Acg guidelines acute diarrhea

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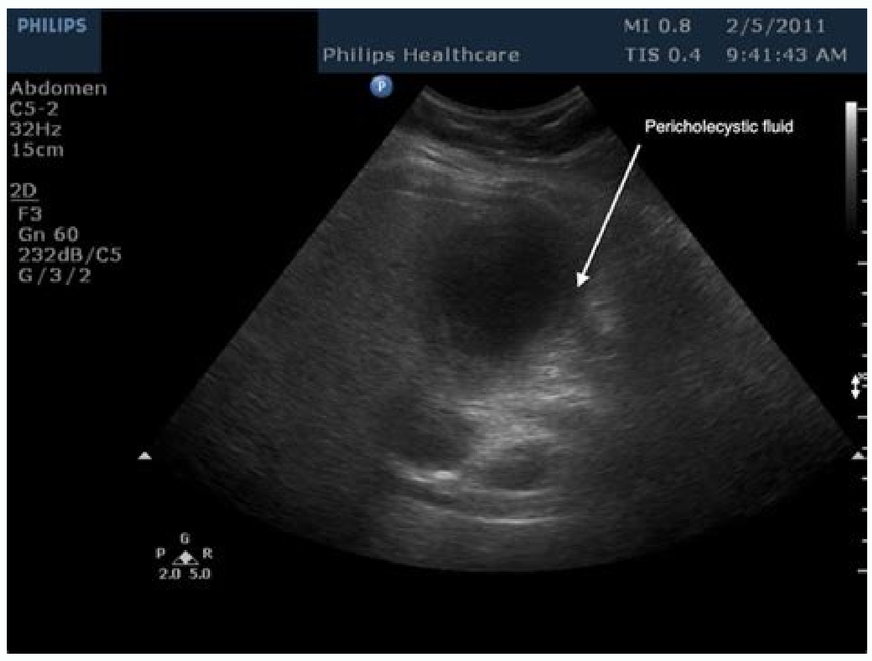
Patient history details	Causes of acute diarrhea			
Food-borne outbreak	Salmonella	Shiga-toxigenic E. coli	Yersinia	Cyclospora
Water-borne transmission	Vibrio	Giardia intestinalis	Cryptosporidium	
Seafood, shellfish	Vibrio	Norovirus	Salmonella	
Poultry	Campylobacter	Salmonella		
Beef, raw seed sprouts	Shiga toxin–producing E. coli (STEC)	Enterohemorrhagic E. coli		
Eggs	Salmonella			
Mayonnaise and cream	Staphylococcus	Clostridium perfringens	Salmonella	
Pets	Salmonella	Campylobacter jejuni	Cryptosporidium	Giardia intestinalis
Antibiotics, chemotherapy	Clostridium difficile			
Person to person	Shigella	Rotavirus		



APACHE Scoring System

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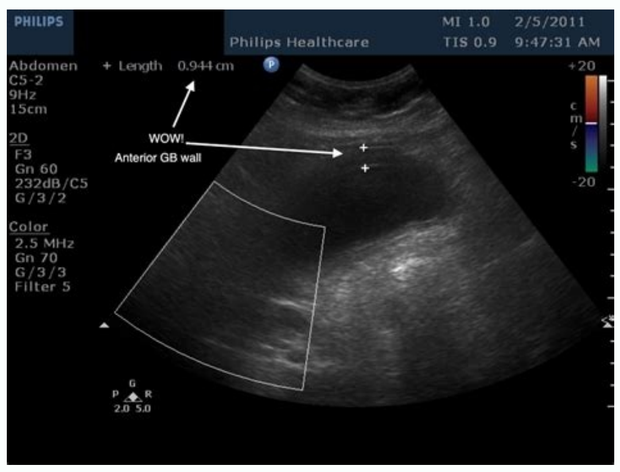
- Immediate assessment of the severity of pancreatitis possible
- Can be used even after 48 hours
- **Unlike ALL pancreatic specific** scoring systems, APACHE (and SOFA) also includes clinical features of patient besides laboratory values
(Clinical findings are more important than lab findings in predicting SIRS,sepsis and other complications)
- Best validated(medscape)



Acute diarrhea in adults guidelines. Acg diarrhea guidelines. Acute diarrhea guidelines. Acute diarrhea guidelines 2019.

Diagnosis, Treatment, and Prevention of Acute Diarrheal Infections in Adults CAPT Mark S. Riddle, MD, DrPH, Enteric Diseases Department, Naval Medical Research Center, Silver Spring, MD; Herbert L. DuPont, MD, University of Texas Health Science Center at Houston; Bradley A. Connor, MD, Weill Medical College of Cornell University Acute diarrheal infections are a common health problem globally and among both individuals in the United States and traveling to developing world countries. Multiple modalities including antibiotic and non-antibiotic therapies have been used to address these common infections. Information on treatment, prevention, diagnostics, and the consequences of acute diarrhea infection has emerged and helps to inform clinical management. The College has published a new ACG Clinical Guideline in which the authors present an evidence-based approach to diagnosis, prevention, and treatment of acute diarrhea infection in both U.S.-based and travel settings. Dr. Riddle comments on what's new here: The new ACG guideline applies the GRADE system of development including weighting of benefit/risk and quality of evidence With the arrival of FDA approved culture-independent multi-pathogen diagnostics, use of these tests are now considered within the algorithm to help identify causes and tailor specific therapy — particularly for symptoms lasting more than 2 weeks Probiotics and prebiotics for treatment are considered (not recommended) Simplified treatment for bacterial diarrheas Dr. Riddle provides suggestions for healthy adult patients about preventing diarrheal infections, particularly travelers' diarrhea: Prevention Handwashing is a good idea (always, for many reasons). However, it may be of limited value in the traveler setting, but may be useful in situations where low-dose pathogens are responsible for illness (e.g., institutional outbreak, cruise ship) While avoiding risky food/hotel water/ice makes a lot of sense, studies do not show that this really works in travelers If the trip is really critical, or the traveler has underlying health conditions (such as inflammatory bowel disease), short term chemoprophylaxis with rifaximin should be considered Treatment Travelers should be given antibiotics and loperamide along with education on how to self-treat should they become ill. Usually it only takes a single dose of antibiotics with loperamide to achieve cure in a majority of cases. READ THE GUIDELINES AGA (American Gastroenterological Association), CI (confidence interval), CRP (C-reactive protein), ESR (erythrocyte sedimentation rate), GRADE (Grading of Recommendations Assessment, Development, and Evaluation), IBD (inflammatory bowel disease), IBS-D (diarrhea-predominant irritable bowel syndrome)This document presents the official recommendations of the American Gastroenterological Association (AGA) on the Laboratory Evaluation of Functional Diarrhea and Diarrhea-Predominant Irritable Bowel Syndrome (IBS-D) in Adults. The guideline was developed by the AGA's Clinical Practice Guideline Committee and approved by the AGA Governing Board. These Guidelines should expire in 5 years.The focus of this guideline is to aid clinicians in choosing appropriate laboratory tests to exclude other diagnoses in the setting of suspected functional diarrhea or IBS-D. These guidelines apply to the evaluation of the immunocompetent patient with "watery" diarrhea of at least 4 weeks duration. This would exclude those patients with bloody diarrhea; diarrhea with signs of fat malabsorption; presentations with alarm features, such as weight loss, anemia, and hypoalbuminemia; those patients with a family history of inflammatory bowel disease (IBD), colon cancer, or celiac disease; and those with a travel history to regions with recognized specific diarrhea-related pathogens.This guideline was developed using a process outlined elsewhere.1American Gastroenterological AssociationAGA Institute clinical practice guideline development process. Briefly, the AGA Institute process for developing clinical practice guidelines incorporates GRADE (Grading of Recommendations Assessment, Development, and Evaluation) methodology and best practices as outlined by the Institute of Medicine.3Institute of MedicineClinical Practice Guidelines We Can Trust. GRADE methodology was used to prepare the background information for the guideline and the technical review that accompanies it. Optimal understanding of this guideline will be enhanced by reading applicable portions of the technical review. The guideline panel and the authors of the technical review met face-to-face on September 8, 2017 to discuss the quality of evidence (Tables 1 and 2) and consider other factors relevant for the risk–benefit assessment of the recommendations. The guideline panel included 2 members of the AGA Clinical Practice Guidelines Committee (WS, SW, YFY), a GRADE methodologist (AC-L), and a primary care physician (CFY). The members of the guidelines panel subsequently formulated the recommendations by consensus. Although quality of evidence was a key factor in determining the strength of each recommendation (Table 2), the panel also considered the balance between the benefit and harm of interventions, patients' values and preferences, and resource utilization. Development of this guideline and its accompanying technical review was fully funded by the AGA Institute with no additional outside funding.Recommendation 1: In patients presenting with chronic diarrhea, the AGA suggests the use of either fecal calprotectin or fecal lactoferrin to screen for IBD. Conditional recommendation; low-quality evidence.Comment: A threshold value of 50 μg/g for fecal calprotectin is recommended to optimize sensitivity for IBD. Threshold values in the range of 4.0–7.25 μg/g for fecal lactoferrin are recommended to optimize sensitivity.Table 1Grading of Recommendations Assessment, Development, and Evaluation Definitions of Quality and Certainty of the EvidenceTable 2Grading of Recommendations Assessment, Development, and Evaluation Definitions of Strength of Recommendation and Guide to InterpretationCalprotectin and fecal lactoferrin have been proposed as markers for inflammatory conditions, such as IBD. There are several studies using fecal calprotectin with different threshold values to identify persons with IBD. Based on a review of the available data, it appears that using fecal calprotectin with a threshold of 50 μg/g yields the optimal performance. Among studies using this threshold, the pooled sensitivity for IBD was 0.81 (95% confidence interval [CI], 0.75–0.86) and the pooled specificity was 0.87 (95% CI, 0.78–0.92). Risk of bias and statistical imprecision influenced the determination that evidence supporting the use of fecal calprotectin was of low quality. Use of a higher threshold value (100–164 μg/g) is associated with a markedly decreased sensitivity without a marked increase in specificity.In a similar fashion, fecal lactoferrin has been studied as a marker for IBD. Utilizing data from the available studies using a threshold value from 4.0 to 7.25 μg/g, the pooled sensitivity for IBD was 0.79 (95% CI, 0.73–0.84) and the pooled specificity was 0.93 (95% CI, 0.63–0.99). Risk of bias, significant heterogeneity, and statistical imprecision influenced the determination that evidence supporting the use of fecal lactoferrin was of low quality.The low quality of evidence supporting the use of these tests is compounded by the small likelihood that a positive test would initiate further confirmatory evaluation, leading to an earlier diagnosis of IBD compared to the 10% likelihood that persons without IBD might be needlessly exposed to further confirmatory testing.Recommendation 2: In patients presenting with chronic diarrhea, the AGA suggests against the use of erythrocyte sedimentation rate or C-reactive protein to screen for IBD. Conditional recommendation: low-quality evidence.Both erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP) have been tested in populations with diarrhea to identify patient with IBD. In studies using a value of 5–6 mg/L as a threshold for CRP level, the pooled sensitivity was 0.73 (95% CI, 0.64–0.80) and the pooled specificity was 0.78 (95% CI, 0.58–0.91). Studies of similar design utilizing threshold values of 10–15 mm/h for ESR resulted in lower estimates of diagnostic accuracy for IBD.While there are few settings where ESR should be considered as an appropriate screening test for IBD, there are some settings where the use of CRP might be a rational option. For example, if testing for fecal lactoferrin or calprotectin are either not available or not covered by insurance, the use of CRP might be considered to be a reasonable option to screen for IBD.Recommendation 3: In patients presenting with chronic diarrhea, the AGA recommends testing for Giardia. Strong recommendation: high-quality evidence.Comments: Use of a Giardia antigen test or polymerase chain reaction for Giardia test is recommended.Throughout the United States, Giardia is a common cause of watery diarrhea that can be readily treated. Modern diagnostic tests for Giardia have excellent performance characteristics, with many studies demonstrating sensitivity and specificity of >95%. The best available tests utilize either detection of Giardia antigens or polymerase chain reaction for the Giardia small subunit ribosomal RNA. Because treatments are straightforward, there is little risk in utilizing these tests in evaluation of chronic watery diarrhea.Recommendation 4: In patients presenting with chronic diarrhea with no travel history to or recent immigration from high-risk areas, the AGA suggests against testing for ova and parasites (other than Giardia). Conditional recommendation: low-quality evidence.In the absence of travel or immigration from high-risk areas, the practice of routinely testing the stool for ova and parasites is highly unlikely to identify important causes of chronic watery diarrhea. Guidance on testing and treating diarrhea among those who have been in a high-risk area can come from several sources.5Traveler's HealthTravelers' diarrhea. Centers for Disease Control and Prevention website., 6Riddle M.S. Connor B.A. Beeching N.J. et al.Guidelines for the prevention and treatment of travelers' diarrhea: a graded expert panel report.Recommendation 5: In patients presenting with chronic diarrhea, the AGA recommends testing for celiac disease with IgA tissue transglutaminase and a second test to detect celiac disease in the setting of IgA deficiency. Strong recommendation: moderate-quality evidence.Comments: Testing options for IgA-deficient subjects include IgG tissue transglutaminase and IgG or IgA deaminated gliadin peptides.Celiac disease is an important cause of chronic diarrhea and other manifestations. Among patients with chronic diarrhea who do not have IgA deficiency, use of serum IgA tissue transglutaminase (tTG) is a highly efficient strategy for determining the presence of celiac disease. In these patients, the sensitivity of serum IgA-tTG using thresholds in the 7–15 AU/mL range is typically >90% and the specificity is typically slightly higher. A positive test would warrant confirmation by duodenal biopsy.Because IgA deficiency can lead to a false-negative result, there are 2 strategies to use among those tested who have a negative IgA-tTG. A quantitative IgA level, if normal, confirms the accuracy of a negative IgG-tTG. The use of either the IgG-tTG or a test for IgG deaminated gliadin peptides might be considered for use in IgA-deficient patients or combined as an initial strategy combined with IgA-tTG when IgA levels are not available.In adults, small bowel biopsy should be used to confirm a serologic diagnosis of celiac disease before committing a patient to a strict gluten-free diet.Recommendation 6: In patients presenting with chronic diarrhea, the AGA suggests testing for bile acid diarrhea. Conditional recommendation: low-quality evidence.Comments: In settings with limited availability of commercial assays, an empiric trial of a bile acid binder could be considered.Bile acid diarrhea may be due to excess production or decreased absorption of bile acids, which then reach the colon and can cause watery diarrhea. There are several tests that have been proposed to identify those persons who have bile acid diarrhea. 75Selenium homotaurocholic acid test is a nuclear medicine test used to identify those with diarrhea due to bile acid malabsorption and has moderate diagnostic efficiency. This test is used in Europe but is not available in North America. In the United States, other tests for bile acid diarrhea are measurement of total bile acids in a 48-hour stool collection (which would document increased fecal bile acids) and serum fibroblast growth factor 19, which measures defective feedback of bile acid synthesis. A test that is not yet available is measurement of serum levels of the marker 7α-hydroxy-4-cholesten-3-one—a measure of bile acid synthesis. Because these tests are not widely available or Food and Drug Administration–approved, it is reasonable to use an empiric trial of bile acid binders in patients in whom bile acid diarrhea is considered, with clinical response suggesting excess bile acids as the cause for diarrhea.Recommendation 7. In patients presenting with chronic diarrhea, the AGA makes no recommendation for the use of currently available serologic tests for diagnosis of IBS.No recommendation; knowledge gap.IBS-D is a major cause of chronic watery diarrhea. Several tests have been proposed to identify those with IBS-D and who might benefit from IBS-D–specific therapy. Specifically, it has been postulated that a strategy of measuring antibodies to cytolethal distending toxin B and the gut mucosal protein, vinculin, might be used to identify persons who have post-infectious IBS-D.The available data are sparse but suggest that the contemporary tests lack the diagnostic accuracy needed for routine use. In addition, the case–control design of the studies and the study setting used (secondary and tertiary care) likely inflate the estimates of the test characteristics compared to what is expected in a general population. The specificity in the 2 studies available for the technical review was in the 90% range, meaning that a positive test would indicate a high likelihood of IBS-D. However, the low sensitivity (20%–40%) would not be sufficient to employ these tests in routine use. More data will be helpful in determining the proper roles of these and similar tests.These practice guideline recommendations for the evaluation of functional diarrhea and IBS-D with the intent of excluding other diagnoses in adults were developed using the GRADE framework and in adherence with the standards for guideline development set forth by the Institute of Medicine for the creation of trustworthy guidelines. These guidelines are intended to reduce practice variation and promote high-quality and high-value care for this patient population. Current evidence supports the use of fecal calprotectin or fecal lactoferrin and stool testing for Giardia in patients presenting with chronic diarrhea. The panel suggests against the use of blood tests ESR or CRP to screen for IBD. Our evidence profiles also strongly recommend testing for celiac disease with IgA-tTG and a second test to detect celiac disease in the setting of IgA deficiency. In addition, testing for bile acid diarrhea is suggested. The AGA makes no recommendation for the use of currently available serologic tests for the diagnosis of IBS and should be the focus of future research (Table 3). A clinical decision support tool is included to guide the evaluation of patients with chronic watery diarrhea (>4 weeks) (Figure 1).Table 3Summary of Recommendations of the American Gastroenterological Association on the Laboratory Evaluation of Functional Diarrhea and Diarrhea-Predominant Irritable Bowel Syndrome in AdultsThis guideline/update was produced by the AGA Institute.Published online: July 11, 2019Reprint requests Address requests for reprints to: Chair, Clinical Guidelines Committee, American Gastroenterological Association, National Office, 4930 Del Ray Avenue, Bethesda, Maryland 20814. e-mail: Conflicts of interest All members were required to complete the disclosure statement. These statements are maintained at the AGA headquarters in Bethesda, Maryland, and pertinent disclosures are published with this report.Funding Development of this guideline and its accompanying technical review was fully funded by the AGA Institute with no additional outside funding.DOI:

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