Diarrhoea: travellers' diarrhoea

“Wash it, peel it, boil it, cook it or forget it!” This was the first of two pieces of excellent advice from the hospital treasurer when I arrived at the remote hospital in Uganda. “You are the only doctor for miles around and we don’t need you to be ill.” Only 18 months out of medical school, the realisation of what I had taken on was slowly dawning on me. Getting ill and getting shipped out seemed quite an enticing prospect! A decade on, Obed’s advice has stood me in good stead in my travels. (His second piece of advice was not to go out at night, in case I got shot by rebels! Needless to say, that was not included in my letters home!!)

Travellers’ diarrhoea statistics

- Affects up to 60% of travellers.
- 10% confined to bed or consult a physician during the illness.
- Pathogen identified in 30–60% of cases.

This useful review summarises the key points we need to know (BMJ 2016;353:i1937).

Symptoms

- Classically defined as 3 or more loose stools per day during a trip abroad.
- Most episodes start during the first week of travel.
- May be accompanied by one or more of these symptoms:
  - Abdominal cramps
  - Fever
  - Nausea/vomiting
  - Blood in stools.
- Usually lasts 1–7d, but 10% have symptoms for more than a week and 1% have symptoms for more than 1m.
- Protozoa, e.g. Giardia lamblia can cause acute diarrhoea but more often associated with chronic diarrhoea lasting >2w.

Causes

- Cause is ingestion of contaminated food/water.
- Causative organism partly depends on the country of travel.
- Enterotoxigenic E.coli is the commonest cause of acute travellers’ diarrhoea globally.
- Other common bacterial causes include: Campylobacter, Salmonella and Shigella.
- Viruses: norovirus and rotavirus are causes of travellers’ diarrhoea and may lead to large outbreaks on cruise ships.
- Parasites such as Giardia, Cryptosporidium and Entamoeba histolytica can also cause travellers’ diarrhoea, but are seen less commonly.

Prevention

I think the things people forget about most often are salads and ice cubes (which people forget are often washed in/made from water which may be contaminated), and teeth cleaning.

Some of this advice sounds obvious, but it is worth reminding travellers.

- Cook food thoroughly, peel fruit and vegetables, avoid shellfish.
- Restaurants: avoid salads and buffets where food may have been unrefrigerated for several hours, avoid condiments on restaurant tables.
- Drinks: avoid ice, use a straw to drink from bottles, drink bottled water where available or if not available then purify water by boiling, filtering or using chlorine-based tablets.
- Adhere to good hand hygiene measures. There is some weak evidence that use of alcohol gel may reduce diarrhoea rates in travellers. Hand washing with soap reduces the risk of diarrhoeal illness by 30–40%.

(So, as Obed advised, “Wash it, peel it, boil it, cook it or forget it!”)

Vaccination

Vaccination against Salmonella typhi is recommended for most travellers to areas where this is endemic.

Chemoprophylaxis

- Antibiotic chemoprophylaxis refers to antibiotics taken daily for the whole trip.
- This is NOT recommended for most travellers because of the risk of adverse effects such as candidiasis and Clostridium difficile associated diarrhoea.
• Severe immunosuppression, e.g. from chemotherapy, after tissue transplant, advanced HIV.
• Underlying bowel disease, e.g. IBD, ileostomy, short bowel syndrome.
• Other conditions where reduced oral intake may be particularly dangerous, e.g. sickle cell disease or diabetes.

Options for chemoprophylaxis:
• Ciprofloxacin 500mg once a day offers 80–100% protection.
• Alternatives are norfloxacin 400mg once a day, or rifaximin 200mg once or twice a day, or bismuth subsalicylate 2 tablets 4 times a day.
• For travellers to South East Asia and South Asia, use azithromycin instead of ciprofloxacin or norfloxacin.

Treatment whilst abroad

N.B. Local medical assistance should be sought if high fever, severe abdominal pain or bloody diarrhoea.

• **Hydration is critical.** Liberal intake of clear fluids is important for all. Oral rehydration salts are recommended for young children, the elderly and travellers with medical conditions.
• **Loperamide** can be used for **mild symptoms** (1–2 unformed stools/d). Adding loperamide to antibiotic treatment significantly increases cure rates at 24 and 48h compared to antibiotics alone. Avoid loperamide if high fever, severe abdominal pain or bloody diarrhoea.
• **Bismuth subsalicylate**: RCTs show small benefit but less effective than loperamide.
• **Antibiotics** shorten duration of illness to about 1.5d compared to 3d with placebo. It may be appropriate to provide a short course of antibiotics for some people travelling to areas with high and moderate risk of travellers’ diarrhea, e.g. those going to areas with poor access to sanitation or healthcare. Advise them to start the antibiotic as soon as they develop diarrhoea and keep well hydrated.

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<th>High risk area</th>
<th>Choice of antibiotic</th>
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<tr>
<td>South and central America, North, West and East Africa</td>
<td>Ciprofloxacin 500mg twice a day for 3d</td>
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<tr>
<td>South and South East Asia</td>
<td>Azithromycin 1g single dose or 500mg once a day for 3d Rifaximin 200mg three times a day for 3d</td>
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Returning travellers with acute diarrhoea

The BMJ article did not provide any recommendations on how to manage returning travellers with acute diarrhoea that has lasted <14d. NICE CKS about gastroenteritis in adults makes the following recommendations (July 2015).

**Clinical assessment:**
Check temperature, BP, pulse, RR, abdominal tenderness and for other features of dehydration.

**Hospital admission:**
• Arrange hospital admission if the person is also vomiting and unable to tolerate oral fluids or has signs of severe dehydration or shock.
• Other factors that should influence your decision about whether to admit to hospital include the history of recent foreign travel, age ≥60y, home circumstances, fever, blood in stool, abdominal pain and tenderness, diarrhoea lasting >10d, increased risk of poor outcome, e.g. medical co-morbidities such as immunodeficiency or drugs that can exacerbate dehydration and renal failure, e.g. ACEi.

**Investigation:**
A stool sample should be sent for all patients with diarrhoea after foreign travel to anywhere other than Western Europe, North America, Australia or New Zealand. Ensure you include clinical details as well as information on countries visited.

**Management:**
Provide advice about rehydration and diet.
• Normal fluids are usually sufficient. Can supplement with ORS if increased risk of poor outcome, e.g. ≥60y, co-morbidities where dehydration could be problematic such as CVD.
• Once rehydrated, consume solid foods as guided by appetite. Small, light meals that are not fatty or spicy may be better tolerated.

**Antiemetics:**
• Not usually needed as part of primary care management. If vomiting is severe then CKS suggest 10mg metoclopramide IM may be helpful.
Antimotility drugs e.g. loperamide:

- Not usually necessary.
- Can be used for patients with mild to moderate symptoms where quicker resolution would enable them to continue essential activities.
- Do NOT prescribe antimotility drugs if any of the following:
  - Blood (may trigger haemolytic uraemic syndrome) or mucus in stools
  - High fever
  - *E. coli* 0157 (confirmed, probable or suspected; may trigger haemolytic uraemic syndrome)
  - Shigellosis (may make it worse).

(Haemolytic uraemic syndrome is characterised by a haemolytic anaemia, acute renal failure and thrombocytopenia: it usually develops 5–10d after bloody diarrhoea from some *E.coli* strains, Shigella or Campylobacter. Patients (children are more susceptible than adults) present with reduced urinary output, haematuria, oedema and bruising. Admission is needed.)

Antibiotics:

Antibiotics are NOT recommended for adults with acute diarrhoea of unknown cause. They may be appropriate once the microbiological cause has been identified – see table below.

<table>
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<tr>
<th>Pathogen</th>
<th>When to prescribe antibiotics</th>
<th>Antibiotic options</th>
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| *Campylobacter jejuni*    | Consider antibiotics if:  
  - High fever  
  - Bloody diarrhoea  
  - >8 stools/d  
  - Immunocompromised  
  - Worsening symptoms  
  - Symptoms >1w.  

  | Erythromycin 250–500mg 4 times a day for 5–7d.  
  If not tolerated then clarithromycin or azithromycin may be considered.  
  If allergy to macrolides then ciprofloxacin 500mg twice a day for 5–7d. |
| **Salmonella** (non-typhoidal) | If healthy, NO antibiotics needed.  
  Consider antibiotics if:  
  - >50y old  
  - Immunocompromised  
  - Cardiac valve disease  
  - Endovascular abnormalities, e.g. prosthetic vascular grafts.  

  | Ciprofloxacin 500mg twice a day for just 1d (provided the isolate is sensitive to ciprofloxacin). |
| **Shigellosis**            | If healthy, antibiotics not recommended for mild symptoms.  
  Consider antibiotics if:  
  - Severe symptoms  
  - Immunocompromised  
  - Bloody diarrhoea.  
  Avoid antimotility drugs.  

  | Seek advice from microbiology about choice of antibiotic. |
| **E.coli** 0157             | Do NOT prescribe antibiotics.  
  Avoid antimotility drugs.  
  Avoid NSAIDs.  

  | Discuss with specialist. |
| **Giardiasis**             | Treat everyone  

  | Metronidazole 400mg three times a day for 5d, or 500mg twice a day for 7–10d or 2g once a day for 3d. |
| **Entamoeba histolytica** (amoebiosis) | Seek advice from local microbiologist |
| **Cryptosporidiosis**      | NO effective antibiotics.  

  | Seek specialist advice if patient immunocompromised or frail. |

Returning travellers with persistent diarrhoea

Most bacterial causes of travellers’ diarrhoea do not cause persistent symptoms. Further investigation is needed in returning travellers with:

- Diarrhoea lasting >14d after travel.
- Diarrhoea with fever or dysentery (severe diarrhoea with blood/mucus).

If signs of severe colitis or local tenderness, then need to exclude toxic megacolon, inflammatory phlegmon or hepatic collection – likely to need admission to hospital.

The commonest pathogen identified in returning travellers with chronic diarrhoea is *Giardia lamblia*. This may cause bloating,
nausea, belching and greasy malodorous stools.

Consider non-infectious causes, e.g. coeliac disease, IBD, IBS, hyperthyroidism, lactose intolerance, malignancy.

**Investigations**

- FBC, LFTs, renal function, inflammatory markers.
- Stool samples for microscopy and culture and examination for ova, cysts and parasites. Previous advice used to be to send 3 stool samples for culture but this is unlikely to increase diagnostic yield. PCR tests are now available for common gastrointestinal pathogens such as *Campylobacter* and *Giardia lamblia* which can increase detection.

**Post-infectious irritable bowel syndrome**

This is a diagnosis of exclusion in those with persistent diarrhoea where infections and non-infectious causes have been excluded.

- The incidence is 30% after acute travel-associated gastroenteritis.
- There is weak evidence that exclusion of foods high in FODMAPs may be helpful.
- Other management options include excluding lactose, loperamide, bile acid sequestrants and probiotics, but there is limited evidence for long-term benefits.

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**Travellers’ diarrhoea**

- Common, and usually resolves spontaneously within 1–7d, but 10% have symptoms for more than 1w and 1% have symptoms for more than 1m.
- In prolonged illness (>14d) think of parasitic infections such as *Giardia* or other causes of diarrhoea.
- Sending 3 stool samples is unlikely to increase diagnostic yield.
- Advise good hand hygiene — soap and water, alcohol gel.
- Avoid ‘high risk’ foods: “Wash it, peel it, boil it, cook it or forget it!”.
- Chemoprophylaxis can be considered in patients with bowel disease or who are immunocompromised.
- Standby antibiotics may be considered for some patients travelling to areas with high or moderate risk of travellers’ diarrhoea, e.g. when in remote locations with poor access to sanitation and healthcare.
- Treatment is with hydration +/- loperamide +/- antibiotics.
- Wait for stool culture results before prescribing antibiotics to returning travellers with diarrhoea.

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**For patients:**

WHO travel advice:


The Foreign and Commonwealth Office offers advice on travel which includes health advice but also other issues (visas, security risks, local laws and customs, risks of natural disasters, how to register on arrival in the country and what to do if things go wrong):


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MSK problems are the most common reason for seeing a GP and represent 30% of repeat GP visits. We want to help build your confidence. On the course we will tackle:

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- Why chronic pain is ‘in the brain’ – and more importantly, what we and our patients can do about it.

We will provide you with a new narrative and a tool box of strategies you can take back to the surgery and start using the next day.

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