CHICAGO HEALTH COLLEAGUES

Clinical Guideline | Acute Diarrhea

SUMMARY OF CLINICAL GUIDELINE	
Disease or Condition	Acute Diarrhea
Guideline Title:	Approach to Acute Diarrhea in Adults
Guideline Source:	American College of Gastroenterology (ACG) ; Infectious Disease Society of America (IDSA)
Guideline Link	http://gi.org/guideline/diagnosis-treatment-and-prevention-of-acute-diarrheal-infections-in-adults/ https://www.idsociety.org/practice-guideline/infectious-diarrhea/
Guideline Original Date	ACG - 4/2016 ; IDSA - 2001
Guideline Most Recent Revision Date	ACG – 4/2016 IDSA – 10/2017
CHC Review Date(s)	Guidelines and Components in Summary were reviewed and approved January 2019 by the Acute Diarrhea Workgroup. Recommendations for adoption referred to the Board of Managers for approval on January 17, 2019. Guideline Approval/ Update/Revision Meetings: • Approved January 17, 2019 • Will be reviewed with updates or at least every two years.
Rationale	Diagnostic testing and empiric antibiotic therapy are overused in the management of acute diarrheal disease without evidence of efficacy with a resultant increase risk of antimicrobial resistance and opportunistic infections as well as increased overall health care cost.
Guideline Summary	Clinicians should not initiate diagnostic stool testing or empiric antibiotics in immunocompetent adults with acute diarrhea and the absence of high risk symptoms. Rather oral hydration and non-antibiotic therapeutic options should be used.
Implementation Components **Identify component(s) of the guideline CHC should adopt.**	**Key Component/Messages:** Acute diarrhea is defined as passage of a greater number of stools of decreased form from the normal for < 14 days. The diarrhea may be accompanied by nausea, emesis, bloating, cramping and low- grade fever. Most cases of acute diarrhea are infectious, with the vast majority being viral in origin. Severe acute diarrhea however, is more likely to be bacterial.

	Evaluation of acute diarrhea should involve identifying the presence of dysentery (passage of grossly bloody stools), severe disease (defined as total disability and fever >101), prolonged disease (defined as duration > 72 hours) and the presence of recent travel. Diagnostic testing using stool culture based or culture independent methods should be reserved for patients with severe febrile non-travel based diarrhea lasting > 72 hours or in cases of dysentery. Fecal leukocyte testing is neither sensitive nor specific for infectious diarrhea and should not be used in the evaluation of acute diarrhea. Travelers diarrhea has a very high likelihood of being secondary to a non-toxigenic bacterial infection and thus, should be treated empirically with antibiotics in combination with anti-secretory or anti-peristaltic agents. All patients with acute diarrhea should be treated with oral hydration and increased salt intake (soups, broths, saltine crackers, baked and broiled foods). Non-antibiotic therapies such as anti-peristaltic and anti-secretory agents are effective in reducing symptom duration in most patients and carry minimal risk.
Recommendations/ Other Considerations	• Diagnostic stool testing using culture-based or culture-independent methods should be reserved for the following scenarios: 1. Dysenteric diarrhea (defined as passage of bloody diarrhea) 2. Moderate-to-severe disease with fevers > 101 lasting > 72 hours 3. Cases lasting > 7 days 4. Individual patients at high risk of spreading disease to others (ex: food handlers, health care workers, day care personnel and residents of institutional facilities) • Fecal Leukocyte testing should not be used in the evaluation of patients with acute diarrhea. • Empiric therapy with antibiotics is not recommended for routine acute diarrheal infection, as the majority of pathogens are viral. • Patient's with Travel-Associated Diarrhea, either watery or dysenteric, should be treated empirically with antibiotics with adjunctive loperamide to decrease duration of diarrhea and increase chances of cure. • Patients with immunocompromised state and/or patients with severe dysenteric illness can be considered for empiric antibiotic therapy.

	• Prebiotics and Probiotics are not recommended for the treatment or prevention of acute diarrhea illness except in the case of post-antibiotic associated diarrhea. • Electrolyte-Balanced Oral Rehydration Therapy (ORTs) are recommended for the elderly with severe diarrhea or any patient with cholera-like travelers' diarrhea. • All patients with acute diarrhea should be treated with oral hydration and increased salt intake (soups, broths, saltine crackers, baked and broiled foods) • Non-antibiotic therapeutic options for acute diarrhea include anti-secretory therapy (Bismuth Subsalicylate two 263mg tablets every 30-60min , not to exceed 8 tablets in 24hrs) or anti-motility drugs (loperamide 4mg PO once, then 2mg after each bowel movement , not to exceed 16mg in 24 hrs) • Antibiotics selections for empiric therapy for acute diarrhea include: 1. Levofloxacin 750mg PO once or 3 day course 2. Ciprofloxacin 500mg PO once or 3 day course 3. Azithromycin 1000mg PO once or 3 day course 4. Rifaxamin 200mg PO TID for 3 day course
CHC Adoption and Implementation Resources	• http://gi.org/wp-content/uploads/2016/05/ajg2016126a.pdf
Other Supplemental Documents (to support guideline adoption/education)	www.uptodate.com/approachtotheadultwithdiarrheainresourcerichsettings https://www.uptodate.com/contents/diarrhea-in-adolescents-and-adults-the-basics?topicRef=2717&source=see_link
Quality Measures and Associated Programs List of current related CHC and ACO quality measures	**BCBS ACO Improvement Initiative:** • Appropriately reduce ER utilization
Strategies to Improve Performance	• Educate staff on guidelines and treatment options • Detailed history is key to guide treatment recommendations and diagnosis • Provide patient and caregivers handouts on rehydration and appropriate foods while recovering • Conduct a follow-up call to patient to check for improvement/adjust treatment

	• Educate staff on importance of timely access to an appointment when patients call complaining of acute diarrhea • Have staff pre-screen for issues with dehydration and exacerbation of other co-existing health conditions
Coding and Documentation Tips	na
HCC Coding and Documentation Tips	na
CHC Acute Diarrhea Clinical Guideline Workgroup	• Daniel O'Reilley MD • Antoinette Sperelakis MD • Stephen Spontak MD
Misc. References	*ACG Clinical Guideline. Am J Gastroenterol* 2016; 111:602–622; doi:10.1038/ajg.2016.126 *Clinical Infectious Disease IDSA Guideline* 2017 Shane et al. **2017;65(12):e45–e80**