

Understanding & Managing Chronic Diarrhea

A Patient Guide to Chronic Diarrhea Care

What Is Chronic Diarrhea?

Diarrhea is considered **chronic** once loose or watery stools persist for more than 4 weeks — distinguishing it from acute diarrhea, which is usually caused by a short-lived infection and resolves on its own. Chronic diarrhea affects roughly 5% of people at any given time, and the range of possible causes is broad, from harmless dietary triggers to conditions that need specific, targeted treatment. Because the right treatment depends heavily on the underlying cause, the evaluation process below matters just as much as the treatments themselves.

What Causes It?

- **IBS with diarrhea (IBS-D) and functional diarrhea** — among the most common causes; the gut looks structurally normal, but its sensitivity and motility are altered. See our separate IBS guide for more detail on this condition specifically.
- **Bile acid diarrhea** — excess bile acid reaching the colon over-stimulates fluid and electrolyte secretion. This is more common than many people realize: studies suggest it explains roughly a third of patients investigated for chronic watery diarrhea, and up to two-thirds of those with prior gallbladder removal.
- **Microscopic colitis** — a form of colon inflammation visible only under the microscope (the colon looks normal on colonoscopy itself), causing chronic watery diarrhea, more common in older adults and associated with certain medications.
- **Food-related triggers** — lactose intolerance, excess fructose, sugar alcohols (sorbitol, mannitol, xylitol found in sugar-free gum and candy), and excess caffeine or alcohol can all cause or worsen chronic loose stools.
- **Medications** — metformin, certain antibiotics, proton pump inhibitors, some blood pressure medications, and many others list diarrhea as a common side effect.
- **Celiac disease and inflammatory bowel disease** (Crohn's or ulcerative colitis) — less common than the causes above, but important not to miss; see our separate guides on these conditions.
- **Prior infection (post-infectious IBS)** — some people develop persistent altered bowel habits after a resolved gastrointestinal infection, even once the infection itself is gone.
- **Pancreatic exocrine insufficiency** — when the pancreas doesn't make enough digestive enzymes, undigested fat can cause loose, greasy, foul-smelling stools.

How We Evaluate It

The workup is tailored to your history and exam findings rather than being one-size-fits-all, but generally includes some combination of the following:

- **Fecal calprotectin or lactoferrin** — a stool test that screens for intestinal inflammation, helping distinguish inflammatory causes (like IBD) from functional ones (like IBS-D) without necessarily requiring a colonoscopy first.
- **Celiac disease blood testing** (tTG-IgA, with a total IgA level to make sure the test itself is reliable) — recommended for anyone being formally evaluated for chronic diarrhea.
- **Stool studies** for specific infections, particularly *Giardia*, when the history suggests a possible exposure (such as recent travel or well water) — routine testing for less likely parasites is generally not necessary.
- **Bile acid testing**, or sometimes simply a treatment trial with a bile acid sequestrant, when bile acid diarrhea is suspected based on your history (for example, prior gallbladder removal).
- **Colonoscopy with biopsies** — needed to diagnose microscopic colitis (since the colon looks normal to the eye) and to rule out inflammatory bowel disease; also appropriate for anyone with an alarm feature (see below) or who is due for routine colorectal cancer screening.
- Not everyone needs every test above — if your symptoms clearly fit IBS-D and there are no alarm features, we may recommend a treatment trial before pursuing more extensive testing.

How Chronic Diarrhea Is Treated

Because chronic diarrhea has so many possible causes, treatment is most effective when it's targeted to the specific cause identified during evaluation, rather than starting with the same medication for everyone. A couple of terms come up below: a study “compared to a dummy pill (placebo)” means some patients got the real treatment and others a fake version, without knowing which, so researchers could isolate the treatment's true effect.

Dietary & Lifestyle Measures

Goal: identify and remove common dietary triggers — reasonable first steps for almost everyone, regardless of the eventual diagnosis.

- **Identify and limit trigger foods** — common culprits include dairy (lactose), excess fruit juice or foods high in fructose, sugar-free gum or candy (sorbitol/mannitol/xylitol), and large amounts of caffeine or alcohol.

- **Soluble fiber (psyllium)**, taken daily.

Evidence: Psyllium has a somewhat unusual, dual regulatory effect: the same gel-forming fiber that helps constipation also helps firm up loose stool, by absorbing excess water and adding bulk — making it a reasonable first-line option to trial for chronic loose stools as well.

- **Review your medication list** with us or your pharmacist, since several common medications list diarrhea as a frequent side effect.

Antidiarrheal Medications

Goal: control symptoms directly while the underlying cause is identified, or as ongoing management for IBS-D.

- **Loperamide (Imodium)**, taken as needed or on a scheduled basis.

Evidence: Consistently improves stool frequency and urgency in trials, though its effect on abdominal pain specifically is less consistent. Widely available, over-the-counter, and generally well tolerated at recommended doses, since it acts mainly on the gut and doesn't meaningfully cross into the brain.

- **Diphenoxylate-atropine (Lomotil)**, a prescription option taken several times daily, generally reserved for diarrhea that doesn't respond well enough to loperamide.

Evidence: Works similarly to loperamide by slowing gut transit, with a small dose of atropine added mainly to discourage taking more than prescribed. Unlike loperamide, diphenoxylate does cross into the brain at higher doses, so it carries more potential for central opioid effects and is classified as a controlled substance; the added atropine can also cause dry mouth, blurred vision, or a fast heart rate. It's a reasonable second option when loperamide alone isn't enough, but isn't typically used as the first choice.

- **Serum-derived bovine immunoglobulin (SBI, sold as EnteraGam)** — a medical food taken daily under medical supervision, thought to work by binding inflammatory triggers in the gut and supporting the intestinal lining.

Evidence: Evidence here is mixed: some studies of IBS-D patients found meaningful improvement in stool frequency, consistency, and pain, but a separate placebo-controlled trial found no significant difference from placebo once compared directly, despite improvement in both groups. It's classified as a medical food rather than a drug, and may be reasonable to trial in diarrhea that hasn't responded to other measures, but shouldn't be considered strongly proven at this point.

Bile Acid Diarrhea Treatment

Goal: bind excess bile acids in the small bowel before they reach the colon, for diarrhea confirmed (or strongly suspected) to be bile acid–related.

- **Cholestyramine**, a bile acid–binding powder mixed with water or juice, taken before meals.

Evidence: Across studies, cholestyramine successfully controlled symptoms in about 70% of patients with confirmed bile acid malabsorption, making it the most established treatment for this cause. It can be gritty or unpleasant to take, and may reduce absorption of other medications taken at the same time, so timing doses apart from other medications matters.

- **Colesevelam (Welchol)**, a tablet form of a bile acid sequestrant, as an alternative.

Evidence: Not officially approved for bile acid diarrhea specifically, so its use here is considered off-label, but many patients find it easier to tolerate than cholestyramine. In one study of patients with a similar chemotherapy-related bile acid diarrhea, 88% responded and 68% had complete resolution of symptoms.

Prescription Options for IBS-D

Goal: for IBS-D that doesn't improve enough with the steps above — both medications below are FDA-approved specifically for this indication.

- **Rifaximin (Xifaxan)**, a minimally absorbed antibiotic, taken 3 times daily for 14 days.

Evidence: In two large placebo-controlled trials, about 41% of patients had sustained relief of overall IBS symptoms after a single 2-week course, meaningfully more than with placebo. Because it acts locally in the gut and isn't significantly absorbed, it avoids many of the side effects of traditional antibiotics; symptoms can return over time, and a repeat course is sometimes used.

- **Eluxadoline (Viberzi)**, taken twice daily with food.

Evidence: Reduces both diarrhea and abdominal pain in placebo-controlled trials. It isn't appropriate for everyone: it's not recommended for anyone without a gallbladder or who drinks more than 3 alcoholic drinks a day, due to a risk of pancreatitis in these groups specifically.

Microscopic Colitis Treatment

Goal: treat the underlying colon inflammation directly, once diagnosed by colonoscopy with biopsies.

- **Budesonide**, a corticosteroid that acts mainly within the gut lining rather than throughout the body, taken daily for induction and often continued at a lower dose for maintenance.

Evidence: A placebo-controlled trial found 100% of patients responded to budesonide compared with 20% on placebo — one of the more dramatic treatment effects in gastroenterology. It's considered the first-line treatment for both major subtypes (collagenous and lymphocytic colitis), with good long-term safety in the doses used for this condition.

- **Stopping a contributing medication**, if one is identified (certain NSAIDs, proton pump inhibitors, and other medications have been linked to microscopic colitis in some patients).

When to Contact Our Office

- Blood in the stool, unintentional weight loss, or fevers
- Signs of dehydration — unusual thirst, dizziness, dark urine, or reduced urination
- Diarrhea that wakes you from sleep, which is less typical of IBS and warrants a closer look
- New chronic diarrhea starting after age 50, or a family history of colon cancer or IBD
- Diarrhea that doesn't improve despite an appropriate treatment trial
- Before starting, stopping, or combining any medication or supplement in this guide

This guide supports your personalized plan and isn't a substitute for individualized medical advice. Check with your provider before starting, stopping, or combining anything mentioned here.