



removal. The likely cause is the continuous presentation of bile to the intestine that results from the loss of storage capacity in the gallbladder; this continuous flow increases the level of bile salts in the colon, leading to diarrhea. Postcholecystectomy diarrhea usually responds to bile acid-binding agents such as cholestyramine and often resolves over time.

Secretory diarrhea is uncommon and typically manifests with large-volume (>1 L/day), watery diarrhea that occurs both day and night and continues in spite of fasting. Although this diagnosis can usually be established by the history and a trial of stool monitoring while fasting, calculation of the stool osmolar gap from measured stool electrolytes can be helpful (see previous discussion). A secretory diarrhea will have an osmolar gap of less than 50 mOsm/kg, whereas the gap in an osmotic diarrhea will be greater than 125 mOsm/kg. Causes of secretory diarrhea are rarely infectious. They include fairly uncommon but often quite dramatic syndromes such as Zollinger-Ellison syndrome (gastrinoma), vasoactive intestinal peptide-producing tumor (VIPoma), and carcinoid syndrome. For the evaluation of chronic secretory diarrhea, stool cultures should be done. Imaging of the small bowel and colon should be considered, and appropriate testing for hormones and other secretagogues should be based on the history and findings.

### SUGGESTED READINGS

#### A. Abdominal Pain

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#### D. Diarrhea

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