**Assessment**

**Diarrhea** (increased frequency; loose, large volume, or liquid stools)

**Grade 1 (Mild)**
- Increase of ≥4 stools/day over baseline
- Mild increase in ostomy output compared with baseline

**Grade 2 (Moderate)**
- Increased frequency >10 stools/day over baseline
- Moderate increase of output in ostomy compared with baseline
- Limiting instrumental ADLs

**Grade 3 (Severe)**
- Increased ≥17 stools/day over baseline; incontinence
- Hospitalization indicated
- Severe increase in ostomy output compared with baseline
- Limiting self-care ADLs

**Grade 4 (Potentially Life-Threatening)**
- ≥18 stools/day with dehydration
- Urgent intervention required

**Grade 5 (Death)**
-生命-threatening intestinal perforation
- Urgent intervention indicated

**Colitis** (inflammation of the intestinal lining)

**Grade 1 (Mild)**
- Asymptomatic; clinical or diagnostic observation only; intervention not indicated

**Grade 2 (Severe)**
- Abdominal pain, blood or mucus in stool

**Grade 3 (Severe)**
- Severe abdominal pain; perianal inflammation; medical intervention indicated

**Grade 4 (Potentially Life-Threatening)**
- Life-threatening (e.g., hemorrhagic, toxic megacolon)
- Urgent intervention indicated

**Grade 5 (Death)**
- Life-threatening (e.g., hemorrhagic, toxic megacolon)

**Management (including Anticipatory Guidance)**

**Overall Strategy**
- Rule out infectious, non-infectious, disease-related etiologies
- Assess patient & family understanding of recommendations and rationale
- Identify barriers to adherence

**Diabetes Mellitus**

- May continue immunotherapy
- Consider loperamide
- Book nursing follow-up call for next business day

**Diabetes Mellitus**

- Insulin based diet; decrease fiber, unsweetened fruit/cruciferous vegetables, fats, dairy, oil, caffeine, alcohol, sugar
- Assure adequate hydration

**Immunotherapy**

- Administer corticosteroids:
  - High-dose steroid therapy: clear liquids; very bland, low fiber and low residue diet
  - Avoid alcohol/acetaminophen or other hepatoxins
  - Avoid corticosteroids when patient is not fasting

**Dietary adjustments**

- Consider additional antiviral and antifungal coverage
- Consider antimicrobial prophylaxis (sulfamethoxazole/trimethoprim double dose MWI, single dose if used daily) or alternative if sulfa-allergic
- Avoid alcohol/acetaminophen or other hepatoxins
- If extended steroid use, risk for osteoporosis; inhibit calcium and vitamin D supplements

**Infectious vs immune-related adverse event**

- Early identification and evaluation of patient symptoms
- Early intervention with lab work and office visit if colitis symptoms are suspected

**Evaluation of patient symptoms**

- Has the patient lost weight?
- Does the patient appear weak?
- Look:
  - For signs of dehydration
  - For signs of recurrent symptoms
  - For signs of rapid change in gastrointestinal function, decreased appetite

- Listen:
  - For symptoms of drug toxicity
  - For symptoms of drug toxicity

**Recognize:**

- Serum chemistry/hematology abnormalities
- Infections in immune-related adverse event
- Perianal signs of bowel perforation (e.g., pain, tenderness, bleeding)

**Gastrointestinal Toxicity:**

- Diarrhea
- Fever
- Abdominal pain or cramping
- Increased fatigue
- Upset stomach, nausea, or vomiting
- Bloating/increased gas
- Increased appetite or food aversions

**Implementation:**

- Compare baseline assessment: grade & document bowel frequency and stool consistency
- Evaluate frequency and evaluation of patient symptoms
- Grade symptom & determine level of care and interventions required
- Use anti-diarrheal care, since increase in patients with colitis can lead to toxic megacolon and bowel perforation
- Early intervention with lab work and usual office visit if colitis symptoms are suspected
- Diarrhea and colitis may occur together or separately