Gloucestershire Hospitals NHS Foundation Trust

Capecitabine/5FU Diarrhoea

This can be a life-threatening or fatal toxicity and early, appropriate intervention is crucial

INITIAL ASSESSMENT: TELEPHONE TRIAGE

Key features in history:
Characterise diarrhoea severity and presence of any red flag features (Tables 1 and 2)
Use of antidiarrhoeals - type and dose already taking
Day and cycle of capecitabine/5FU - which day of oral capecitabine or last dose of 5FU infusion
DPD status and any dose modifications (DPD deficiency increases risk of toxicity)

Have they also received immunotherapy? Consider whether this is IO colitis

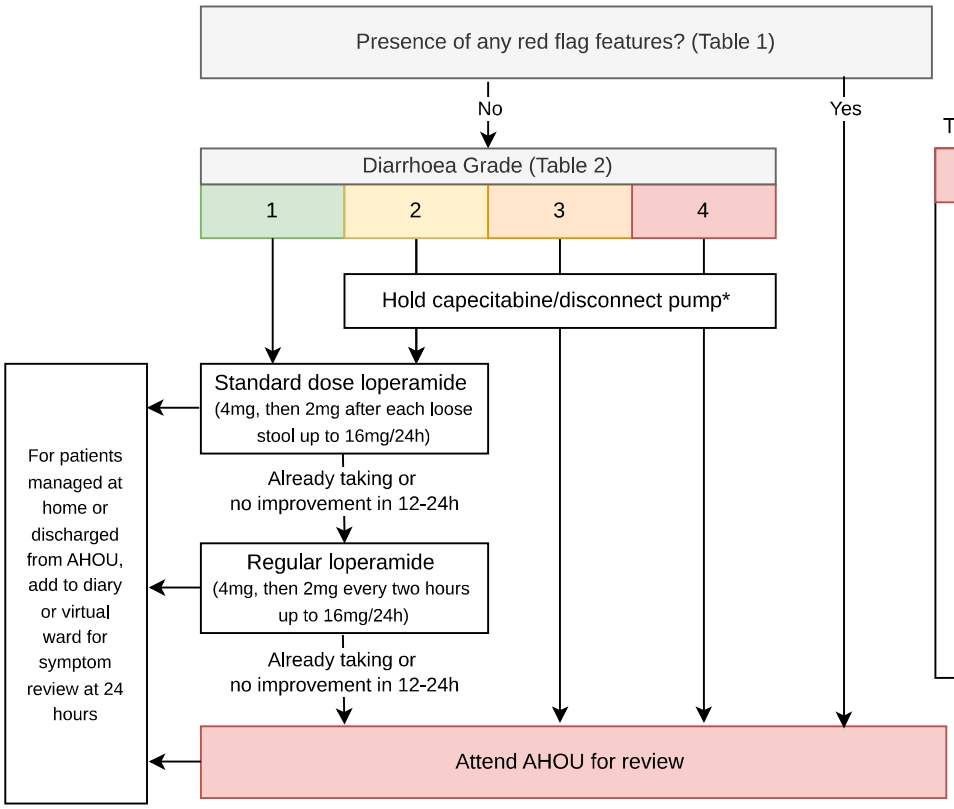

Table 1

Red Flag Features
Blood/mucous in stool Faecal incontinence Nausea/vomiting Moderate/severe abdominal cramping Nocturnal diarrhoea Fever >38C Orthostatic symptoms Previous admission with same symptoms Previous dose reduction or omission for other toxicities Neutropenia

Table 2

Grading of Diarrhoea Severity (CTCAE/UKONS)	
1	<4 stools/day over baseline Mild increase in stoma output
2	4-6 stools/day over baseline Moderate increase in stoma output
3	7-9 stools/day over baseline; Incontinence Severe increase in stoma output
4	10+ stools/day over baseline; Life-threatening consequences requiring urgent intervention

Advice on medications
Check whether patients are taking capecitabine tablets within 30 mins of a meal, and the correct dose. Taking tablets on an empty stomach increases absorption and therefore the risk of toxicity Do not wait for stool sample results prior to giving loperamide in patients on SACT For patients with stomas or watery diarrhoea, use loperamide tablets rather than capsules as they are better absorbed Where possible advise taking loperamide 30 minutes before meals for optimum effect

*Inform treating team for decision on restart/delay/dose adjustment

Authors: A Doyle, A DiMambro, J Helbrow, L Malins, A Skaria. V1.0 16.9.2026

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INITIAL ASSESSMENT: AHOU REVIEW

All patients:
Thorough history and examination
Observations + lying and standing BP
Bloods - FBC, UE, CRP, LFT, Ca/Mg/Phos, VBG
Stool cultures

Consider:
Blood cultures
Imaging - AXR / CTAP

Remember analgesia and antiemetic while awaiting review/results!

Presence of high risk features

Abnormal observations
Ongoing vomiting/diarrhoea in department
Signs of dehydration

Red flag features (page 1) or any of:

High volume diarrhoea
Other toxicities - mucositis, neutropenia, palmoplantar rash

No

Low risk:
DISCHARGE

Hold capecitabine - inform treating team
Continue loperamide until 24 hours after resolution
Encourage oral hydration
Safety net
Follow-up telephone symptom review

Non-resolution or recurrence of symptoms after discharge

Consider differentials

Other SACT-induced diarrhoea
- irinotecan - consider atropine
- IO colitis - consider steroids

Infectious diarrhoea
Obstruction/ileus
Disease progression

Yes

High risk
ADMIT

Start: loperamide tablets 4mg QDS (30 mins before meals)
codeine 30mg QDS
IV fluids - boluses if hypotensive
strict input/output monitoring

Stop: prokinetics
laxatives

Consider: antibiotics +/- GCSF if neutropenic
IV conversion of regular medications
Hold nephrotoxics
Referral to stoma nurses

VTE assessment

If peritonitic or guarding > CTAP +/- surgical review + keep NBM

If unstable or life-threatening - early consultant review for consideration of uridine triacetate (UTA) + alert DCC

UTA (Uridine Triacetate)/Vistogard

Currently only approved for life-threatening toxicity following first cycle, or known overdose/pump malfunction. Must be given within 96h of last dose capecitabine/5FU pump disconnection.

Requires consultant approval and Bluteq form. Contact pharmacy urgently (on call pharmacist via switchboard if out of hours) once decision made to give, as the drug is not stocked on site.

10g sachet PO/NG QDS for 20 doses (5 days). Mix granules into c.100ml soft foods. Coprescribe antiemetic (can cause nausea and vomiting in 8%). If vomits within 2 hours of dose, repeat full dose.

Link to full UTA guideline

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ONGOING MANAGEMENT ON WARD

Consultant post-take review within 24 hours
or sooner if unstable/critically unwell

- consider CT imaging
- escalate antidiarrhoeals as required
- review escalation status

Daily review checklist

Review stool frequency and red flags
Examine abdomen
Oral intake and input/output charts
- are further IV fluids required?
- is gut rest required (>1L/24h output)?
Daily bloods (FBC UE LFT CRP Mg Ca Phos)
- check and replace electrolytes
Chase stool cultures

If worsening or not improving despite escalation of antidiarrhoeals

- re-escalate for further senior review
- consider CT imaging if not already done
- refer to dieticians for consideration of TPN
- gastro referral for advice +/- consideration of flexible sigmoidoscopy with biopsies, addition of budesonide
- consider alternative/concomitant diagnoses

Early referral to nutrition team for assessment (for enteral or parenteral nutrition) if:

High volume diarrhoea >1L/24h where gut rest is indicated
Suspected mucositis of GI tract
High malnutrition/refeeding risk: MUST ≥4 OR any of:
- BMI <16.5
- weight loss >15% in last 3-6 months
- little/no nutritional intake in last 10 days

Refer early to vascular access team for PICC line if planning TPN

For nursing staff

Ensure accurate fluid balance chart
Ensure accurate stool chart
Check CBG 6-hourly if on octreotide

Escalate to medical team if you are worried about deterioration/lack of improvement in a patient

Escalation of antidiarrhoeals

Regular loperamide
4mg QDS (tablets)

Consider higher doses of loperamide with consultant or gastro advice

For patients with stomas, see also
High Output Stoma Guidance

↓
Reassess 12-24h

Add codeine
30mg QDS

Reassess 12-24h

Add octreotide CSCI
300mg/24h
Increase codeine to 60mg QDS

Monitor for haemodynamic instability (bradycardia risk) and check CBGs 6-hourly while on octreotide

↓
Reassess 12-24h

Uptitrate octreotide every 12-24h in 100-300mcg increments. Max 1500mcg/24h

Consider budesonide with gastro advice

Once symptoms improving:
1. Wean octreotide to stop over 24-48h
2. Wean codeine to stop over 24-48h
3. Continue loperamide until 24h after resolution

DISCHARGE

Consider discharge planning once symptoms manageable on oral agents only and tolerating oral fluid intake >2L/24h

On discharge:
- continue loperamide until 24h after resolution
- continue to hold capecitabine
- inform treating team for decision on restart/dose reduction
- safety net
- consider 24h telephone follow-up via AHOU

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