High Fecal Output

Guiding Principles
- Patients will be supported with IV hydration and/or nutritional supplementation while high fecal outputs are managed.
- Referral to Dietitians and Pharmacists are required.
- Pharmaceutical and dietary interventions should occur simultaneously.
- All interventions should be tried for a minimum of 72 hours before moving onto the next step.
- Individualized care plans and patient engagement are critical to success.

Goals of Care
- Provide adequate protein, energy, vitamins, minerals, fluids and electrolytes to maintain or improve nutritional status.
- Decrease or eliminate the need for parenteral nutrition or intravenous fluids when possible.
- Implement appropriate drug therapy.
- Reduce fecal output to less than 1500 ml daily.
- Maintain minimum of 1 litre urine output daily.
- Re-establish activities of daily living/usual routines.

Nutrition Interventions: Patients with Ostomies/Fistulas

Step I
- **Ostomy diet**
- No caffeine
- 6 meals per day
- Gatorade 2 (G2)

Step II - Add
- Low-osmotic diet**, low lactose

Step III - Add
- 1 gram of NaCl with 250ml of low simple sugar beverages
- Eliminate all other fluids
- Add 3 salt packets to meal trays (2g NaCl)
- Separate liquids from solid food by 45 minutes

Step IV
- Change all liquids to: Gastrolyte® or SMH Oral electrolyte solution

Nutrition Interventions: Patients with Colon

Step I
- Low roughage, high bulk diet
- No caffeine
- 6 meals per day
- Gatorade 2 (G2)

Step II - Add
- Low-osmotic diet**, low lactose

Step III - Add
- 1 gram of NaCl with 250ml of low simple sugar beverages up to 6g NaCl/day
- Eliminate all other fluids
- Add 3 salt packets to meal trays (2g NaCl)
- Separate liquids from solid food by 45 minutes

Step IV
- Change all liquids to: Gastrolyte® or SMH Oral electrolyte solution

Pharmaceutical Interventions

Step I
- All patients with extensive small bowel resection should be on PPI
- Initiate as oral tablets; if there is a concern with absorption, change to IV
- SMH Formulary: pantoprazole, esomeprazole
- Review all liquid medications to avoid sugar alcohols

Step II - Add
- Imodium® (loperamide) 4mg po tid ac, hs
- For patients with a colon, psyllium 1 tsp bid (titrate dose to effect max. 3 tbsp bid)

Step III - Add
- Lomotil® (diphenoxylate/atropine) 1 tab po tid ac & hs
- For patients with a colon, psyllium 1 tsp bid (titrate dose to effect max. 1 tbsp bid)

Step IV - Add
- Increase Lomotil® to 2 tabs tid ac & hs AND increase loperamide to 8mg tid ac & hs
- Increase octreotide to 50mcg sc bid ac

Step V
- Initiate octreotide 25mcg sc bid ac
- Increase octreotide to 50mcg sc tid ac
- Increase octreotide to 100mcg sc tid ac

NOTE
- For patients with bile acid diarrhea AND those with <100cm of SB resected AND an intact colon, consider cholestyramine 4 g po daily

High fecal output occurs when there is insufficient bowel (or insufficient working bowel) to maintain fluid and/or nutritional requirements. While individual patient experiences may differ, this typically manifests as greater than 1500 ml of stool loss/24 hours.
Helpful Hints - Pharmacy

- Avoid liquid drug products (e.g., syrups); sweeteners (sorbitol) may exacerbate outputs
- Administer medications 30 min before meals to increase absorption
- Lomotil is preferred to Cadeine to slow outputs
- Octreotide is more beneficial in net secretors: those with outputs > 3 L/24 h
- Oral PPI’s require >50 cm of small bowel for absorption
- Dilute psyllium in 1 cup of water
- If trialing cholestyramine, other medications should be taken 1 h before or 4 h after or as great an interval as possible
- Once a patient's outputs are under control, it may be advisable to trial scaling back or reducing the dose of anti-diarrheal medications
- Once stable on the appropriate dose of octreotide you may consider converting to a long acting product.

References


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