Chronic diarrhoea, Acute and Chronic Bloody diarrhoea and potential IBD

This is a relatively common problem and may present as acute diarrhoea, with or without blood usually due to infection. Stooling is usually four or more times a day and less than two weeks duration. Early investigation with stool M C and S (and consideration of C difficile toxin request and flagging up the clinical indication to the laboratory) and virology is indicated. If there is delay in getting a sample during acute diarrhoeal illness, the stools may be negative despite an infection being present during the acute phase: this may be a bacterial or viral infection. For the majority, who may be otherwise well with a more chronic diarrhoea problem, short term (a few weeks) symptomatic management of their colicky pain with an antispasmodic and / or anti-diarrhoeal, may be all that is required. On occasion, the judicious use of an empirical course of metronidazole or ciprofloxacin may also be useful.

Chronic diarrhoea is of two to three weeks or longer duration. There may or may not be blood in stools, abdominal pain and urgency, tenesmus and night-time stooling causing suspicion of IBD. Children may also complain of abdominal pain and diarrhoea that would be consistent with irritable bowel syndrome. Stools for MC and S, and again consideration of C difficile, and bloods are indicated prior to referral. This will also help speed up management and triage of the referral.

Dietary triggers for loose stools need to be excluded before embarking on investigations- milk as well as simple sugars/fruit juice / squash regardless of sugar or artificial sweeteners such as sorbitol, mannitol and xylitol (in chewing gum and 'sugar free' sweets) can also contribute.

Recommended workup for chronic diarrhoea (and suspected IBD) would be FBC, ESR, U & E, creatinine, LFTs, CRP, calcium, phosphate and magnesium. Stools should be sent for M C and S, and again consideration of C diff toxin (has to be specifically requested) to exclude specific enteric infections. Stools should also be sent for faecal calprotectin if IBD is suspected, but the laboratory will often refuse this unless this is on the recommendation of a Gastroenterologist. If requested after discussion with one of our team, please put that on the form with the name of the relevant consultant you discussed the patient with and this will help. Patients who are more likely to have diarrhoea-predominant IBS might also benefit from having these investigations (see later).

If the problem is chronic diarrhoea, and Coeliac disease is suspected, an IgA level and coeliac screen should be requested in addition to the list above. In this case, faecal calprotectin would not be required.

We are more than happy to offer advice directly if it would be helpful. For children who are suspected of having significant symptoms but who do not require immediate attention at A&E, these investigations are very useful to have available. For children who cannot have bloods performed in general practice, the phlebotomy service at RHSC is available and children may be sent up within working hours (see resources) for these tests, either with a relevant form or letter. If stool samples are also being requested, it may be better to have the family bring those up on the day the bloods are performed so they all go away at the same time.

Children with suspected IBD or bleeding that may be related to a polyp and who are not suspected of having a surgical problem should be referred directly to the GI service.

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