UKINETs Bitesize Guidance- Management of Bile Acid Diarrhoea (BAD) in Patients with Gastroenteropancreatic Neuroendocrine Neoplasms

Patients should be screened for malnutrition using a validated nutrition risk screening tool e.g. MUST, SGA, NRS-2002. Patients at risk should be referred to a dietitian. Specialist dietitian or clinical nurse specialist input is recommended alongside this guidance.

Risk Factors

- Cholecystectomy
- Ileal resection
- Small intestinal bacterial overgrowth

BAD is reported in up to 80% of Gastroenteropancreatic-NET patients.

Symptoms

- Increased stool frequency
- Urgency
- Nocturnal defecation
- Flatulence
- Incontinence
- Abdominal pain

Diagnosis

SeHCAT scan or where access is limited, a therapeutic trial of bile acid sequestrants.

- >20%= Normal
- 15-20%= Borderline
- 10-14.9%= Mild
- 5-9.9%= Moderate
- 0-4.9%= Severe

Treatment

For mild to severe BAD- Bile acid sequestrants are recommended.

Colesevelam is more palatable and has improved gastrointestinal tolerance than Colestyramine and Colestipol however is used off license. Refer to BNF guidance on dosage.

For borderline-mild BAD, a low-fat diet alone may be adequate.

For moderate-severe BAD, a low-fat diet can be used in conjunction with bile acid sequestrants.

A low-fat diet is defined as <20% of energy from fat or <40g per day.

Patients who follow a low-fat diet may receive fat supplementation using medium-chain triglycerides as these do not require bile acids for solubulisation.

Patients prescribed bile acid sequestrants should avoid taking other medications 4 hours before or after bile acid sequestrants as these can reduce absorption. Pancreatic enzyme replacement and Loperamide is not affected by bile acid sequestrants.

In patients with severe BAD, consider a multivitamin and mineral. Patients prescribed bile acid sequestrants may require fat-soluble vitamin monitoring: A, D, E and K.

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