- Are symptoms compromising the patient’s nutritional status / likely to result in hospitalisation?
- Are symptoms affecting daily activities / quality of life?
- When changes in bowel habit persist for > 3 weeks despite management attempts refer for GP / specialist consultation
- Refer **RED FLAG** patients for specialist consultation

### ORAL NUTRITIONAL SUPPLEMENTS (ONS)

Is the patient at **HIGH RISK** (2 or more symptoms) or **LOW RISK** of GI intolerance?

If **HIGH RISK**

- Consider an energy dense (1.5kcal/ml) peptide-based ONS\* for a minimum of 2-4 weeks (or until symptoms improve / resolve) then consider a long-term plan

If **LOW RISK**

- Consider a whole protein ONS\* (+/- low volume)
- Review in 2-4 weeks and switch to peptide-based ONS\* if symptoms persist

### FOR PATIENTS ALREADY TAKING A WHOLE PROTEIN ONS

- Consider an energy dense (1.5kcal/ml) peptide-based ONS\* for a minimum of 2-4 weeks (or until symptoms improve / resolve) then consider a long-term plan

### FOR ALL PATIENTS RECEIVING ONS\*

- Give guidance on the frequency / dose / timing of ONS\* administration according to symptom(s) to be managed
- For all patients taking ONS\* for >2 months refer to a dietitian in accordance with local care plans

## SPECIFIC NUTRITIONAL GUIDANCE FOR GI SYMPTOMS



## CLINICAL FACTORS



- Manage any underlying conditions contributing to GI symptoms
- Those at **HIGH RISK** of GI intolerance in the community may include:

Any patients needing nutritional support

The elderly

Cancer patients pre, post or during treatment

Patients with upper / lower GI disease

Patients who have undergone recent GI surgery

IBD and IBS patients

Colostomy / ileostomy / jejunostomy patients

Coeliac patients

Patients on long-term antibiotics, laxatives or Proton Pump

Inhibitor (PPI) therapy

Patients on polypharmacy

Any patients with chronic conditions (e.g. COPD, heart failure, diabetes, gut neuropathies, cystic fibrosis)

Lactose intolerant patients

## MEDICINES



- Medicines which may exacerbate or contribute to GI intolerance include the following main drug classes:

Antibiotics

Laxatives

Proton Pump Inhibitors (PPIs)

Calcium, iron and magnesium tablets

Others: prokinetics; anti-diarrhoeal medications; rehydration salts; anti-emetics; lactose- / sorbitol-containing medications; opioid analgesics; antiretroviral agents; pancreatic enzymes; chemotherapy / targeted therapies; antispasmodics; medications for IBS; statins

**CONSULT WITH A PHYSICIAN / PHARMACIST ON MODIFICATIONS TO DRUG TREATMENTS AND REGIMENS THAT MAY HELP ALLEVIATE GI SYMPTOMS**

### DIARRHOEA

- If the cause of diarrhoea is unknown: consider work-up for infectious cause
- Consider physician review for prescription of anti-diarrhoeal if severe
- **Nutritional intervention(s):** Low fibre diet if eating; rehydration (solutions under supervision); avoid artificial sweeteners which may exacerbate diarrhoea and bloating; consider probiotics according to current guidance

### STEATORRHOEA

- This symptom is a **RED FLAG**
- All new patients should be referred for specialist dietetic review, if available locally
- **Nutritional intervention(s):** Until the cause of steatorrhea is determined, use a peptide-based ONS containing fat as medium-chain triglycerides (MCT) first line
- If there is pancreatic insufficiency – ensure that the optimal dose of pancreatic enzyme replacement therapy (PERT) is being given and taken at appropriate times with food, fluids and ONS\* (such patients should be under the care of a gastroenterologist)

### NAUSEA / VOMITING

- **Nutritional intervention(s):** Small frequent meals; cold food; dry food; eat and drink separately; rehydrate; avoid cooking smells; consider ginger / gingerol
- Avoid acidic foods such as citrus fruits and tomatoes, coffee, fizzy drinks, peppermint, caffeine, nicotine and alcohol; avoid eating late at night; avoid heavy and spicy foods; avoid ingesting large volumes of food / fluids
- **Practical advice:** Elevate head of bed; manage with anti-reflux medicines (discuss with physician or pharmacist)
- Risk of dehydration is indicated by urine colour (dark); dry mouth; lack of skin turgor; dry eyes; thirst. If 10 waking hours since urine has been passed – contact A&E
- If vomiting escalates – contact A&E
- **Additional considerations:** Is the patient also constipated?

### BLOATING / FLATULENCE / BURPING

- **Nutritional intervention(s):** Avoid gas producing foods (e.g. onions, beans, pulses, broccoli, cabbage, cauliflower, garlic); avoid polyols (e.g. xylitol / sorbitol in chewing gum); avoid drinking through a straw / speaking while eating; avoid fizzy drinks; avoid consumption of resistant starch. Do eat / drink peppermint containing foods; for wind and bloating include nonfermentable bulking agents (e.g. golden linseeds) in diet
- Consider referring patient to specialist dietitian for use of FODMAP plan if carbohydrate malabsorption / small bowel bacterial overgrowth is implicated
- **Additional considerations:** Is the patient also constipated?

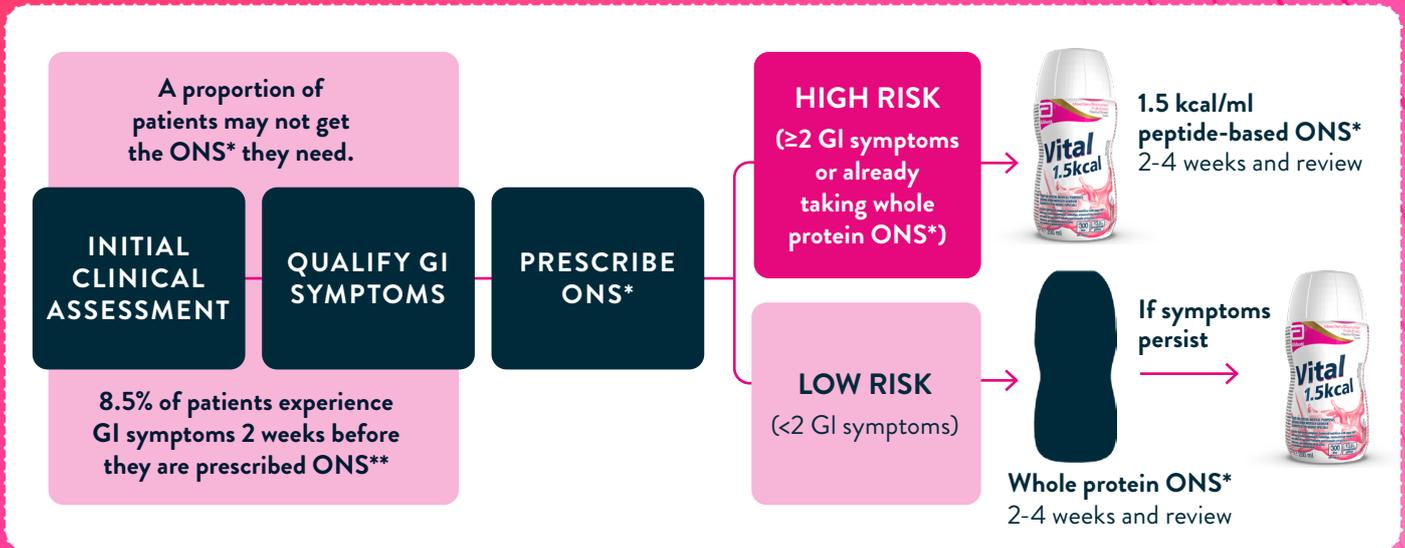
### CONSTIPATION

- Follow advice for bloating, plus:
- **Nutritional intervention(s):** Increase fluid and soluble and insoluble fibre intake
- **Practical advice:** Consider use of drug treatments for constipation / laxatives (discuss with physician or pharmacist); encourage increased physical activity

### PAINS / CRAMPS

- Follow advice for constipation / flatulence, plus:
- **Additional considerations:** Is there also wind or bloating? Severe / unrelenting pain is a **RED FLAG**
- **Practical advice:** Consider antispasmodic agents (discuss with physician or pharmacist)

# PEPTIDE-BASED NUTRITION IS RECOMMENDED FOR PATIENTS AT HIGH RISK OF SYMPTOMS OF GI INTOLERANCE



## CHECK FOR SYMPTOMS OF GI INTOLERANCE EARLY

Using peptide-based ONS\* first line is an effective strategy when malabsorption is suspected<sup>1</sup>



**VITAL 1.5KCAL – THE UK’S MOST TRUSTED PEPTIDE-BASED FEED†**

## CHOOSE VITAL 1.5KCAL TO REDUCE GI SYMPTOMS<sup>§2</sup>



**Clinically proven to improve nutritional status and decrease symptoms in 12 weeks<sup>2</sup>**



**Highest % of fats as MCTs in a 1.5 kcal/ml peptide-based ONS\*†**



**98% compliance in adults with impaired GI function<sup>~3</sup>**

GI – Gastrointestinal; \*ONS – Oral Nutritional Supplement. \*\* Patients who experienced vomiting, diarrhoea or nausea in the 2 weeks prior to receiving an ONS prescription (data from a longitudinal GP database). † Based on UK prescriptions for peptide-based feeds (both ONS & tube feed) over a 12 month period (May 2024-April 2025). § Observational, prospective, multi-centre study assessed the nutritional status and compliance of 90 adults (≥18 years) with gastrointestinal intolerance and malnutrition or at risk thereof ('MUST' ≥2) who were given Vital 1.5kcal for 12 weeks. ‡ Vital 1.5kcal provides the highest proportion of fat as MCTs in the UK 1.5kcal peptide-based ONS category, with 64% of total fat as MCTs, compared to 60% in Peptisp Energy HP and 50% in Survimed OPD 1.5kcal Drink. ~ Vital 1.5kcal ONS was given to 35 adults twice a day for 16 days. The average proportion of product consumed was 98%.  
1. Diéguez Castillo C et al. *Nutrients* 2025;17(9):1426. 2. López-Medina JA et al. *Nutrition* 2022;102:111734. 3. Nelson JL. *Clin Nutr Exp* 2019;28:123-130.