Diarrhea is a common side effect of chemotherapy regimens, particularly fluorouracil- and irinotecan-based therapies and abdominal and pelvic radiation regimens. Diarrhea can cause depletion of fluids and electrolytes, malnutrition, dehydration, and hospitalization, all of which can lead to cardiovascular compromise and death. Therefore, diarrhea can interfere with and detract from cancer treatment by causing dosing delays or reductions. Evidence supports pharmacologic interventions such as loperamide and octreotide as recommendations for practice. Emerging evidence suggests that probiotics are likely to be effective, but more extensive research is warranted as the field evolves. Soluble fiber supplements are likely to be effective for treating chemotherapy- or radiotherapy-induced diarrhea; however, additional research is needed because the type and dose of soluble fiber most effective in treating and preventing these types of diarrhea are unknown. This article is limited to recommendations for chemotherapy- and radiotherapy-induced diarrhea. The chemotherapy regimens included in most of the studies reviewed were the commonly used regimens containing drugs such as fluorouracil, cisplatin, adriamycin, and irinotecan.
Diarrhea is a common side effect of certain chemotherapy regimens and abdominal and pelvic radiation.

Pharmacologic interventions have the highest level of evidence for managing cancer treatment-induced diarrhea.

Dietary modifications, provided by a registered dietitian, are consistent with clinical guidelines for management of cancer treatment-induced diarrhea.

Clinical Journal of Oncology Nursing • Volume 13, Number 3 • Interventions for Diarrhea

Methods

Articulating an accurate definition of diarrhea was a challenge because a universally accepted definition does not exist. Most sources refer to the National Cancer Institute (NCI) Common Terminology Criteria for Adverse Events (CTCAE) version 3.0 (see Table 1). For the purposes of this review, diarrhea is defined as an abnormal increase in stool liquidity, stool frequency (four to six stools or more per day over baseline), with or without nocturnal bowel movements and/or moderate abdominal cramping (Eastern Cooperative Oncology Group, 2007; NCI, 2006; Sabol & Carlson, 2007; U.S. Food and Drug Administration, n.d.). The definition was chosen to capture a broader picture of diarrhea than the CTCAE guidelines, which primarily focus on the number of stools. However, the CTCAE toxicity grading system is referenced throughout this article when referring to grades of diarrhea.

An extensive literature search of multiple databases, including CINAHL®, PubMed®, MEDLINE®, EMBASE®, Cochrane Database of Systematic Reviews, and UpToDate® with the search terms listed in Figure 1 was performed. Originally, the search was conducted on published reports from 2002–2007, but it was extended to 1997 because of older medications commonly used to manage diarrhea (i.e., tincture of opium).

Critical Review of the Evidence

Each member of the team, which included advanced practice nurses, staff nurses, a nurse scientist, and a registered dietitian (RD), analyzed the articles specific to their discipline using standardized guidelines to promote a systematic and consistent approach to study analysis. Each study was organized into a level of evidence (LOE) table according to the following information.

• Author and year of publication
• Characteristics of the intervention (e.g., treatment drug, diet intervention)
• Sample characteristics (e.g., age, sex, diagnosis)
• Setting characteristics (e.g., inpatient versus outpatient)
• Study design and conceptual model
• Measures assessed during the study (e.g., definition of diarrhea used to assess effectiveness of treatment)
• Results and conclusions of study and limitations, flaws, cautions, and/or contraindications of study.

Based on the previous information, each study was assigned a LOE rating according to criteria recommended by the ONS Research Team. The criteria were expanded upon by the review team to include more precise delineation and guidance for each LOE (see Figure 2). To further refine the process and provide guidance for the review team in evaluating each of the studies, an additional rating system based on Melnyk and Fineout-Overholt’s (2005) hierarchy of evidence was developed to facilitate the critique process as each study was reviewed for strengths and weaknesses in the various levels of design. This was done for the edification of the team members for this review to assist in assigning LOE and is not a part of the ONS LOE rating system.

Table 1. Common Terminology Criteria for Adverse Events Version 3.0: Diarrhea Definition

<table>
<thead>
<tr>
<th>ADVERSE EVENT</th>
<th>GRADE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase of four stools per day over baseline; mild increase in ostomy output compared to baseline</td>
<td>1</td>
</tr>
<tr>
<td>Increase of four to six stools per day over baseline; IV fluids indicated less than 24 hours; moderate increase in ostomy output compared to baseline; not interfering with activities of daily living</td>
<td>2</td>
</tr>
<tr>
<td>Increase of seven or more stools per day over baseline; incontinence; IV fluids 24 hours or more; hospitalization; severe increase in ostomy output compared to baseline; interfering with activities of daily living</td>
<td>3</td>
</tr>
<tr>
<td>Life-threatening consequences (e.g., hemodynamic collapse)</td>
<td>4</td>
</tr>
<tr>
<td>Death</td>
<td>5</td>
</tr>
</tbody>
</table>

After reviewing all of the available studies, team members participated in a series of conference calls to combine all pertinent studies into one LOE table, which was used as the basis for the ONS PEP resource. This article discusses only the interventions that have sufficient evidence to warrant recommendation for practice or are likely to be effective. Many of the commonly used interventions require further research, and the details regarding those interventions can be found on the ONS PEP resource and online in the supporting documentation.

Effective Interventions for Prevention and Treatment

Interventions with the best evidence to prevent and treat CID or RID primarily are pharmacologic, which are discussed in detail in the section on interventions recommended for practice. The section, as well as the ensuing sections for recommendations likely to be effective or expert opinion, are divided into treatment for CID and RID. The information also can be found more expeditiously in the ONS PEP resource.

Recommended for Practice

**Chemotherapy-induced diarrhea:** A loading dose of 4 mg of loperamide, an oral opiate, followed by 2 mg orally every four hours is the standard first-line therapy for CID (Benson et al., 2004; Halmos, 2007). High-dose loperamide has shown moderate effectiveness in controlling CID associated with irinotecan. High-dose loperamide is 2 mg orally every two hours (4 mg every four hours at night), but the dose should not be given for more than 48 hours (Benson et al.; Janssen Pharmaceutica, 1998).

Another agent that has shown good efficacy is octreotide acetate, a somatostatin analog administered subcutaneously at a standard dose of 100–150 mcg three times daily (Benson et al., 2004; Zidan et al., 2001).

**Radiotherapy-induced diarrhea:** No recent studies specifically addressing RID reached the LOE needed to be recommended for practice; however, based on a review of current clinical practice guidelines, the use of loperamide and diphenoxylate continue to be recommended as the standard of practice for patients with mild symptoms (Benson et al., 2004). Mild symptoms generally are classified as grade 1 or 2 with no added risk factors like cramping, nausea and vomiting, impaired performance status, fever, sepsis, neutropenia, dehydration, or frank bleeding (Benson et al.).

Likely to Be Effective

**Chemotherapy-induced diarrhea:** One study examined long-acting repeatable (LAR) octreotide (Sandostatin LAR® Depot, Novartis Pharmaceuticals Corporation) as an intramuscular injection. LAR octreotide was given as a 20–30 mg monthly injection as secondary prophylaxis after patients failed loperamide with or without Lomotil® (Pfizer, Inc.). Even higher doses of octreotide (i.e., 30 mg–40 mg) have been suggested to be effective, but no specific recommendations exist at this time (Rosenoff, 2004; Rosenoff et al., 2006).

**Radiotherapy and diarrhea:** Several studies have investigated the potential use of probiotics for patients with cancer with treatment-related diarrhea. Probiotics, as defined in a joint report

---

**Chemotherapy and diarrhea**

**Radiotherapy and diarrhea**

**Cancer and diarrhea**

**Cancer surgery and diarrhea**

**Constipation related to diarrhea**

**Immunosuppression and diarrhea**

**Infectious diarrhea in cancer patients**

**Dietary diarrhea**

---

**Note:** This wide variety of search terms was used to help narrow the focus of the review.

---

Octreotide may be titrated upward from 150 mcg–500 mcg subcutaneously administered three times daily until symptoms are controlled. The dose may be more effective than standard doses in patients with CID who fail loperamide. No optimal dose of loperamide has been determined (Benson et al., 2004).

**Expert Opinion**

Clinicians must be highly vigilant when monitoring gastrointestinal toxicity in patients receiving irinotecan-based therapies and other intensive combination therapies (Benson et al., 2004). Assessment should include baseline bowel habits, duration of symptoms, constellation of signs and symptoms (i.e., gas, bloating, and abdominal pain), and severity of symptoms. A tool such as the NCI (2006) CTCAE can help with the assessment. However, as previously noted, the tool does not include volume of stool, which is an important consideration when assessing the presence and severity of diarrhea. Other assessment strategies are outlined in the ONS PEP resource.

When treating CID and RID, clinicians also should include an evaluation of dietary intake to identify foods or fluids that may contribute to or exacerbate diarrhea (American Institute for Cancer Research, 2009; Benson et al., 2004; Kornblau et al., 2000; Maroun et al., 2007; McCallum & Polisena, 2000). General diet strategies and recommendations are included in the PEP resource. An RD should be consulted at the onset of diarrhea to assist with nutritional management.

Older medications, such as tincture of opium, commonly are used to manage cancer treatment-induced diarrhea, and expert opinion considers the practice useful. However, because of a lack of randomized controlled trials, the treatment cannot be unequivocally recommended for practice. Two different preparations of tincture of opium are available but the morphine content is different, so careful dosing is essential.

---

**Radiotherapy-Induced Diarrhea**

**Prevention**

Probiotic supplementation is a rapidly growing area of interest in the treatment of bowel disorders. Several studies have investigated the potential use of probiotics for patients with cancer with treatment-related diarrhea. Probiotics, as defined in a joint report...
Implications for Practice

Patient assessment should include baseline bowel habits; change in bowel habits; consistency of stool; presence of abdominal pain, gas, or cramping; and signs and symptoms of dehydration. Assessment must be ongoing throughout the treatment trajectory. Medications such as loperamide and tincture of opium are opiate derivatives, so a change in the patient’s abdominal status, especially the onset of nausea, pain, or bloating or a decrease in bowel movements, should alert the practitioner to evaluate for other potential underlying issues such as an ileus.

Currently, strong empiric evidence supports pharmacologic interventions as recommendations for practice. Emerging evidence suggests that probiotics are likely to be effective, but this field continues to evolve, so more extensive research is warranted. Soluble fiber supplements are likely to be effective for treating CID or RID, but further research is needed because the type and dose of soluble fiber most effective in treating or preventing these types of diarrhea is unknown.

Oncareotide has been studied in various methods of administration (Benson et al., 2004; Rosenoff et al., 2006), but more research is needed to support administration of intramuscular LAR octreotide. Larger clinical trials using LAR octreotide versus short-acting octreotide are needed and would be beneficial to patients. LAR octreotide would allow fewer injections, thus improving patient comfort. A significant issue with octreotide is cost, considering the amount needed to treat diarrhea and the current limitations regarding insurance coverage.

The value of an RD on the team cannot be overstated. An RD can make recommendations that could help alleviate diarrhea, decrease dehydration, and maintain nutritional status. Nurses should be encouraged to consult with an RD at the onset of diarrhea and as needed during or after treatment to improve patient outcomes. However, if this is not possible, the recommendations described in the ONS PEP resource provide a guide for nurses in assisting patients with food choices and meal planning. Interventions as simple as eliminating sorbitol-containing substances, such as sugar-free gums and sugar-free candy, may help diminish diarrhea. Encouraging intake of oral rehydration solutions, such as sports drinks, also will assist with rehydration and electrolyte repletion.
reviewed were the commonly used regimens containing drugs such as fluorouracil, cisplatin, adriamycin, and irinotecan. The review did not include biologic therapies, such as interferon, interleukin-2, or monoclonal antibodies, or targeted therapies, such as EGFR inhibitors or multikinase inhibitors. Additional clinical trials and more clinical experience are needed to provide the best recommendations for patients receiving these biologic and targeted therapies. GVHD in particular was excluded from the review because of the wide scope of the problem with GVHD-induced diarrhea. Clinical experience and expert opinion may suggest that treatment approaches for diarrhea for these therapies are similar to the approaches outlined in the review, but the evidence base established in the review can reliably be applied only to standard chemotherapies, as cited in the literature studied, and to pelvic and abdominal radiation therapy.

The challenge in developing evidence-based practice is to expect the evidence to be in peer-reviewed literature to support practice. Evidence-based guidelines can help direct the clinician in assessing and managing patients with specific problems, in this case with CID and RID. Care should be evidence-based when the evidence exists, but because research is a necessarily slow process, clinicians still have to rely on clinical experience and good judgment to provide expert care and ensure good patient outcomes.

In light of the aforementioned limitations, the authors of the review conclude that diarrhea continues to be a problem for patients undergoing some chemotherapy regimens and pelvic or abdominal radiotherapy. Diarrhea can adversely impact quality of life, integrity of cancer treatment, and patient survival, and therefore, it needs to be vigorously managed to avoid complications, hospitalization, or serious harm. A multidisciplinary approach will best address and control cancer treatment-induced diarrhea.

The authors gratefully acknowledge Oncology Nursing Society staff members, including Mark Vrabel, MLS, AHIP, ELS, Kristen Baileys, RN, MSN, CRNP, AOCNP®, and Kelly Egnatovich for their contributions to this article.

The authors take full responsibility for the content of the article. The authors did not receive honoraria for this work. The content of this article has been reviewed by independent peer reviewers to ensure that it is balanced, objective, and free from commercial bias. No financial relationships relevant to the content of this article have been disclosed by the authors, planners, independent peer reviewers, or editorial staff.

Author Contact: Paula M. Muehlbauer, RN, MSN, OCN®, can be reached at paula.muehlbauer@gmail.com, with copy to editor at CJONEditor@ons.org.

References


induced diarrhea: Results of the STOP trial. *Journal of Supportive Oncology*, 4(6), 289–294.

Receive free continuing nursing education credit for reading this article and taking a brief quiz online. To access the test for this and other articles, visit http://evaluationcenter.ons.org. After entering your Oncology Nursing Society profile username and password, select CNE Listing from the left-hand tabs. Scroll down to *Clinical Journal of Oncology Nursing* and choose the test(s) you would like to take.