# Clinical Information Sheet

## ALTERED BOWEL HABIT

### Clinical Presentation/syndrome

- New onset constipation and/or diarrhoea

### Eligibility

**History of altered bowel habit must include:**

1. Describe normal bowel habit for patient & specify what the change is
2. Onset - sudden vs gradual
3. History of any travel +/- antibiotics
4. Other family members/friends affected
5. Episodes previously investigated for similar symptoms - When
6. Character –
   a. Consistency
   b. Volume
   c. Mucus
   d. Blood
   e. Pain
   f. Need to strain
7. Family history – especially: CRC cancer, IBD, coeliac disease, IBS
8. Medications - especially laxatives
9. Associated symptoms:
   a. Weight loss
   b. Pain
   c. Rectal bleeding
10. Previous relevant GI surgery &/or treatment

### Information required with referral

- **Blood tests:** CBE, CRP, Coeliac serology + TFTs (if loose stools), iron studies, biochemical screen including albumin
- **Faecal M,C & S**

Consider doing faecal calprotectin if loose stools for >6 weeks.

**NOTE:** If stool is bloody or contains mucus, consider FHH testing for ASYMPTOMATIC individuals >50 years of age who are at AVERAGE risk of colorectal cancer. FHH testing should NOT be done to investigate a change in bowel habit.