

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



This guidance has been developed by a multidisciplinary group with an interest in GI intolerance: Kelly McCabe, Lead Oncology Dietitian, London (Chair); Emily Albon, Specialist GI Dietitian, Devon; Jordan Barnard, Specialist Community Dietitian, Kent; Pam O'Donoghue, Oncology (Hepato-Pancreato-Biliary) Clinical Nurse Specialist, London; Elizabeth Piggott, Community Lead Dietitian, Manchester; Dr Marion Sloan, FRCGP, GP, Sheffield and Committee member of Primary Care Society for Gastroenterology (PCSG).

1 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]

2 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?)

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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 ($\geq 10\%$ loss of body weight in 3–6 months); blood (fresh or 'coffee ground' appearance) and pain associated with symptoms

STEATORRHOEA

- How do the stools appear? (pale yellow / grey in colour; frothy; floating or oily?)*
- 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

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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

5 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 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

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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 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

* Determine stool appearance using a validated tool (for example Bristol Stool Chart <http://www.gpnotebook.co.uk/simplepage.cfm?ID=x20100606160522260465> King's Stool Chart <http://www.kcl.ac.uk/medicine/research/divisions/dns/projects/stoolchart/index.aspx>)

SPECIFIC NUTRITIONAL GUIDANCE FOR 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
- 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?

NAUSEA / VOMITING

- **Nutritional intervention(s):** 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)

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

PAIN / 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)

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

All management strategies for malnourished patients should be developed by a multidisciplinary team and considered in accordance with local practice guidelines for screening, referrals and management, and in line with existing NICE guidance regarding nutritional support and the management of associated conditions. Readers are also referred to Collins et al (Managing malabsorption and poor feed tolerance in adults: a practical guide. July 2012. https://www.abbottnutrition.co.uk/media/24709/managing_malabsorption_and_poor_feed_tolerance_in_adults_a_practical_guide.pdf Accessed 16th July 2014) for practical guidance on the management of malabsorption and poor feed tolerance in adults.

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