Dr Melissa White
MBBS (QLD) FRACP
Gastroenterologist
Provider No: 034161CL

Suite 2/52 Burnett St
Buderim, Qld, 4556
(07) 5456 4278
(07) 5450 1045
www.melissawhitegastro.com.au

Chronic Diarrhoea

Diarrhoea that lasts for more than 4 weeks is considered chronic and is evaluated differently from diarrhoea of shorter duration. A number of small intestinal infections can cause symptoms that last for months or years if untreated and should be excluded with appropriate studies. Similarly, easily treated problems such as lactose intolerance and hyperthyroidism should be ruled out. A careful history also helps to direct diagnostic attention to the small or large bowel and distinguish organic from functional diarrhoea.

Colonoscopies play a central role in the evaluation of chronic diarrhoea. This is an easily performed test that has specific advantages in further examining the bowel. Biopsies are taken at the time of your procedure to determine if any underlying abnormalities are present. It is an invaluable diagnostic tool when looking for causes of chronic diarrhoea.

A detailed past medical history helps to direct testing to the colon when the patient complains of small volume diarrhoea, squeezing pain (even in the absence of proctitis), rectal bleeding or lower abdominal cramps. Diarrhoea that emanates from the small bowel tends to be of greater volume and is associated with abdominal distension, bloating and pain. Weight loss is more common with small bowel disease. Several characteristics suggest that an organic cause will not be found for a patient's diarrhoeal disorder. The symptoms of functional causes for chronic diarrhoea are as follows:

- Diarrhoea that occurs only during the day
- The absence of blood or white cells in the stool
- The absence of substantial weight loss
- A long history of bowel problems dating back to adolescence or childhood.

On careful questioning, many patients are actually found to have alternating diarrhoea and constipation or diarrhoea that turns out to be frequent, incomplete evacuations of small pellet-like stools. In all patients with chronic diarrhoea, the possibility of surreptitious ingestion of laxatives or diuretics should be considered. Daily stool weight is also often helpful.

Patients who continue to have diarrhoea, but in whom a specific organic cause has not been documented, may require some medical therapy to reduce the frequency and volume of diarrhoeal movements. In general, initial attempts should employ non-addictive medications because the problem can be expected to last for a considerable length of time. Sequential 2 to 3 week trials of psyllium (hydrophilic), cholestyramine and loperamide can be undertaken. Loperamide is not addictive and is quite effective in this setting.

When a colonoscopy is performed during the course of the evaluation of chronic diarrhoea and the visual appearance is normal, it is important to obtain random mucosal biopsies. Occasionally, patients with chronic watery diarrhoea are found to have a visually normal colon but abnormal mucosal biopsies. The histology may show an abnormality of the mucosa of a layer of collagen thickening of the membrane under the colonic epithelium.

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This entity has been called lymphocytic, microscopic or collagenous colitis. Most of the microscopic changes in lymphocytic and collagenous colitis are seen in the proximal colon and can be missed in sigmoidoscopic biopsies. Some patients have associated changes in the small bowel and stomach. A wide spectrum of treatments can be used such as sulfasalazine, steroids and loperamide, with a variable response. This is a treatment that should be guided by a specialist in these rare conditions.

Collagenous colitis is most commonly seen in women, with 80% of women with chronic diarrhoea developing this disease. Alternatively, lymphocytic colitis is found equally in both sexes. There is no difference in the response to many of the therapies that have been provided for this entity. Most investigators attempt administering anti-diarrhoeal therapy before corticosteroids because spontaneous remission has been reported and serious complications of the diarrhoea are unusual.