Management of High Output Stoma Guideline

Definition – Stoma output ≥ 1500ml

Exclude potential causes:

- Intra-abdominal sepsis
- Bowel obstruction
- Enteritis (including C. difficile and salmonella)
- Disease in remaining bowel (including Crohn's or radiation-induced)
- Drug withdrawal (e.g. sudden withdrawal of steroids or anticholinergics)
- Consider stopping any prokinetics (laxatives, metoclopramide, domperidone, erythromycin, etc)

Initial Management

- IV fluid REPLACEMENT – follow NHSL Fluid Management Protocol
- Daily U&E and Magnesium
- Restrict oral hypotonic fluids (water, tea, coffee, fruit juice)
- Accurate Fluid Balance Chart
- Weekly weights
- Nutritional Screening (MUST Chart)

Notify immediately:

- Consultant
- Stoma Nurse
- Dietician

Oral Rehydration Therapy

Stoma output > 1.5L/day	**Dioralyte** 2 sachets in 200ml of water 5 times daily
If hyperkalaemic	**Electrolyte Mixture** 1L over the course of the day * see over

Pharmacological Therapy

Start - Omeprazole 40mg BD *and* Loperamide 4mg QDS

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Can slowly titrate Loperamide by 2mg QDS as patient requires up to 8mg QDS (ie 32mg/day)

** Follow BIFA recommendations (see over)*

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Add codeine 30mg QDS can titrate to 60mg QDS

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Continue to slowly titrate Loperamide by 2mg QDS as patient requires up to 16mg QDS (64mg/day)

** Follow BIFA recommendations (see over)*

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If high output continues**: Refer to consultant**

Author: Sarah Connelly/Alisdair MacDonald/Linda Thomson October 2019
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Review patient daily, as output decreases work backwards through pharmacological regime until patient stabilises

British Intestinal Failure Alliance (BIFA) Recommendations on The use of high dose loperamide in patients with intestinal failure

1. Perform an ECG in all patients with a high output stoma/fistula before starting high dose loperamide (more than 4 mg four times a day) and the QT interval should be measured and documented. The ECG should be repeated after starting the high dose and then every 3 years if the patient remains on high dose loperamide therapy.

2. If the QT interval is prolonged cardiac co-morbidities are considered, drugs known to prolong the QT interval are rationalised and metabolic causes (e.g. hypomagnesaemia) are treated. A cardiological opinion may be sought.

3. Patients already taking high dose loperamide should continue with it and the QT interval measured on an ECG. The loperamide should not be stopped.

4. The total daily dose of loperamide should normally be below 80 mg.

5. Loperamide toxicity should be considered in any patient with fainting episodes not accounted for by dehydration or other drugs. It should also be considered if there is QT prolongation on the ECG or a serious ventricular arrhythmias including torsades de pointes or cardiac arrest occur.

6. If symptoms of toxicity/overdose occur, naloxone can be given as an antidote but as the duration of action of loperamide is longer than that of naloxone (1–3 hours), repeated treatment with naloxone may be needed and the patient should be monitored closely for at least 48 hours to detect possible CNS depression.

7. Report all suspected adverse reactions, including those associated with abuse or misuse, to the Yellow Card Scheme.

Electrolyte Mixture

The patient should make the solution up fresh every day using the following measurements:

- 20g (six level 5mL spoonfuls) of Glucose powder
- 2.5g (one heaped 2.5mL spoonful) of Sodium Bicarbonate powder (baking soda) / if the patient cannot tolerate sodium bicarbonate, use Sodium Citrate powder
- 3.5g (one level 5mL spoonful) of Sodium Chloride (table salt)

This is then dissolved in 1 Litre of tap water, and the patient should drink up to the prescribed volume throughout the day. Two to three litres per day may be necessary to maintain hydration. The solution can be stored at room temperature or in the fridge but it must be discarded 24 hours after mixing and a fresh solution prepared the next day.

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