Dr. Ibrahim Albedaiwi Clinic

Patient Guide

Gastroenterology, Hepatology & Endoscopy

Clear information. A confident next step.

Dr. Ibrahim Albedaiwi

124 guides and practical cards · Patient edition

Select a topic in the contents to go to its page.
Your care team will tailor medicine and preparation instructions to you.

11 November 2026

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WhatsApp for non-urgent inquiries only

055 669 6019

WhatsApp is not a service for diagnosis or treatment and does not replace a medical appointment or follow-up. Do not use it for urgent or emergency inquiries.

What should your inquiry include?

1. Your full name, medical record number and the hospital where you receive care.
2. A brief summary of your condition and diagnosis, if known, or a clear photo of the relevant report.
3. Your specific question, with the date of the visit or procedure if relevant.

These details help the doctor understand your inquiry accurately. The doctor sees dozens of patients each day and cannot recall every detail for every patient.

Enter these details in your WhatsApp message to the clinic, not in the guide or visit feedback form. Please avoid sending an identity document or information unrelated to your inquiry.

When should I expect a reply?

Replies may be delayed by the doctor’s schedule or leave; the doctor is not always available. If you have not received a reply after 72 hours, please send a WhatsApp reminder. This is a reminder interval, not a guaranteed response time. This number does not accept phone calls.

Which contact route should I use?

Non-urgent inquiry	Send a WhatsApp message with your identifying details, a brief summary and your question. If there is no reply after 72 hours, send a reminder.
Urgent problem	Seek prompt medical assessment: attend the clinic if it is open and can assess you; otherwise go to the emergency department. Do not wait for WhatsApp.
Emergency	Go to the emergency department immediately, or call the Saudi Red Crescent on 997 if an ambulance is needed. Do not wait for messages.

This site and its guides do not replace medical consultation, appointments or follow-up. Advice and treatment plans may differ between patients depending on their condition, tests and medicines. Do not start, stop or change treatment based on this guide alone.

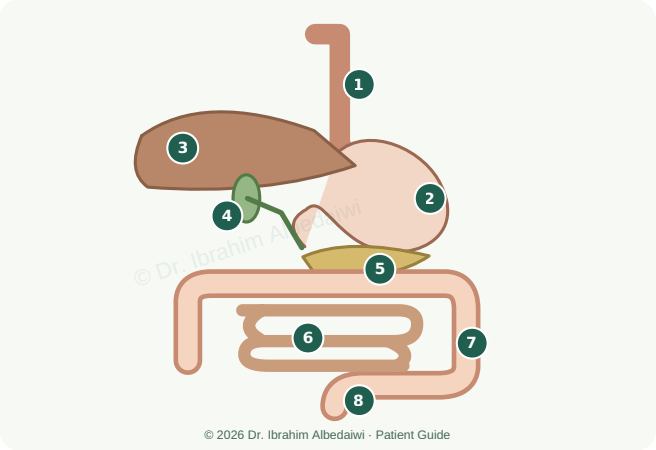
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ILLUSTRATED PATIENT GUIDE

Your digestive system

Select an organ name or number to browse all its available guides.



1 · Esophagus

Carries food from the mouth to the stomach.

2 · Stomach

Mixes food and begins digestion.

3 · Liver

Produces bile and processes nutrients.

4 · Gallbladder and bile ducts

The gallbladder stores bile; ducts carry it into the bowel.

5 · Pancreas

Releases enzymes that help digest food.

6 · Small intestine

Absorbs most nutrients.

7 · Colon

Absorbs water and helps form stool.

8 · Rectum and anus

Store and pass stool.

> Simplified front view: the body’s right is on the left of the drawing. Organ positions are approximate, not to scale.

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NIDDK: Your digestive system

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Fatty liver and steatohepatitis

Last updated: 10 November 2026 · MASLD / MASH

Fat in the liver can improve. What matters most is assessing liver scarring, protecting your heart and managing diabetes—not simply tracking liver enzyme levels.

Your next step

Choose one dietary change and a time to walk, and confirm when your liver scarring assessment is due.

What happens inside the liver?

The liver processes food, stores energy and makes substances your body needs. In fatty liver, more fat than usual builds up inside liver cells. This often happens when the body responds less well to insulin. It may be linked to diabetes, a larger waist and abnormal blood fats, but can also occur at a normal weight.

Fat accumulation differs from steatohepatitis, where liver cells are also injured and inflamed. Persistent injury may cause scar tissue called fibrosis. Stages F1–F3 describe fibrosis before cirrhosis; F3 is advanced fibrosis. F4 means cirrhosis, with changes to the liver’s structure. Not everyone with liver fat develops these stages.

Why do I need follow-up when I feel well?

Fatty liver often causes no clear symptoms and may be discovered on a blood test or scan performed for another reason. Sometimes there is tiredness or discomfort in the upper right abdomen, but pain severity does not show how severe the disease is. The amount of fat seen on ultrasound alone also cannot determine the degree of scarring.

Treatment aims to reduce liver fat and inflammation and protect the liver over the long term, while protecting the heart too. Improvement is possible, but we assess it using weight, risk factors, tests and the degree of scarring together—not simply because tiredness disappears or one blood test improves.

Can liver scarring improve?

Fibrosis at stages F1–F3 can regress when its cause is treated, particularly at earlier stages. Improvement is not guaranteed, and F3 is advanced scarring that still needs careful follow-up.

Cirrhosis (F4) can also improve in some people, but this does not necessarily restore a normal liver. Follow-up and any prescribed surveillance for liver cancer and varices remain important, even if blood tests or a stiffness measurement improve.

How do we assess your condition?

- We review diabetes, cholesterol and other blood fats, blood pressure and medicines, and rule out other causes when necessary. We may use blood tests to estimate the likelihood of scarring, followed by a liver stiffness measurement such as FibroScan.
- Normal liver enzymes do not rule out scarring. Only some people need a biopsy.

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A realistic weight goal

- If you are overweight, losing about 5% may reduce liver fat; 7–10% may improve inflammation, and around 10% or more may help scarring. Your goal should be gradual and tailored to you.
- For example, at a weight of 90 kg, losing 5–10% means approximately 4.5–9 kg.

Your everyday plan

- Fill half your plate with vegetables, a quarter with protein and a quarter with a moderate portion of rice or other grains. Choose grilled rather than fried food, and cut back on sugary drinks, juices and sweets.
- Start walking, then gradually build up towards 150 minutes of activity a week according to your ability, adding muscle-strengthening exercise. Movement helps even without weight loss.
- Manage diabetes, blood pressure and cholesterol, and avoid alcohol. Do not stop your cholesterol medicine yourself; fatty liver alone does not prevent its use.

Treatment and follow-up

- Weight-management or diabetes medicines may suit some patients. Targeted treatments for steatohepatitis include semaglutide and resmetirom for selected adults with stage 2 or 3 scarring, without stage 4. These medicines are not suitable for everyone with liver fat; your specialist assesses eligibility, regulatory approval and local availability, alongside continued balanced eating and activity.
- Do not start vitamin E or herbal “liver cleanses” without a prescription. Have your weight, blood tests and scarring assessment reviewed as planned, even if you feel well.
- Bariatric surgery may be useful for suitable patients; advanced liver scarring requires specialist assessment before a decision.

When to get help

Get urgent medical care / go to the emergency department

Vomiting blood, black, tarry stools even without dizziness, new confusion, or severe jaundice with a general deterioration.

Contact your care team promptly

New jaundice, swelling of the abdomen or legs, or unintentional weight loss.

Related guides: Food guide for fatty liver · Liver cirrhosis (F4) · Herbs, mixtures and supplements: benefits and risks · Liver biopsy and FibroScan · Raised liver enzymes: what do they mean? · Alcohol-related liver disease

Sources and further information NIH: Fatty liver EASL: Fatty liver guidelines NIDDK: Fatty liver symptoms and causes EASL–EASD–EASO targeted MASH therapy guidance · 2026-09-29 EASL–EASD–EASO MASLD CPG · 2024 AASLD: fibrosis stages AASLD: regression of fibrosis and cirrhosis (2026) EASL: diet and lifestyle for fatty liver

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Mediterranean-style eating for fatty liver

Mediterranean-style eating for fatty liver

A balanced eating pattern you can maintain. Choose simple foods and adjust portions to your weight and health needs.

Choose less often

Sugary drinks and sweets

Reduce sweetened drinks, juices, frequent sweets and pastries.



Saturated fat and fried meals

Reduce fried meals and large amounts of ghee or butter. Watch rich pastries.

Processed and fatty meat

Reduce sausages, mortadella, fatty red meat and highly processed meals.

Choose more often

Vegetables and whole fruit

A variety of vegetables daily. Choose whole fruit instead of juice.



Whole grains

Oats, bulgur and wholegrain bread, in portions that suit your needs.



Legumes

Lentils, broad beans, other beans and chickpeas, as tolerated. Replace some meat meals with legumes.



Healthy fats

Measured olive oil instead of ghee or butter. Small portions of unsalted nuts.



Protein

Fish, skinless chicken and legumes. Grill or bake instead of frying.



Drinks and dairy

Water, unsweetened tea or coffee, and unsweetened laban or yogurt as tolerated.



A practical plate

Half non-starchy vegetables, one quarter protein and one quarter starchy food. These are proportions of plate space, not calories. For kabsa or mandi, reduce rice and fat, add salad and choose a suitable protein. Rice and dates do not need to be cut out completely.

Portions still matter

If overweight, aim for gradual weight loss with regular activity and a plan suited to you. Avoid alcohol. Do not start a weight-loss diet if underweight or malnourished without professional advice.

Nuts and oils are high in calories despite their benefits. Tailor portions to your weight, diabetes and activity. If you have cirrhosis (stage 4 liver scarring, F4) or are underweight, do not start a weight-loss diet without assessment. This diet is different from the low-FODMAP diet.

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Patient Guide · English edition

Enlarge the chart to read it. The complete diet guidance follows on the next page.

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Mediterranean-style eating for fatty liver

A balanced eating pattern you can maintain. Choose simple foods and adjust portions to your weight and health needs.

Choose more often

- A variety of vegetables and whole fruit rather than juice.
- Whole grains such as oats, bulgur and wholegrain bread, in portions that suit your needs.
- Legumes such as lentils, broad beans, other beans and chickpeas, as tolerated; use them to replace some meat meals.
- Fish, skinless chicken and a variety of protein sources, including legumes. Grill or bake instead of frying.
- Measured amounts of olive oil instead of ghee and butter.
- Small portions of unsalted nuts.
- Water, unsweetened tea or coffee, and unsweetened laban or yogurt as tolerated.

Reduce gradually

- Sweetened drinks and juices.
- Frequent sweets and pastries.
- Processed meat, such as sausages and mortadella, fatty red meat and highly processed meals.
- Fried meals and large amounts of ghee.
- Large portions of rice and bread.

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A practical plate

Fill half the plate with non-starchy vegetables, one quarter with protein and one quarter with starchy foods. These proportions refer to plate space, not calories.

For kabsa or mandi, reduce the rice and fat, add salad and choose a suitable protein. You do not need to cut out rice or dates completely.

Portions matter, even with healthy choices

If you are overweight, aim for gradual weight loss with regular activity and a plan suited to you. Avoid alcohol. Do not start a weight-loss diet if you are underweight or malnourished without professional advice.

> Nuts and oils are high in calories despite their benefits. Tailor portions to your weight, diabetes and activity. If you have cirrhosis (stage 4 liver scarring, F4) or are underweight, do not start a weight-loss diet without assessment. This diet is different from the low-FODMAP diet.

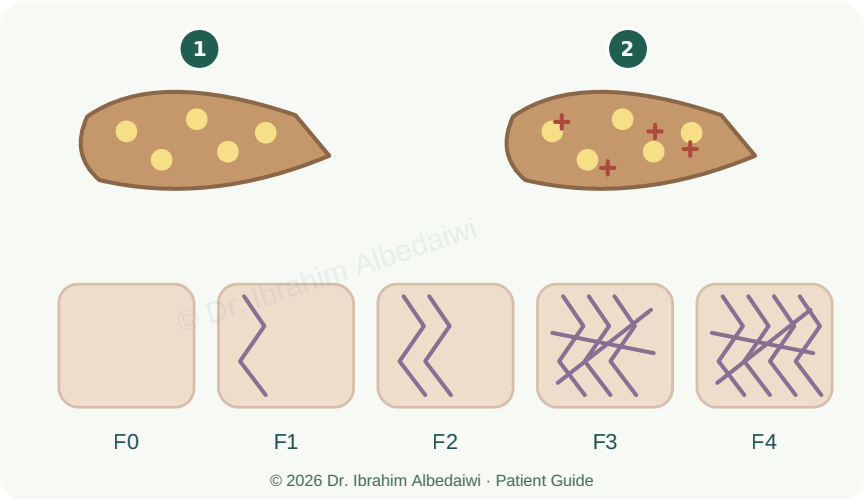
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ILLUSTRATED PATIENT GUIDE

Fat, fibrosis and cirrhosis: what is the difference?

Fat in the liver does not automatically mean fibrosis or cirrhosis. Not everyone develops these stages.



1 · Fat accumulation: MASLD

Fat builds up inside liver cells.

2 · Steatohepatitis: MASH

Fat accompanies liver-cell injury and inflammation; scars may develop.

F0 · No fibrosis

This staging system describes scarring, not the amount of liver fat.

F1–F3 · Fibrosis before cirrhosis

F1: mild · F2: moderate · F3: advanced bridging fibrosis, before F4.

F4 · Cirrhosis

Extensive scarring alters liver structure and may affect blood flow and function.

> Fibrosis can regress when its cause is treated, especially earlier stages. F4 can also improve, but this does not guarantee a normal liver or remove the need for follow-up. Progression is not inevitable; enzymes or stiffness alone cannot establish the stage.

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AASLD: fibrosis stages
AASLD: regression of fibrosis and cirrhosis (2026)

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Gastroesophageal reflux disease

Last updated: 10 November 2026 · GERD

Heartburn and reflux can usually be controlled with simple everyday changes and suitable medicine. Difficulty swallowing or new chest pain needs a different assessment.

Your next step

If symptoms occur at night, arrange to raise the head of your bed correctly. If you smoke, ask for a quit plan and review your medicine timing.

Understanding the condition: what exactly happens?

The esophagus is the tube carrying food from your mouth to your stomach. A muscle at its lower end acts as a valve, opening to let food through and closing to limit backflow. If it relaxes at the wrong time or weakens, acid and stomach contents may flow back into the esophagus, causing irritation and heartburn.

Occasional reflux can happen in healthy people. It is called reflux disease when it repeatedly causes troublesome symptoms or complications. This does not always mean the stomach makes too much acid; often the problem is acid flowing into the wrong place. A hiatus hernia or increased abdominal pressure may contribute.

How does it appear, and what is treatment for?

Typical symptoms are a burning feeling rising behind the breastbone, or food or sour fluid coming back into the mouth. Symptoms may worsen after meals or with bending and lying down. Reflux can sometimes cause inflammation or narrowing of the esophagus, but most people do not develop serious complications. Not every cough or hoarse voice is due to reflux.

Treatment aims to relieve symptoms, heal any inflammation and protect the esophagus. An endoscopy may be normal despite reflux; acid monitoring can help when there is uncertainty. The need for ongoing treatment varies, so the plan is reviewed according to the diagnosis and response—not simply because of fear of taking or depending on medicine.

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Raise the head end: support the upper body



Raise the head end by about 15–20 cm

Use stable, purpose-made risers or an adjustable bed. Another option is a long wedge supporting the back, shoulders and head together.

A stack of ordinary pillows under the head alone does not create the same incline. Illustration is not to scale.

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Do I need an endoscopy?

- Treatment for typical symptoms may begin without an endoscopy. We request one for warning signs, risk factors or a lack of improvement. Reflux monitoring may be needed if the diagnosis remains unclear.

Use your medicine correctly

- Many proton pump inhibitors are taken 30–60 minutes before a meal, usually before breakfast. Follow the instructions for your particular medicine; timing differs between products.
- Antacids or alginates may relieve occasional symptoms. Review the lowest effective dose and duration of treatment; some conditions need long-term treatment. Do not change the dose yourself.

Changes that can help

- Allow about 3 hours between your last meal and lying down. During Ramadan, avoid a large meal immediately before sleep.
- Lose weight gradually if you are overweight, and try smaller meals.
- Reduce foods you notice trigger your symptoms; there is no single forbidden-food list for everyone.

Raising the head of the bed: why and how?

- Raising the head of the bed is particularly helpful for nighttime heartburn or fluid coming back up when lying down. Keeping your chest and head higher than your abdomen allows gravity to reduce the backflow of stomach contents into the esophagus. This supports treatment rather than replacing it.
- Raise the head end of the bed by about 15–20 cm using purpose-made, stable risers under the legs at that end, or use an adjustable bed. A long wedge pillow that supports the back, shoulders and head together on a gradual incline is another option.

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- Stacking ordinary pillows under the head alone does not provide the same incline and may bend the neck or increase pressure on the abdomen. Make sure the bed is stable and your back comfortable, and ask someone to help set it up safely. Continue to leave about 3 hours between your last meal and lying down.

Smoking and reflux: make quitting part of treatment

- Smoking may weaken the muscular barrier between the stomach and esophagus, allowing acid to flow back more easily. Quitting is an important step in relieving reflux and protecting your health, particularly if symptoms persist despite medicine.
- The goal is to stop completely. If that feels difficult now, start cutting down as part of a clear plan to quit, and ask a smoking cessation clinic or your doctor about suitable support. Cutting down is a step towards quitting and does not remove the harm.

If you are not improving

- Check that you take your medicine regularly and at the right time, and record when heartburn occurs and its relationship to food and sleep. Do not double the dose yourself.
- Tell your doctor about difficulty or pain with swallowing, repeated vomiting, anemia or weight loss. Anti-reflux procedures are suitable for selected patients after assessment.

When to get help

Get urgent medical care / go to the emergency department

New or pressure-like chest pain, especially with breathlessness or sweating; vomiting blood, black stools, or food remaining stuck or liquids not passing, even if you can swallow saliva.

Contact your care team promptly

Increasing difficulty swallowing, unintentional weight loss, or symptoms continuing despite taking treatment correctly.

Related guides: Everyday eating with reflux · Gastroscopy · Acid medicines: proton pump inhibitors (PPIs) · Vonoprazan · Barrett’s esophagus

Sources and further information NIDDK: Treatment NIDDK: Diet NIDDK: Reflux definition and symptoms NHS: Raising the head of the bed and reflux Ministry of Health: Gastroesophageal reflux Clinical guidelines: 2022 NIDDK: eating and nutrition for acid reflux NIDDK: treatment of acid reflux

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Eating with acid reflux

Eating with acid reflux

Meal size and timing matter. There is no single list of foods that everyone must avoid.

Options to try

Lighter meals

Moderate portions of rice, oats or bread, with grilled or baked chicken or fish instead of fried food.

Vegetables and fruit as tolerated

Try cooked or fresh vegetables, bananas, melon or pears. You do not need to avoid all fruit.

Drinks and dairy

Choose water instead of drinks that trigger symptoms, and lower-fat dairy if you tolerate it. Watch the portion and preparation method.

Reduce your own triggers

Fat and heavy meals

Fried and fatty meals and large portions may worsen reflux, especially before bed.

Triggers for some people

Coffee, caffeine, chocolate, mint and spicy foods. Reduce the items you notice trigger your symptoms.

Acidic foods and drinks

Tomatoes and citrus fruit may bother some people. Reduce them if they trigger symptoms; they are not forbidden for everyone.

Leave time before bed

Finish your last meal three hours before lying down or going to sleep, and avoid lying down after eating.

Try one clear change

Record food, portion size, timing and symptoms, then assess the effect of the change. Lose weight gradually if you are overweight.



Diet can help but does not replace treatment. Difficulty swallowing, bleeding or unintentional weight loss needs medical assessment.

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Enlarge the chart to read it. The complete diet guidance follows on the next page.

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Crohn’s disease

Last updated: 10 November 2026 · Crohn’s disease

Crohn’s is a chronic inflammatory condition that can be controlled. The goal is to improve your quality of life and settle inflammation inside the bowel, even when symptoms ease.

Your next step

Check that you have enough medicine and know when your inflammation assessment is due, and record any change from your usual pattern.

Understanding the condition: what exactly happens?

Crohn’s disease is a chronic inflammatory bowel disease. The immune system becomes inappropriately active in the digestive tract, causing inflammation that may persist or return in flares. Genetic and environmental factors and gut microbes contribute; it is not caused by one dietary mistake or by stress alone.

It can affect anywhere from the mouth to the anus, most commonly the end of the small intestine and the colon. Inflamed areas may be separated by healthy areas. Inflammation can extend deep into the bowel wall, explaining the possibility of narrowing, an abnormal tunnel called a fistula, or a collection of pus called an abscess.

How is it confirmed, and can it be controlled?

Symptoms depend on the location of inflammation: diarrhea, abdominal pain, tiredness and weight loss, sometimes with problems around the anus. Some people also have joint, eye or skin involvement. No single symptom or test establishes the diagnosis; the doctor combines your history, blood and stool tests, endoscopy and biopsies, and may need small-bowel imaging.

Crohn’s is not an infection that spreads to others, and differs from irritable bowel syndrome. Treatment aims to calm the immune response, heal inflammation, maintain nutrition and avoid complications. Long periods of remission are possible, but pain disappearing does not remove the tendency to develop disease, so follow-up and preventive treatment continue according to the plan.

Active disease or remission?

A flare means increased disease activity, often with more symptoms. In remission, activity settles and symptoms are absent or minimal. Tests may still be needed to assess inflammation; continue treatment and follow-up as planned.

How do we monitor it?

- We monitor symptoms, blood tests and fecal calprotectin (a marker of inflammation), and may need endoscopy or imaging. Improved symptoms do not prove inflammation has gone. We review nutrition, iron and vitamin B12 according to your needs.
- Agree a written flare plan and a schedule for tests and endoscopy with your team. You may need regular colonoscopies for bowel cancer surveillance if colonic inflammation has lasted a long time; your doctor sets the timing according to your risk factors.

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Treating flares and maintaining remission

- Corticosteroids settle a flare for a limited period and are not used for long-term maintenance of remission in Crohn’s. Follow the tapering plan and do not stop suddenly.
- Immunomodulators such as azathioprine or methotrexate may be used in specific circumstances and require blood-test monitoring. Methotrexate is taken weekly, not daily, and is unsuitable during pregnancy. Mesalazine is not a usual effective treatment for Crohn’s; do not change your prescription yourself.

Biologic and targeted treatments

- Biologics target specific parts of the inflammatory process and are given by intravenous infusion or injection under the skin. Examples include infliximab, adalimumab, vedolizumab, ustekinumab and risankizumab. We may choose them early for moderate or severe disease; they are not necessarily a last resort.
- Targeted tablets are also available for some patients, with particular precautions concerning infection, blood clots and pregnancy depending on the medicine. Your team chooses treatment after reviewing your condition, tests and vaccinations.

Using treatment safely

- Continue maintenance treatment even when you improve. If you have a fever or infection, contact your team before the next dose, and do not double a missed dose. Injection, storage and monitoring instructions differ between medicines; open your medicine card in the related guides below.

Fistulas in Crohn’s: what are they?

- A fistula is an abnormal tunnel-like channel connecting the bowel to the skin or another organ. It can form because Crohn’s inflammation extends deep into the bowel wall. Fistulas around the anus are most common, but they may also connect parts of the bowel to each other, or the bowel to the bladder or vagina.
- A fistula differs from an anal fissure, which is a small tear in the lining of the anal opening. It also differs from an abscess, a collection of pus, although a fistula and an abscess may occur together. A fistula does not mean poor hygiene, and not every fistula is caused by Crohn’s.

What symptoms should I report?

- A fistula around the anus may appear as an opening that drains pus, fluid or blood, with skin irritation or recurring swelling and pain. Depending on the connection, there may be gas in the urine, recurrent urinary infections, or gas or stool passing through the vagina. Tell your team if these occur.
- Increasing pain or a tender swelling around the anus, especially with fever, chills or marked tiredness, may indicate an abscess and needs urgent assessment. Do not wait for a clinic appointment or squeeze the swelling. A deep abscess can occur without a visible opening or fever.

How are fistulas investigated and treated?

- An examination, pelvic MRI or examination under anesthesia may be needed to map the tract and rule out an abscess. The gastroenterologist and colorectal surgeon usually coordinate care, protecting the muscles that control bowel movements.

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- An abscess may need drainage; antibiotics alone are usually insufficient. A flexible drainage thread called a seton may be placed through the fistula tract to keep it draining and reduce pus buildup. It is part of treatment; do not pull it out or cut it yourself.
- Biologic treatment may be used to control Crohn's inflammation and help the fistula heal after treating any infection or abscess. Some cases need further surgery. Drainage stopping or the skin opening closing does not by itself prove that the internal tract has healed; follow-up matters.

Food and everyday life

- No single diet cures Crohn's. Eat a varied diet with enough protein, and seek dietitian support if you lose weight or find eating difficult.
- If you have a narrowing, your team may temporarily recommend soft foods low in coarse fiber. Do not begin a high-fiber diet without advice if you have a stricture.
- Avoid painkillers such as ibuprofen and diclofenac without medical advice.

Smoking affects the course of Crohn's itself

- Smoking increases the likelihood of Crohn's flares, surgery and recurrence after surgery. Quitting is therefore an important part of treatment, not simply general health advice, and can help at any stage of the disease.
- Complete cessation is best; even light smoking is not considered safe in Crohn's. If you cannot stop immediately, make cutting down a step within a quit plan, and agree a date and suitable support with your doctor. Quitting does not replace prescribed treatment.
- Ask for a referral to a smoking cessation clinic and discuss behavioral support, stop-smoking medicines or nicotine replacement as appropriate for you. If you resumed smoking after a previous attempt, try again with your team and adjust the plan.

When to get help

Get urgent medical care / go to the emergency department

Severe pain with bloating and vomiting or inability to pass gas, heavy bleeding or fainting, or increasing pain and a tender swelling around the anus, especially with fever, chills or general deterioration.

Contact your care team promptly

Persistent worsening diarrhea, new nighttime diarrhea, weight loss, or fever while taking immunosuppressive treatment; contact your team the same day for fever. Also report an opening or recurrent discharge around the anus, gas in the urine, or gas or stool passing through the vagina.

Related guides: Biologic infusions: what to expect · Nutrition with Crohn's disease and ulcerative colitis · IBD medicine safety · Pregnancy and breastfeeding with bowel and liver disease · Infliximab medicine card · Adalimumab medicine card · Vedolizumab medicine card · Ustekinumab medicine card · Risankizumab medicine card · Mesalazine / mesalamine medicine card · Corticosteroid medicine card · My IBD flare plan · Azathioprine / Imuran · C. difficile infection

Sources and further information NIDDK: Crohn's treatment Crohn's & Colitis UK: Treatments NIDDK: Understanding Crohn's disease NIDDK: Crohn's disease BSG: IBD guidelines and smoking Crohn's & Colitis UK: Fistulas ASCRS: Fistula

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and abscess AGA: Crohn’s medicines Crohn’s & Colitis UK: Steroids Crohn’s & Colitis UK: Methotrexate ACG: Crohn’s guidelines 2025

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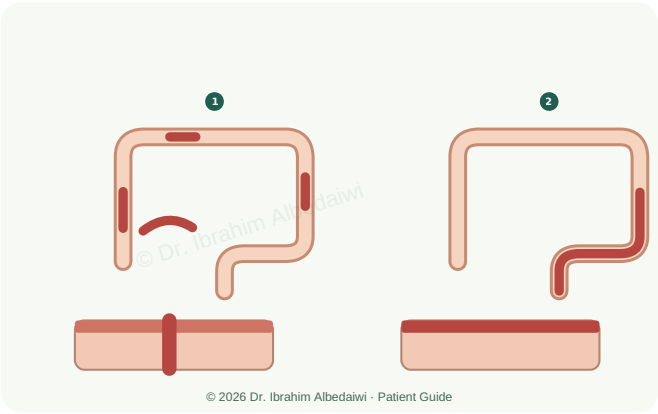
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ILLUSTRATED PATIENT GUIDE

Crohn’s disease and ulcerative colitis

Darker areas show example sites of inflammation, not a measure of disease severity.



1 · Crohn’s disease

Can affect any part from mouth to anus, commonly the small bowel and colon. Inflamed areas may be separated by healthy bowel, and inflammation can involve the full bowel wall.

2 · Ulcerative colitis

Affects the colon and rectum. It usually starts in the rectum and extends continuously, mainly affecting the inner lining.

> Both can have active periods and periods of remission. These are general patterns; tests, endoscopy and biopsies establish the diagnosis.

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Crohn’s & Colitis Foundation: Crohn’s and colitis

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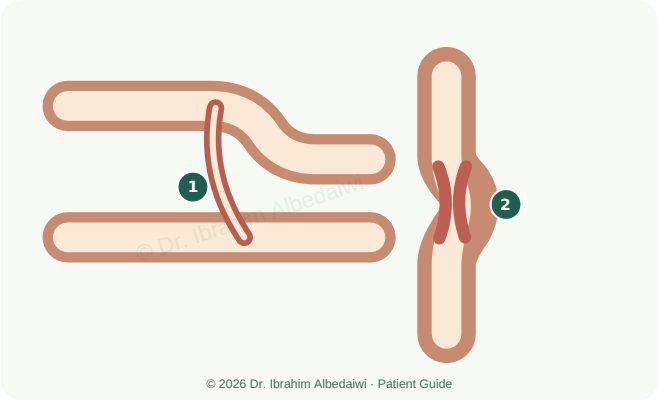
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ILLUSTRATED PATIENT GUIDE

Fistulas and strictures in Crohn’s disease

These complications occur in some patients; they are not inevitable.



1 · Fistula

An abnormal tunnel linking bowel to another bowel segment, another organ or skin. This example connects two bowel segments. A fistula can also occur around the anus; it differs from an anal fissure.

2 · Stricture

A narrowed bowel segment caused by inflammation, scarring or both, which may obstruct passage.

> Severe pain with swelling, vomiting or inability to pass gas needs urgent assessment. Painful anal swelling with fever may indicate an abscess.

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Crohn’s & Colitis UK: Fistulas
Crohn’s & Colitis UK: Surgery and strictures

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Ulcerative colitis

Last updated: 10 November 2026 · Ulcerative colitis

Controlling inflammation protects the colon and reduces flares. Continue your remission-maintenance treatment even when bleeding stops and bowel movements return to normal.

Your next step

Continue your remission-maintenance treatment, and record bowel movement frequency and any blood to help assess a flare.

Understanding the condition: what exactly happens?

Ulcerative colitis is a chronic inflammatory bowel disease. An abnormal immune response causes inflammation and ulcers in the inner lining of the colon, which absorbs water and stores stool. The disease usually begins in the rectum and may extend continuously through part or all of the colon.

It differs from Crohn’s, which can affect the small intestine or other locations and extend deep into the bowel wall. It also differs from irritable bowel syndrome: ulcerative colitis involves actual inflammation in the tissue. It is not contagious and is not simply caused by spicy food or emotional stress, although some circumstances may worsen symptoms.

Why do bleeding and urgency occur, and what is remission?

The inflamed lining bleeds more easily and functions less effectively, causing diarrhea with blood or mucus. You may feel an urgent need to pass stool or a sense that the bowel has not emptied completely, even when only a small amount passes. A flare may cause tiredness and anemia, and sometimes symptoms in the joints, skin or eyes.

Diagnosis is usually confirmed by colonoscopy and biopsies after excluding causes such as infection. There are periods of active disease (flares) and inactive disease (remission). We aim to stop bleeding and diarrhea and heal the lining, then prevent inflammation from returning. Treatment intensity depends on disease severity and extent; few symptoms do not mean you can stop maintenance treatment without review.

Active disease or remission?

A flare means increased disease activity, often with more symptoms. In remission, activity settles and symptoms are absent or minimal. Tests may still be needed to assess inflammation; continue treatment and follow-up as planned.

Treating flares and maintaining remission

- Mesalazine is an important treatment for mild to moderate disease, taken orally or as suppositories or enemas depending on where inflammation is located. Your doctor may combine oral and rectal forms, with kidney function monitoring.
- Corticosteroids are short-term treatment for a flare, not long-term maintenance of remission; follow the tapering plan. Immunomodulators such as azathioprine may be used for maintenance or alongside certain biologics, and require monitoring tests.

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Biologic and targeted treatments

- Biologics target specific parts of the inflammatory process and are given by intravenous infusion or injection under the skin. Examples include infliximab, adalimumab, vedolizumab, ustekinumab and risankizumab. We may choose them early for moderate or severe disease; they are not necessarily a last resort.
- Targeted tablets are also available for some patients, with particular precautions concerning infection, blood clots and pregnancy depending on the medicine. Your team chooses treatment after reviewing your condition, tests and vaccinations.

Using treatment safely

- Continue maintenance treatment even when you improve. If you have a fever or infection, contact your team before the next dose, and do not double a missed dose. Injection, storage and monitoring instructions differ between medicines; open your medicine card in the related guides below.

How do we know treatment is working?

- We monitor symptoms, blood tests and fecal calprotectin (an inflammation marker), with endoscopy when necessary. We may check for infection if your condition worsens.
- Some medicines require blood, liver or kidney monitoring even when symptoms improve.

Food and activity that suit you

- Eat balanced meals and drink enough fluids. During a flare, choose foods you tolerate easily and avoid prolonged highly restrictive diets without a dietitian.
- Not everyone needs to avoid milk or gluten; adjust food according to tolerance and diagnosis. Treat iron deficiency and nutritional deficiencies based on your tests.
- Avoid anti-inflammatory painkillers such as ibuprofen without advice. Do not use anti-diarrheal medicines during a severe bloody flare or abdominal swelling without medical direction.

Protecting your long-term health

- Discuss vaccinations and infection screening before immunosuppressive medicines. Tell your team if you are pregnant or planning pregnancy before changing treatment.
- Regular colonoscopies for bowel cancer surveillance may be needed after years of disease; timing depends on the duration and extent of inflammation and other risk factors.
- Surgery may be the best option for complications or inflammation that does not respond to treatment; your team will discuss the alternatives with you.

When to get help

Get urgent medical care / go to the emergency department

Frequent bloody diarrhea with fever, a racing heartbeat or severe weakness; severe pain and swelling, heavy bleeding, or inability to drink fluids.

Contact your care team promptly

More bleeding or bowel movements than usual; contact your team early rather than waiting for a severe flare.

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Sources and further information NIH: Ulcerative colitis NIDDK: Ulcerative colitis AGA: Ulcerative colitis medicines Crohn’s & Colitis UK: Biologic and targeted treatments Crohn’s & Colitis UK: Steroids Crohn’s & Colitis UK: Methotrexate ECCO: Ulcerative colitis treatment 2026

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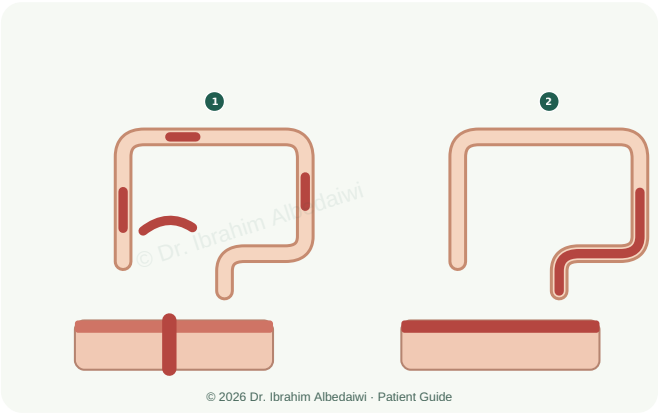
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ILLUSTRATED PATIENT GUIDE

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Crohn’s & Colitis Foundation: Crohn’s and colitis

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Microscopic colitis

Last updated: 10 November 2026 · Microscopic colitis

The colon may look normal during colonoscopy, but biopsies reveal inflammation. This is a treatable condition that differs from IBS and needs its own treatment plan.

Your next step

Record episodes of diarrhea and bring your medicine list to your review, without stopping medicines yourself.

Understanding the condition: why “microscopic”?

The colon absorbs water from bowel contents to form stool. In microscopic colitis, inflammation of its lining affects water handling, causing recurrent watery diarrhea. “Microscopic” describes how the inflammation is identified under a microscope; it does not mean symptoms are mild or unimportant.

There is a lymphocytic type, with increased numbers of certain immune cells, and a collagenous type, with thickening of a thin layer beneath the lining. Symptoms and treatments are similar. There is no single known cause for everyone; immunity, genetic susceptibility, smoking and certain medicines may contribute. Taking a medicine associated with the condition does not alone prove it caused your disease.

How does it differ from other conditions?

Diarrhea is usually non-bloody and may wake you at night or cause urgency and stool leakage. Symptoms may come and go or persist for weeks or months. It is not an infection that spreads to others, is not a type of irritable bowel syndrome, and is not known to increase bowel cancer risk.

The lining can look normal to the eye during colonoscopy, so a “normal colonoscopy” does not rule it out if appropriate biopsies were not taken. Treatment aims to reduce diarrhea, restore sleep and activity, and maintain hydration and nutrition. Good control is possible; recurring symptoms may need an adjusted plan or maintenance treatment.

Why are biopsies necessary?

- The colon lining may look completely normal. Small samples are taken during colonoscopy and examined under a microscope.
- We may also look for infection, celiac disease or other causes of diarrhea according to your symptoms. Visible blood in stool needs assessment and should not automatically be attributed to this condition.

How is it treated?

- Budesonide is a commonly used, effective treatment prescribed by your doctor. Symptoms may return after it finishes; you may then need a different plan or maintenance treatment at a dose chosen by your doctor.

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- Some people benefit from an anti-diarrheal medicine or a medicine that binds bile acids inside the bowel if these contribute to diarrhea. Do not start these yourself, particularly if you have fever, blood or severe pain.

What can I do at home?

- Drink fluids regularly and use oral rehydration solution for significant fluid loss if your team recommends it. Follow any fluid restriction for heart or kidney disease.
- Temporarily reduce caffeine and sweeteners such as sorbitol, and review milk if you notice it worsens diarrhea. Do not exclude whole food groups without a reason.
- Record daytime and nighttime bowel movements, dizziness or reduced urine, and how symptoms affect your activities.

Review medicines without stopping them yourself

- The condition may be associated with some painkillers, acid-suppressing medicines and other drugs, but an association does not prove your medicine is the cause.
- Bring a complete list of medicines and supplements. Your doctor balances their benefits against the possibility of switching them. Stop smoking.
- A relapse does not mean treatment has permanently failed. Return to the clinic to adjust the plan rather than repeating steroids yourself.

When to get help

Get urgent medical care / go to the emergency department

Fainting, markedly reduced urine, inability to drink, severe persistent pain, or obvious heavy bleeding.

Contact your care team promptly

Diarrhea continuing after treatment, returning after stopping medicine, or weight loss; fever or blood needs prompt assessment.

Related guides: Irritable bowel syndrome · Budesonide MMX 9 mg / Cortiment

Sources and further information NIDDK: Disease and diagnosis NIDDK: Treatment NIDDK: Definition of microscopic colitis Clinical guidelines: 2021

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Eosinophilic esophagitis

Last updated: 10 November 2026 · Eosinophilic esophagitis · EoE

A chronic immune-mediated inflammation that may make swallowing difficult. Thorough chewing helps, but does not replace treatment of inflammation and biopsy follow-up.

Your next step

Check how to use your treatment and when biopsies are due, and do not ignore food sticking.

Understanding the condition: what are eosinophils?

The esophagus is the muscular tube that moves food from the mouth to the stomach. Eosinophils are white blood cells involved in immune and allergic reactions. In this condition they accumulate in the esophageal lining, causing chronic inflammation, often through an immune response to food or environmental triggers.

Persistent inflammation may reduce flexibility and cause rings or narrowed areas, making solid food harder to pass. Difficulty swallowing meat or bread and food sticking are characteristic. People may automatically learn to eat slowly and avoid certain foods, appearing well despite the ongoing problem. Tell your doctor if you need to cut food into small pieces or drink water to push it down.

Is it reflux or an ordinary food allergy?

Some symptoms resemble reflux, and the two conditions can coexist, but their mechanisms and follow-up plans differ. You may also have asthma, eczema or allergic rhinitis. This does not mean skin or blood allergy tests will accurately identify the trigger food; the response is not always the same as a familiar immediate allergy.

Your doctor confirms the diagnosis using symptoms, esophageal biopsies and assessment of other causes of increased eosinophils. Treatment aims to settle inflammation and prevent scarring and food impaction, not simply make swallowing easier. Medicines or an appropriate diet can control it, with dilation if needed. Long-term follow-up is usually necessary even when swallowing improves.

How is it diagnosed?

- We need compatible symptoms and an endoscopy with esophageal biopsies, while assessing other causes. The endoscopic appearance alone may not be enough.
- Asthma or eczema may occur alongside it, but standard allergy tests do not accurately identify the foods causing esophageal inflammation.

Treatment options

- Options include acid-reducing medicines, a topical corticosteroid swallowed in a specific way, or a supervised elimination diet. Biologic treatment may suit selected patients.
- Your doctor may recommend dilating a narrowing. Dilation improves the passage of food but does not treat the inflammation itself, so anti-inflammatory treatment continues.

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Using treatment and diet

- If a topical steroid is prescribed, ask how to swallow it and how long to avoid food and drink afterwards for your particular product. Do not substitute another inhaler yourself.
- Do not remove milk, wheat, eggs and other foods all at once without supervision. A limited elimination diet may be started and adjusted according to treatment response and biopsy results.
- The diet treats the disease and needs nutritional monitoring. Excluded foods should be reintroduced according to a plan, not based on symptoms alone.

Safer swallowing and follow-up

- Eat sitting upright, take small bites and chew thoroughly. Avoid large or dry pieces that have previously become stuck.
- We may repeat endoscopy and biopsies after starting or changing treatment. Better swallowing does not guarantee that inflammation has disappeared.
- Continue the agreed treatment to maintain control; the disease may relapse if treatment stops.

When to get help

Get urgent medical care / go to the emergency department

If food remains stuck or liquids will not pass, go to the emergency department without waiting, even if you can swallow saliva. Inability to swallow saliva, drooling, difficulty breathing or severe chest pain needs immediate help. Stop eating and drinking; do not try to push food down with water or make yourself vomit.

Contact your care team promptly

Recurring or increasing difficulty swallowing, weight loss, or constantly needing water to pass food.

Related guides: Gastroscopy · Difficulty swallowing and food getting stuck

Sources and further information ACG: Patient guide ACG: 2025 guidelines Clinical guidelines: 2025

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Celiac disease

Last updated: 10 November 2026 · Celiac disease

Once the diagnosis is confirmed, treatment is a lifelong gluten-free diet. Repeated small amounts of gluten may damage the bowel even without obvious symptoms.

Your next step

Review the ingredients and preparation utensils for one meal, and confirm your dietitian appointment.

Understanding the condition: what does gluten do?

Celiac disease is a chronic immune condition in genetically susceptible people. When gluten—a protein in wheat, barley and rye—is eaten, the immune system reacts in a way that damages the small-intestinal lining. The small intestine absorbs many nutrients and is covered with tiny projections called villi that increase its absorption area.

Inflammation can flatten the villi and impair absorption, so the problem extends beyond abdominal pain. Iron deficiency, tiredness, weight loss or bone problems may occur, sometimes without obvious digestive symptoms. It can appear in childhood or after years of eating wheat without a noticeable problem.

Why confirm the diagnosis and follow the diet?

Celiac disease differs from immediate wheat allergy, intolerance of certain food components and irritable bowel syndrome. Symptoms can overlap, but diagnosis and follow-up differ. Appropriate antibody tests and sometimes small-intestinal biopsies are used; coordinate testing before removing gluten to avoid misleading results.

Once confirmed, a gluten-free diet is ongoing treatment that allows the lining to recover and protects against nutrient deficiencies. Food safety cannot be judged by pain alone; exposure and damage may occur without clear symptoms. Health usually improves with adherence, but symptoms and the lining recover at different speeds, so we monitor nutrition and blood tests and review hidden gluten sources.

Before starting the diet

- Do not stop gluten before completing testing unless your doctor advises it; blood tests and biopsies may otherwise become misleadingly negative.
- We usually start with celiac antibody testing and measure a type of antibody called IgA to help choose the right test. Endoscopy and small-intestinal biopsies may be needed; a specialist decides when blood tests alone are sufficient in selected cases. If you have already started the diet, do not reintroduce gluten yourself; discuss a diagnostic plan.

What can I eat?

- Rice, potatoes, corn, vegetables, fruit, eggs and meat without flour coatings are naturally gluten-free, but additives and preparation methods matter.
- Choose only oats labeled “gluten-free,” and discuss tolerance with your dietitian.

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Examples from our table

- Jareesh, qursan, marqooq, wheat bread and semolina usually contain gluten. The rice in kabsa is suitable if spices, stock and additions are gluten-free.
- Watch for barley, malt and some sauces, soups and processed meats. Read ingredients with every purchase because formulations may change.
- Clean preparation utensils thoroughly and use a dedicated gluten-free toaster or protective toaster bags, avoid frying oil shared with gluten-containing food, and prevent bread crumbs from reaching your food. At restaurants, explain that avoiding gluten is a medical necessity.

Monitoring improvement

- See a dietitian and have antibody, iron and vitamin tests according to the plan. Some people need bone assessment or repeat biopsies.
- If symptoms persist, we review hidden gluten exposure and other causes; do not simply restrict more foods.
- First-degree relatives may need testing even without symptoms. Symptom improvement alone does not prove the bowel lining has healed.

When to get help

Get urgent medical care / go to the emergency department

Severe dehydration or fainting, vomiting that prevents drinking, severe persistent pain, or gastrointestinal bleeding.

Contact your care team promptly

Continued weight loss, anemia that does not improve, ongoing diarrhea despite following the diet, or difficulty maintaining balanced nutrition.

Related guides: A gluten-free table · Iron deficiency, anemia and the digestive system

Sources and further information NIDDK: Diet NIDDK: Treatment and follow-up NIDDK: Definition of coeliac disease NIDDK: Coeliac disease Clinical guidelines: 2025 ESsCD Part 1 NIDDK: eating and nutrition for coeliac disease NIDDK: treatment of coeliac disease

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Celiac disease: a gluten-free diet

Celiac disease: a gluten-free diet

After the diagnosis is confirmed, the diet must continue even when symptoms disappear.

Choose safe alternatives	Avoid gluten
Naturally gluten-free starches Rice, corn, potatoes and quinoa. Choose bread and pasta labeled “gluten-free”.	**Grains that contain gluten** Wheat, barley and rye, including bulgur, semolina, freekeh and wheat-based jareesh.
Simple, varied foods Vegetables, fruit, legumes, eggs, fish and meat without flour coatings or sauces containing gluten.	**Their usual products** Bread, pasta, biscuits and cakes, unless they are reliable gluten-free alternatives.
Dairy and oats Plain dairy as tolerated. Use oats only if labeled “gluten-free”, in consultation with your dietitian.	**Hidden sources** Check for barley malt and check sauces, soups and marinades. Read the label every time.

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Prevent cross-contact from crumbs

Clean surfaces and utensils. Use a separate toaster and avoid frying oil shared with flour-coated foods.

Ask at restaurants

Explain that you have celiac disease and ask about ingredients and preparation. “Wheat-free” does not always mean “gluten-free”.



Do not start the diet before completing celiac testing. Improvement in symptoms does not mean the disease has gone away; continue follow-up.

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Patient Guide · English edition

Enlarge the chart to read it. The complete diet guidance follows on the next page.

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Choose safe alternatives

Naturally gluten-free starches

Rice, corn, potatoes and quinoa. Choose bread and pasta labeled “gluten-free”.

Simple, varied foods

Vegetables, fruit, legumes, eggs, fish and meat without flour coatings or sauces containing gluten.

Dairy and oats

Plain dairy as tolerated. Use oats only if labeled “gluten-free”, in consultation with your dietitian.

Avoid gluten

Grains that contain gluten

Wheat, barley and rye, including bulgur, semolina, freekeh and wheat-based jareesh.

Their usual products

Bread, pasta, biscuits and cakes, unless they are reliable gluten-free alternatives.

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Colon polyps

Last updated: 10 November 2026 · Colon polyps

Most polyps are not cancer. Removing types that may change over time, then following up their laboratory results, helps prevent bowel cancer.

Your next step

Ask for the polyp pathology result and the next colonoscopy date in writing.

Understanding the condition: is a polyp cancer?

A polyp is extra growth in the inner lining of the colon or rectum. It may look like a small bump on a stalk, or be broad-based or flat. “Polyp” describes a growth, not a diagnosis of cancer. Most are not cancerous when found, but some types may gradually become cancer if left in place.

Removing polyps therefore prevents disease rather than simply treating symptoms. Many cause no pain or bowel changes and are found during an examination in someone who feels well. They become more likely with age or a personal or family history, but can still occur without these factors.

What does the tissue analysis tell us?

The laboratory examines the cells after removal to identify whether the polyp is a precancerous type or another type, and whether advanced changes are present. You cannot determine this from size alone or from a lack of symptoms. The tissue result is interpreted alongside the colonoscopy report and whether removal was complete.

Removing a polyp does not prevent new polyps from developing. Follow-up depends on the combined findings, bowel preparation quality and family history. The aim is to remove concerning growths and follow up at the right time, without repeating colonoscopy unnecessarily often or delaying it too long. Keep the colonoscopy and pathology reports together.

How are they treated?

- Most polyps are removed during colonoscopy and sent to the laboratory. Large or complex polyps may need a specialist therapeutic endoscopy or, in selected cases, surgery.
- Ask whether removal was complete, whether there were other polyps, and whether the bowel preparation was good.

When should colonoscopy be repeated?

- Timing depends on the number, size and laboratory type of polyps, bowel preparation quality, completeness of removal and family history. It is not the same for everyone.
- An early repeat may be necessary if a polyp was removed in pieces or preparation was inadequate. Do not rely on a general timetable before the laboratory result is available.

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After polyp removal

- Follow discharge instructions about food, activity, travel and restarting blood thinners. Do not stop or restart a blood thinner yourself.
- A small amount of blood can occur after some procedures, but persistent or repeated bleeding or bleeding with dizziness is not normal.
- Bleeding may be delayed for several days, sometimes around two weeks. Keep your colonoscopy report and tell emergency staff you have had a polyp removed.

How can I reduce risk?

- Maintain a healthy weight, be physically active and do not smoke. Include fiber and vegetables in a balanced diet and limit processed meat.
- Do not start aspirin solely to prevent polyps without medical assessment; it can increase bleeding.
- Tell your doctor about bowel cancer or multiple polyps in the family, especially at a young age. If your tissue result has not arrived, contact the clinic rather than assuming it is normal.

When to get help

Get urgent medical care / go to the emergency department

Heavy bleeding, blood clots or dizziness, severe or worsening abdominal pain, fever, or fainting after colonoscopy.

Contact your care team promptly

A missing pathology result or an unclear date for the next colonoscopy.

Related guides: Colonoscopy · Colorectal cancer screening · After colon polyp removal and biopsy results · Colon and rectal cancer

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Sources and further information NIDDK: Definition NIDDK: Removal and follow-up NCI: Screening and polyps Clinical guidelines: 2020 USMSTF

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Gastroscopy

Last updated: 10 November 2026 · Gastroscopy / upper endoscopy

A flexible-camera examination of the esophagus, stomach and first part of the small intestine. Correct preparation and a clear medicine plan help make the procedure safe and the examination clear.

Your next step

Complete the preparation sheet with your unit and arrange your escort before the procedure day.

What can a gastroscopy see?

A thin flexible tube with a camera and light allows direct inspection of the esophageal, stomach and duodenal lining. It does not examine the colon or show every abdominal organ. It may help diagnose inflammation, ulcers or narrowing, and treat bleeding or dilate a narrowed area when necessary.

Small samples may be taken even when the lining looks normal because some conditions are identified only under a microscope. The initial endoscopy report therefore differs from the later biopsy result; taking a sample does not mean the doctor found cancer.

Why is it performed?

- To assess swallowing difficulty, bleeding, anemia or other symptoms, and to take biopsies or treat certain problems. A biopsy is a small tissue sample and does not mean cancer is present.

Tell the team before your appointment

- Report heart, lung or kidney disease, sleep apnea, possible pregnancy, allergies and previous anesthesia problems.
- Send a medicine list, especially blood thinners, insulin and diabetes or weight-management medicines such as semaglutide and tirzepatide. Do not stop them yourself.

Complete the accompanying preparation checklist

- Follow your unit’s food and fluid fasting times; these may vary with stomach emptying and anesthesia. Call if instructions are unclear or you have broken the fasting rules.
- Arrange an adult escort if sedation is planned, and bring reports and medicines. Review the “Gastroscopy preparation checklist” with the unit beforehand.

Diabetes and weight-management medicines before endoscopy

- Contact the team at least a week before your appointment to review medicines. Some tablets used for diabetes, heart or kidney conditions in the SGLT2 class, such as dapagliflozin and empagliflozin, usually need to be stopped temporarily three days before planned endoscopy, or four days for certain types; the team sets the plan and restart date.

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Fasting and preparation may increase ketoacidosis risk even without very high blood glucose.

- GLP-1 medicines such as semaglutide and tirzepatide may delay stomach emptying. Tell the team your last dose, any recent dose increase, and any nausea, vomiting or persistent fullness. Diet, fasting or medicine timing may need adjustment; no single instruction fits everyone, so follow your endoscopy and anesthesia team’s plan.

What happens during the examination?

- A throat spray or intravenous sedative may be used according to the plan, while breathing and pulse are monitored. The scope passes through the mouth into the esophagus and usually does not block breathing.
- You may burp, feel bloated or have a mild sore throat afterwards. Uncommon risks include bleeding, perforation, stomach contents entering the lungs or a reaction to sedation; some risks increase with therapeutic procedures.

After gastroscopy

- If throat spray was used, wait until the team permits food and drink and swallowing is safe again. Follow any special instructions after dilation or treatment.
- After sedation, do not drive, operate machinery, sign important documents or make important decisions for 24 hours, or longer if advised. Leave with an escort and arrange for an adult to stay as directed in your discharge instructions.
- Ask about initial findings, when biopsy results will be available and when to restart usual medicines. This leaflet does not replace informed consent or your unit’s instructions.

Regular medicines before endoscopy

Review your complete medicine and supplement list with the endoscopy unit at least a week before the appointment, and earlier if a longer interruption may be needed. Get a written plan for every medicine that needs adjustment.

- **Medicines that may continue:** Examples include amlodipine or bisoprolol for blood pressure, levothyroxine for thyroid disease and levetiracetam for epilepsy, according to the team’s plan. Bring asthma inhalers. Fasting does not mean stopping every medicine.
- **Taking an approved dose:** Use a small sip of water at the agreed time. Any dose after the drinking cutoff needs explicit instructions from the unit. Do not independently stop seizure medicines, long-term steroids or transplant medicines.
- **Medicines needing a separate plan:** Insulin and diabetes medicines, including SGLT2 and GLP-1 medicines, diuretics and some heart and blood-pressure medicines. The team sets what to continue or hold and when to restart. Do not stop all insulin yourself.
- **Blood thinners:** Examples include warfarin, apixaban and clopidogrel. Any interruption or adjustment needs an agreed plan from the prescribing doctor and gastroenterologist. Low-dose aspirin usually continues for most endoscopic procedures.
- **Acid-suppressing medicines (PPIs):** For planned H. pylori testing, PPIs are usually withheld for 14 days, and antibiotics and bismuth avoided for 4 weeks, if safe and approved by the doctor. This does not mean stopping PPIs before every gastroscopy, interrupting essential treatment or delaying urgent endoscopy.

Full guide: my medicines before endoscopy, interruption and restarting

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Your fasting timetable

Open the online preparation calculator

Enter your procedure date and actual start time; your unit’s individual instructions take priority.

Procedure date / time: ..... | Last meal: .....

Stop milk and other drinks: ..... | Stop water: .....

What can I eat before gastroscopy?

For gastroscopy alone in the afternoon, you may have a light dinner the previous evening. There is no routine need to stop eating the evening before an afternoon procedure. Use the calculator for your last permitted meal and drink times, unless your unit prescribed a different plan.

- **Light food, milk and all drinks other than water:** stop at least 6 hours before the procedure. A light meal means a small amount of plain toast, not a meat or fatty meal.
- **Fatty, fried or meat-containing food:** finish at least 8 hours before; a longer fast may be needed. Examples include meat kabsa, shawarma, burgers and fried food.
- **Water only:** once the food fast begins, only water is allowed. Stop water completely 3 hours before the procedure. No milk, laban, juice, coffee or tea during this water-only period.

Tell the team about slow stomach emptying, persistent vomiting/fullness, swallowing problems or medicines that may delay emptying. These may need a tailored plan; a longer fast alone does not guarantee an empty stomach. If gastroscopy and colonoscopy are combined, follow the prescribed colonoscopy diet and clear-fluid preparation; do not use the water-only rule to omit required preparation fluids.

The 3-hour water cutoff is this clinic’s operational margin. Endoscopy guidance permits water until 2 hours before in suitable patients; follow your unit’s written instructions.

What can I eat after gastroscopy?

- Wait for the recovery team’s permission, be fully awake and able to swallow safely. If throat spray was used, being less sleepy is not enough: the throat numbness must wear off as assessed by the team. You may be told to wait around 30–60 minutes or longer.
- Start with small sips of water. If there is no coughing or choking and swallowing feels comfortable, try a small amount of soft food: lukewarm soup, yogurt, mashed potato, soft eggs or soft rice.
- After a routine examination, gradually return to your usual food as tolerated. If your throat is sore, temporarily avoid very hot, spicy or acidic food if uncomfortable. A prolonged special diet is not usually needed after inspection or a simple biopsy unless instructed.
- Dilation, bleeding treatment, variceal banding or removal of a lesion may require liquids or soft food for a specified period. Follow your discharge plan. Avoid alcohol for at least 24 hours after sedation.

Do not force food if swallowing is difficult or vomiting persists. Severe pain, breathing difficulty, vomiting blood or black tarry stools require urgent assessment.

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When to get help

Get urgent medical care / go to the emergency department

Severe or increasing chest or abdominal pain, shortness of breath, fever, vomiting blood, black, tarry stools even without dizziness, or severe new swallowing difficulty after the procedure.

Contact your care team promptly

Call the unit if mild pain lasts longer than expected or your biopsy result has not arrived by the agreed date.

Related guides: My medicines before endoscopy · Gastroscopy preparation checklist · Endoscopic ultrasound · Stomach cancer · Gastrointestinal bleeding

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Sources and further information ASGE: Gastroscopy NIDDK: Upper gastrointestinal endoscopy ASGE: Diabetes and weight-management medicines before endoscopy 2025 Multisociety recommendations: Individualizing the GLP-1 plan ASGE: Sedation and fasting ASA: Minimum fasting periods NHS: Eating after throat spray BSG/AUGIS 2026: upper endoscopy best practice

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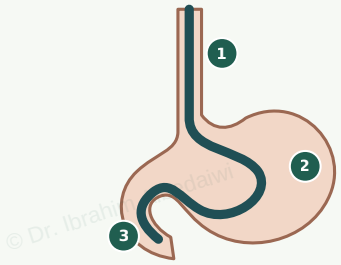
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ILLUSTRATED PATIENT GUIDE

What does gastroscopy examine?

A flexible camera tube enters through the mouth. The dark line shows its route.



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1 · Esophagus

The scope passes down the esophagus into the stomach.

2 · Stomach

The lining is examined; samples may be taken if needed.

3 · Duodenum

The first part of the small intestine. Gastroscopy does not examine the colon.

> Schematic illustration. Use the topic and calculator for your fasting, medicine and preparation instructions.

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ASGE: Upper endoscopy

These illustrations support education and do not replace your doctor’s advice or follow-up. Plans vary by patient.

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Colonoscopy

Last updated: 10 November 2026 · Colonoscopy

A practical colonoscopy guide with exact times for both sachets in the clinic-prescribed Picoprep plan, food advice and a 3-hour drinking cutoff. Other products and special plans need their own written timetable.

Your next step

Confirm your prescribed preparation, calculate both sachet times and keep the timetable.

What exactly is a colonoscopy?

A flexible camera tube is inserted through the anus to examine the rectum and colon and may reach the end of the small intestine. It allows the lining to be viewed, samples taken and many polyps removed during the same procedure. It differs from gastroscopy, which enters through the mouth.

Stool residue must be cleared so it does not hide details of the lining. Biopsies may be taken for chronic diarrhea even when the appearance is normal, as in microscopic colitis. Colonoscopy does not identify every cause of abdominal pain or examine most of the small intestine; your doctor selects additional tests according to the clinical question.

Why is it performed?

- To assess bleeding, inflammation or polyps, and for preventive screening when appropriate. Biopsies may be taken or polyps removed. Poor cleansing can reduce detection or mean the examination has to be repeated.

Before preparation

- Report kidney or heart disease, severe constipation, a previous unsuccessful preparation, possible pregnancy or suspected obstruction.
- Ask for a plan for blood thinners, diabetes medicines, insulin, iron and weight-management medicines. Use only the preparation prescribed for you.

Complete the accompanying preparation schedule

- Follow the split-dose timing below with the product, quantities and extra fluids prescribed for you. Do not add laxatives or change doses yourself.
- For a different appointment time or product, obtain a written plan from the unit. Diarrhea is expected during bowel cleansing.

Diabetes and weight-management medicines before endoscopy

- Contact the team at least a week before your appointment to review medicines. Some tablets used for diabetes, heart or kidney conditions in the SGLT2 class, such as dapagliflozin and empagliflozin, usually need to be stopped temporarily three days before planned endoscopy, or four days for certain types; the team sets the plan and restart date.

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Fasting and preparation may increase ketoacidosis risk even without very high blood glucose.

- GLP-1 medicines such as semaglutide and tirzepatide may delay stomach emptying. Tell the team your last dose, any recent dose increase, and any nausea, vomiting or persistent fullness. Diet, fasting or medicine timing may need adjustment; no single instruction fits everyone, so follow your endoscopy and anesthesia team’s plan.

What is split-dose preparation?

- It means taking part of the laxative the day before and the rest on the day of colonoscopy. Same-day preparation may suit some afternoon appointments. Taking the last dose closer to the examination improves cleansing; your unit sets the exact timing with fasting and anesthesia requirements in mind. Do not use a fixed schedule for a different appointment time.

If you encounter a problem

- Call the unit if you cannot finish the solution, keep vomiting, or still have dark or solid stool close to your appointment. Do not add laxatives yourself.
- Replace fluids with permitted drinks until the drinking cutoff. If you have a fluid restriction, ask for an appropriate plan. Do not ignore severe dizziness or reduced urine.

During and after the examination

- A flexible scope is inserted through the anus, and sedation may be used. Temporary mild bloating or cramps can follow. Bleeding, perforation and sedation complications are uncommon but possible, especially after treatment.
- After sedation, do not drive, operate machinery or make important decisions for 24 hours, and follow instructions about an escort, eating and restarting medicines.
- If a polyp was removed, follow the specific instructions; bleeding can be delayed for days. Confirm when biopsy results are due and when the next colonoscopy is needed.

Regular medicines before endoscopy

Review your complete medicine and supplement list with the endoscopy unit at least a week before the appointment, and earlier if a longer interruption may be needed. Get a written plan for every medicine that needs adjustment.

- **Medicines that may continue:** Examples include amlodipine or bisoprolol for blood pressure, levothyroxine for thyroid disease and levetiracetam for epilepsy, according to the team’s plan. Bring asthma inhalers. Fasting does not mean stopping every medicine.
- **Taking an approved dose:** Use a small sip of water at the agreed time. Any dose after the drinking cutoff needs explicit instructions from the unit. Do not independently stop seizure medicines, long-term steroids or transplant medicines.
- **Medicines needing a separate plan:** Insulin and diabetes medicines, including SGLT2 and GLP-1 medicines, diuretics and some heart and blood-pressure medicines. The team sets what to continue or hold and when to restart. Do not stop all insulin yourself.
- **Blood thinners:** Examples include warfarin, apixaban and clopidogrel. Any interruption or adjustment needs an agreed plan from the prescribing doctor and gastroenterologist. Low-dose aspirin usually continues for most endoscopic procedures.
- **During bowel cleansing:** Oral medicine absorption may decrease; ask the pharmacist about spacing from your preparation. Iron, antidiarrheal medicines or fiber supplements

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may need a temporary pause. Colonoscopy alone does not require stopping a PPI; the plan differs if H. pylori testing is also planned.

Full guide: my medicines before endoscopy, interruption and restarting

Your colonoscopy preparation timetable

This clinic plan uses two prescribed Picoprep sachets and 2 liters of clear fluids after each. The calculator gives exact first- and second-sachet times, the last meal and the drinking cutoff. For another product or a tailored plan, obtain a written timetable from the unit. Count from the actual procedure start, not arrival. Overnight or very early appointments and longer fasting require a written plan from the unit.

Confirm your product and medicine plan first

Tell the team about kidney or heart disease, a fluid restriction, diabetes, pregnancy, severe constipation, previous poor preparation or possible bowel obstruction. You may need a different product or schedule. Get individual instructions for blood thinners, diabetes and weight-management medicines; do not change them yourself.

The last meal

For afternoon appointments from 2 pm, the clinic's standard Picoprep plan permits a small low-fiber dinner the previous evening. Finish by the time shown in your timetable, no later than 9 pm and before the first sachet. Examples: white toast with an egg, or a small portion of plain white rice. Avoid fatty meals, whole grains, seeds, salad, dates and nuts. After that: clear fluids only, with no solid food on the procedure day.

For earlier appointments, finish a light low-fiber lunch by noon the day before, then clear fluids only. A different product or higher risk of poor preparation may require stricter food instructions; your written plan takes priority.

Both sachets have fixed times

First sachet: take it at the exact date and time shown. The time changes with your appointment; for late appointments it can be on the procedure day. **Second sachet:** take it exactly 6 hours before the procedure; do not postpone it to the end of a time window.

Mix each sachet with the water volume specified on your pack and prescription; do not confuse mixing water with the extra fluids. After each sachet in this clinic plan, drink one 250 mL glass of clear fluid every 20 minutes, eight glasses in total (2 liters over 2 hours 40 minutes). The calculator lists the times. Bisacodyl (Dulcolax) in the clinic-prescribed plan: take 10 mg by mouth once only (two 5 mg tablets) with the first Picoprep sachet. Do not repeat the dose with the second sachet or add other laxatives yourself.

Stop all drinking 3 hours before the procedure, including water, clear fluids and preparation. If you start late, vomit or cannot finish, contact the endoscopy unit. Do not rush the remaining fluid or drink past the cutoff. Tell the team what you took and when.

Example only: a 4 pm appointment on the clinic Picoprep plan

Previous evening: finish a light dinner by 9 pm; take the first sachet with bisacodyl 10 mg once at 10 pm and finish its 2 liters of clear fluids by 12:40 am. Procedure day: take the second sachet at 10 am and finish its 2 liters by 12:40 pm. Stop all drinking at 1 pm. For any other appointment time, use the calculator.

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Open the online preparation calculator

Enter your procedure date and actual start time; your unit’s individual instructions take priority.

Procedure date / time: ..... | Last meal: .....

Product: ..... | First sachet date/time: .....

Second sachet date/time: ..... | Stop all fluids: .....

Clear fluids and the expected result

Use a variety of permitted clear fluids: water, tea or coffee without milk, clear pulp-free apple juice or strained broth without pieces or visible fat. Do not rely on water alone. No milk, laban, smoothies, pulpy juice or red/purple drinks. This applies to colonoscopy preparation even when gastroscopy is done at the same session.

Is coffee allowed despite its dark color?

Yes. For colonoscopy preparation, filtered black coffee is an allowed clear fluid if it has no milk, creamer, cream, plant milk, grounds or sediment. Clear does not mean colorless here. Do not use Turkish coffee or Arabic coffee containing grounds, ground cardamom or sediment. Water, plain tea or clear apple juice are alternatives. Vary your fluids rather than relying on coffee alone, and observe the drinking cutoff.

This applies to colonoscopy preparation, including a combined gastroscopy and colonoscopy. For gastroscopy alone, this clinic allows water only during the food fast; coffee and tea are not allowed during that period.

Stool should become watery, light yellow or nearly clear without solid pieces. Complete the prescribed preparation even if this happens early. If stool stays dark or contains pieces, or you cannot finish, contact the unit promptly. Do not depend on a delayed WhatsApp response.

Seek urgent medical care

Sudden severe abdominal pain, marked swelling, fainting, severe weakness, persistent vomiting or markedly reduced urine need prompt assessment. Do not add laxatives to overcome these symptoms.

Confirm my plan before starting

Product and mixing-water volume: .....

First sachet + bisacodyl 10 mg once, date/time: ..... | Second sachet without repeat bisacodyl, date/time: .....

Extra fluids after each: ..... | Stop all fluids: .....

Last meal: ..... | Medicine adjustments: .....

After sedation, arrange an adult escort and do not drive, operate machinery or make important decisions for at least 24 hours, or longer if instructed.

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Why this timetable?

Bisacodyl 10 mg once is a prescribed addition in this clinic plan, not a universal ASGE requirement. ASGE/USMSTF 2025 supports split dosing, starting the second portion 4–6 hours before and finishing at least 2 hours before the procedure. This clinic selects a fixed 6-hour start and a 3-hour drinking cutoff. The dinner allowance is the clinic's individualized low-fiber plan for suitable afternoon patients, not a universal ASGE instruction. Do not use it if your unit prescribed stricter preparation.

What can I eat before colonoscopy?

These examples separate the low-fiber food stage from the clear-fluid stage. Most adults at low risk of poor preparation only need diet changes on the day before; severe constipation or a previous poor preparation may require an earlier start prescribed by the team.

Stage	Suitable choices	What should I avoid?
Low-fiber food stage, before your timetable's last meal	Boiled eggs; white toast or plain white Arabic bread without seeds; plain white rice or pasta; skinless chicken or fish, not fried; peeled potatoes. Plain yogurt or low-fat labneh without pieces can fit if allowed by your plan.	Whole-grain bread or grains; whole-wheat jareesh or harees; oats; dates and dried fruit; nuts and seeds; ful, lentils and chickpeas; salads and fruit or vegetables with skins or seeds.
After your stated last meal until the drinking cutoff	Clear fluids only: water; plain tea or filtered black coffee without milk, creamer or sediment; clear apple juice without pulp; strained chicken or meat broth without pieces or visible fat.	All solid food, even low-fiber food. Milk, laban, yogurt, smoothies and pulpy juices are not clear fluids. Avoid lentil or cream soup and red or purple fluids.
From the drinking cutoff until the procedure	No food or drink. Take medicine with a sip of water only if the team explicitly permits it.	Do not extend drinking because you arrived early or the procedure is delayed; check with the team first.

For an afternoon appointment on the clinic's standard Picoprep plan, a small low-fiber dinner is permitted the previous evening, finished at the calculator's time and no later than 9 pm. For an earlier appointment, stop solids after the prescribed lunch. After the last meal, clear fluids only. Do not use this dinner allowance with a different or stricter preparation plan.

Drink the extra fluids specified for your product gradually. Vary the permitted clear fluids rather than relying only on water. People with diabetes need a glucose and medicine plan; those with heart or kidney disease or a fluid restriction need amounts set by the team.

What can I eat after colonoscopy?

After a routine examination, you can usually resume your normal diet once the recovery team allows it and you are alert, swallowing safely and not very nauseated. You do not need several days of low-fiber food simply because you had a colonoscopy.

- Start with sips of water, then a small meal you tolerate: soup, rice with plain chicken, eggs and bread, mashed potato, or yogurt if you tolerate it.
- Increase portions as comfortable. If bloated or nauseated, temporarily reduce large or fatty meals, spicy foods and fizzy drinks if they worsen symptoms.

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- Replace fluids according to your individual plan. Avoid alcohol for at least 24 hours after sedation and follow escort and driving instructions.
- Removal of a large polyp or another treatment may require a different diet that day or afterward. Follow your discharge sheet rather than a universal restriction, and see the after-polypectomy guide.

Severe or increasing pain, heavy bleeding, fainting, fever or persistent vomiting need urgent assessment; do not try to manage them with food changes alone.

When to get help

Get urgent medical care / go to the emergency department

Severe pain with swelling or inability to pass gas, heavy bleeding or clots, fainting, fever or breathlessness after the procedure; or severe dehydration during preparation.

Contact your care team promptly

Difficulty completing preparation or an unclear medicine or fasting plan: contact the unit before your appointment.

Related guides: My medicines before endoscopy · Colonoscopy preparation instructions · Colon polyps · After colon polyp removal and biopsy results · Gastrointestinal bleeding

Sources and further information ASGE: Bowel preparation ASGE: Preparation recommendations NIDDK: Colonoscopy ASGE: Diabetes and weight-management medicines before endoscopy 2025 Multisociety recommendations: Individualizing the GLP-1 plan USMSTF: Bowel preparation 2025 ASGE / USMSTF bowel preparation 2025 ASGE: Eating after colonoscopy NHS: Low-fiber food examples PICOPREP: trial of product-specific tailored dosing Saudi FDA: PICOPREP product registration

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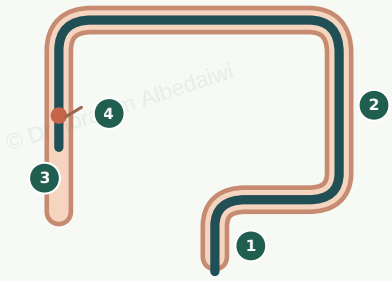
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ILLUSTRATED PATIENT GUIDE

The route of a colonoscopy

The scope enters through the anus and advances through the colon.



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1 · Rectum

The scope enters from below.

2 · Colon

Its inner lining is examined as the scope moves through and is withdrawn.

3 · Start of the colon

The end of the small intestine may also be examined when needed.

4 · Polyp

Some polyps can be removed during the examination.

> Colonoscopy does not examine the stomach or most of the small intestine. Good preparation helps the lining be seen clearly.

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ASGE: Colonoscopy

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Irritable bowel syndrome

Last updated: 10 November 2026 · Irritable bowel syndrome · IBS

Symptoms are real and can be relieved. IBS is a disorder of gut–brain interaction; it does not damage the bowel or itself increase bowel cancer risk.

Your next step

Choose one change and record its effects, and review the food guide before starting a restrictive diet.

Understanding the condition: why pain when tests are normal?

IBS is a disorder of interaction between the gut and brain. Bowel movement and pain signaling work differently, and the bowel may become more sensitive to normal stretching from food or gas. This can cause significant pain and bloating without an ulcer or visible bowel damage.

The name does not mean the problem is imaginary or that you are “nervous.” Symptoms are physically real and can be influenced by bowel movement, sleep, food and stress; sometimes they start after a gut infection. Constipation predominates in some people, diarrhea in others, and the two may alternate or the pattern change over time.

How does it differ from colitis, and what can we expect?

IBS is not Crohn’s or ulcerative colitis; it does not itself erode the lining or turn into cancer. However, the diagnosis does not prevent another condition from occurring, so bleeding, weight loss or unusual new symptoms need reassessment. Not all bloating is IBS or evidence of bacterial overgrowth.

Diagnosis relies on a recurring pattern of abdominal pain associated with bowel movements or changes in stool form and frequency, with selected tests as appropriate. Every possible test and endoscopy is not necessary to establish it. Treatment is tailored to the most troublesome pattern, combining food habits, movement, sleep and suitable medicines when needed. The aim is better ability to eat, work and sleep; control may develop gradually as the plan is adjusted.

What is the difference between IBS and SIBO?

IBS is a disorder of gut–brain interaction, typically causing recurring pain related to bowel movements or a change in stool frequency or form. SIBO is an abnormal increase or change in bacteria in the small intestine that may cause symptoms, and is more common with certain motility disorders or after particular operations.

Both can cause bloating, gas, pain and diarrhea, and they can coexist. Symptoms alone do not prove SIBO, and not all IBS is caused by excess bacteria. SIBO may also cause malabsorption or nutrient deficiencies in some patients.

Your doctor diagnoses IBS from the symptom pattern and selected tests. A hydrogen and methane breath test may be requested if SIBO is suspected; it is not completely accurate and can be misleading, so results are interpreted alongside the history. Not everyone with bloating needs this test.

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Raised methane, particularly with constipation, may indicate intestinal methanogen overgrowth (IMO). These organisms are not bacteria, and this differs from SIBO; they may be in the small or large intestine.

IBS treatment focuses on diet, activity, sleep, the gut–brain relationship and medicines appropriate to the pattern. If SIBO is considered likely, the doctor treats the cause and nutritional deficiencies and may prescribe a limited antibiotic course. Do not take antibiotics or herbal mixtures yourself; improvement with an antibiotic such as rifaximin does not alone prove SIBO.

IBS and SIBO: similar symptoms, different assessment

Irritable bowel syndrome (IBS)

Involves gut sensitivity, movement and communication with the brain. Diagnosis uses the symptom pattern and assessment of warning signs.

Small intestinal bacterial overgrowth (SIBO)

An abnormal increase in small-bowel bacteria. Your clinician reviews risk factors and may request a breath test in selected cases.

Bloating alone does not prove SIBO, and IBS does not automatically mean SIBO. Do not start or repeat antibiotics yourself.

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How is it diagnosed?

- Diagnosis is based on the symptom pattern, examination and selected tests appropriate to your situation. We may test for celiac disease or inflammatory bowel disease when needed.
- Not everyone needs a colonoscopy, but bleeding, anemia, weight loss or family history may change the investigation plan.

Treatment matches your pattern

- Soluble fiber such as psyllium may help when increased gradually; coarse bran may worsen bloating for some people.
- Your doctor may prescribe treatment for constipation, diarrhea or cramps, and sometimes a medicine at an appropriate dose to regulate pain signals between the gut and brain.

Food without unnecessary complexity

- Eat regularly and slowly, and review coffee, fizzy drinks and sweeteners if they trigger symptoms. Keep a food-and-symptom diary instead of excluding many foods at once.
- A low-FODMAP diet is usually a short trial of 2–6 weeks with dietitian supervision, followed by food reintroduction and personalization. It is not a lifelong elimination diet.
- Portion size and cooking method matter: reducing onion and garlic in kabsa may help some patients. Wheat may cause symptoms because of fructans, not necessarily gluten.

Psychological care is part of IBS care

- The gut and brain constantly exchange signals. Anxiety and stress may increase gut sensitivity and pain, while ongoing symptoms can increase anxiety in turn. This is a real physical interaction; it does not mean symptoms are imaginary or that everyone with IBS has a mental health disorder.

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- Regular sleep, activity and relaxation exercises may help. Gut-directed cognitive behavioral therapy or gut-directed hypnotherapy with a qualified professional may also help, even without diagnosed depression or anxiety.
- We may recommend a psychologist and psychiatric follow-up when needed, particularly when anxiety, depression or fear of symptoms affects sleep, work or relationships, or distress persists despite treatment. Assessment determines the right support or medicine in coordination with your gastroenterologist.
- Seeking psychological support is a normal treatment step alongside gastrointestinal and nutritional care. Some medicines regulate pain signaling at appropriate doses even without depression; do not start or stop them yourself, and do not attribute new warning signs to stress without assessment.

Sleep, activity and follow-up

- Stay regularly active within your ability and get enough sleep. Choose a small goal to follow for several weeks.
- Do not start antibiotics or herbal bowel cleanses yourself, and do not assume every new pain is IBS.
- If you do not improve, we review the diagnosis, treatment and nutrition together.

When to get help

Get urgent medical care / go to the emergency department

New severe pain, heavy bleeding or black, tarry stools even without dizziness, persistent vomiting or fainting.

Contact your care team promptly

Recurring blood in stool, unexplained weight loss, anemia, fever, or diarrhea that wakes you from sleep.

Related guides: Eating with irritable bowel syndrome · Constipation, difficult evacuation and bowel leakage · Chronic diarrhea · Medicines for irritable bowel syndrome (IBS) · Linaclotide · Low-dose amitriptyline for IBS

Sources and further information NIDDK: Psychological therapy and IBS symptoms NIDDK: Nutrition NIDDK: Understanding IBS NIDDK: Irritable bowel syndrome Clinical guidelines: ACG 2021 guideline; current portal AGA: Understanding SIBO ACG: Small intestinal bacterial overgrowth AGA: Assessing bloating Monash: food and portion examples Monash: the three phases of the diet Published food portions Food portion examples

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Low-FODMAP diet for IBS

Low-FODMAP diet for IBS

An expanded guide to foods and portions, including Saudi and Arab dishes. A food may contain more than one type of FODMAP. These lists do not mean permanent bans or unlimited portions.

Reduce temporarily

Potential triggers during the trial - not permanent bans.

Choose alternatives

Suitable portions and your tolerance guide the choice.

A food can contain more than one FODMAP. These lists do not mean unlimited portions.

Excess fructose

Apples, pears and mangoes. Honey, agave syrup and high-fructose corn syrup. Concentrated juices and large amounts of dried fruit may trigger symptoms. Read drink and dessert ingredients.



Lactose

Cow, goat, sheep and camel milk are not lactose-free. Condensed milk, ordinary ice cream and ordinary yogurt may cause symptoms. Ricotta and cottage cheese vary with portion size. Not all cheese or dairy is high in lactose.

Fructans

Onion, garlic, asparagus and the white part of spring onions. Large portions of wheat, barley and rye; ordinary bread, pasta, biscuits, cakes and pastries. Check onion and garlic powders in stock, sauces and seasonings. The trigger may be fructans rather than gluten.

Legumes and nuts

Large portions of beans, chickpeas, lentils and peas may cause symptoms, as may cashews and pistachios. Drained, rinsed canned legumes may be tolerated in smaller portions; do not exclude all legumes.



Polyols and sweeteners

Sorbitol, mannitol, xylitol, maltitol and isomalt may occur in sugar-free gum, sweets and other products. Read names and ingredients; “sugar-free” does not mean suitable. Larger amounts may increase gas or diarrhea.

Type and portion matter

Mushrooms, cauliflower, peaches, apricots, plums, cherries and blackberries vary by type and portion. Avocado, celery, sweet potato, hazelnuts and grapes need portion control; they are not automatically banned.

Fruit

Oranges, mandarins, kiwifruit, pineapple and papaya. Choose less-ripe bananas; very ripe bananas need a smaller portion. Cantaloupe, passion fruit, strawberries, blueberries and raspberries can be options in suitable portions. Fresh cranberries differ from dried sweetened ones. Grapes and grapefruit need defined portions. Use lemon in normal cooking amounts. Spread fruit portions through the day.



Vegetables

Carrots, cucumber, lettuce and potatoes. Spinach, eggplant, green beans and zucchini in suitable portions. Green sweet peppers differ from red peppers; tomatoes depend on variety and portion. Olives, parsley and ginger. Check portions for parsnip and fennel. Broccoli heads differ from stalks. Green spring-onion leaves can replace the white part. Celery and sweet potatoes need specific portions.



Grains and fiber

Rice, oats, quinoa and millet; rice or corn pasta. Check bread ingredients and portions, and do the same for tapioca, arrowroot and sorghum. Psyllium is a fiber supplement; increase gradually with fluids. Barley contains gluten. Gluten-free does not automatically mean low-FODMAP.

Dairy and alternatives

Lactose-free milk and yogurt; almond or rice milk depending on product and portion. Soy-protein milk differs from whole-soybean milk. Cheddar, Gouda, Brie and Camembert in suitable portions. Check lactose and sweeteners in ice-cream alternatives. Choose calcium-fortified alternatives.



Saudi and Arab dishes: reduce or adapt

Large portions of wheat-based jareesh, qursan, matazeez and ordinary Arabic bread. Kabsa and shawarma containing onion or garlic. Large portions of ful medames, hummus and lentil soup. Falafel depends on legumes, onion, garlic and portion. Saleeg, muhallabia and umm Ali made with ordinary milk may cause symptoms; other ingredients matter too.

Saudi and Arab alternatives to try

Adapted kabsa or mandi: rice with meat or chicken, without onion, garlic or raisins; check stock and spices. Saleeg with lactose-free milk and no onion or garlic. Grilled fish or chicken with a suitable marinade; plain eggs or omelette. Cucumber, carrot and lettuce salad without onion or garlic. A dish’s name alone does not determine suitability.



Protein, fats and sweetening

Plain eggs, meat, chicken and fish; check marinades. Moderate olive oil or butter. Fat can trigger symptoms despite low FODMAPs. Small amounts of sugar, glucose or maple syrup; molasses and dark syrups depend on product and portion.

Dates, milk and probiotics

Date size, variety and number matter; no fixed number suits everyone. Lactose intolerance is not milk allergy. Try lactose-free milk if appropriate; persistent symptoms need review. Probiotic benefits vary by strain and person; discuss a trial and duration with your doctor.

A temporary trial, then variety

Usually 2-6 weeks, then gradual reintroduction and a personal diet with the widest variety tolerated, guided by a dietitian. Complete celiac testing before stopping gluten if celiac disease is suspected.

No single diet suits everyone. Record foods, portions and symptoms. Do not exclude food groups long term without follow-up. This general guidance does not replace a medical assessment.

Dr. Ibrahim Albedaiwi Clinic

Patient Guide · English edition

Dr. Ibrahim Albedaiwi

Enlarge the chart to read it. The complete diet guidance follows on the next page.

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Low-FODMAP diet for IBS

An expanded guide to foods and portions, including Saudi and Arab dishes. A food may contain more than one type of FODMAP. These lists do not mean permanent bans or unlimited portions.

Choose alternatives: the food and portion both matter

Use suitable portions and choose foods according to their ingredients and your tolerance. Foods listed as alternatives are not unlimited. Foods listed for temporary reduction are not permanently forbidden.

Fruit: type and portion matter

Oranges, mandarins, kiwifruit, pineapple and papaya. Choose less-ripe bananas; very ripe bananas need a smaller portion. Cantaloupe, passion fruit, strawberries, blueberries and raspberries can be options in suitable portions. Fresh cranberries differ from dried, sweetened cranberries. Grapes and grapefruit need a defined portion; use lemon in normal culinary amounts. Spread fruit portions through the day rather than eating several large portions at once.

Vegetables in detail

Carrots, cucumber, lettuce and potatoes. Spinach, eggplant, green beans and zucchini in suitable portions. Green sweet peppers differ from red peppers, which need portion control; tomatoes depend on the variety and portion. Olives, parsley and ginger. Check portions for parsnips and fennel. Broccoli heads differ from the stalks. The green leaves of spring onions can replace the white part. Celery and sweet potatoes need specific portions. Type, quantity and preparation all matter.

Grains and fiber

Rice, oats, quinoa and millet; rice or corn pasta. Check bread ingredients and portion size, and do the same for tapioca, arrowroot and sorghum. Psyllium is a fiber supplement, not a type of bread; increase it gradually with fluids. Barley contains gluten; ordinary barley bread is not gluten-free. A gluten-free product is not automatically low in FODMAPs.

Dairy and alternatives

Lactose-free milk and yogurt; almond or rice milk depending on the product and portion. Soy milk made from soy protein differs from milk made from whole soybeans. Cheddar, Gouda, Brie and Camembert in suitable portions. Check lactose and sweeteners in ice-cream alternatives and choose calcium-fortified alternatives. Cow, goat, sheep and camel milk are not lactose-free. Condensed milk, ordinary ice cream and ordinary yogurt may cause symptoms. Some soft cheeses, such as ricotta and cottage cheese, vary in tolerance with portion size. Not all cheeses or dairy products are high in lactose. Lactose intolerance is not the same as a milk allergy.

Excess fructose and hidden ingredients

Apples, pears and mangoes are examples of fruit that may cause symptoms. Excess fructose in some fruits, honey, agave syrup and high-fructose corn syrup can trigger symptoms. Watch concentrated juices and large amounts of dried fruit. Read drink and dessert ingredients.

Polyols and sweeteners

Sorbitol, mannitol, xylitol, maltitol and isomalt may be present in sugar-free gum, sweets and other products. Sweeteners are not all the same: read the name and ingredients rather than relying on an unclear number or name on the packet. Larger amounts can increase gas or diarrhea. Small amounts of sugar, glucose and maple syrup may be used. Molasses and dark syrups are not guaranteed substitutes: their suitability depends on the product and portion.

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Fructans, legumes and nuts

Watch onion, garlic, asparagus and the white part of spring onions, as well as large portions of wheat, barley, rye and their products. Ordinary bread, pasta, biscuits, cakes and pastries may contain these ingredients. Check onion and garlic powders in sauces, stock and seasonings. The trigger may be fructans rather than gluten. Large portions of beans, chickpeas, lentils and peas may cause symptoms, as may cashews and pistachios. Canned legumes that have been drained and rinsed may be tolerated in smaller portions; do not exclude all legumes automatically.

Foods that are not automatically banned

Avocado, celery, sweet potato, hazelnuts and grapes require portion control. Mushrooms, cauliflower, peaches, apricots, plums, cherries and blackberries vary by type and portion. The size, variety and number of dates matter: there is no rule that three dates suit everyone. A dietitian can help you choose the amount.

Protein, fats and probiotics

Plain eggs, meat, chicken and fish are suitable options; check marinades and seasonings. Use olive oil and butter in moderate amounts. Fat may trigger symptoms even when a food is low in FODMAPs. The benefit of probiotics varies by strain and person; they are not a reliable treatment for everyone. Discuss whether to try one, and for how long, with your doctor.

Saudi and Arab dishes: adapted alternatives to try

- Adapted kabsa or mandi: rice with meat or chicken, without onion, garlic or raisins, in a suitable portion. Check stock and spice ingredients.
- Saleeg made with lactose-free milk and without onion or garlic.
- Grilled fish or chicken with a suitable marinade that contains no onion or garlic; boiled eggs or a plain omelette.
- Cucumber, carrot and lettuce salad without onion or garlic.

Examples to reduce temporarily, depending on portions and ingredients

- Large portions of wheat-based jareesh, qursan and matazeez, and ordinary Arabic bread.
- Kabsa and shawarma when they contain onion or garlic.
- Large portions of ful medames, hummus and lentil soup. Falafel may cause symptoms depending on the legumes, onion, garlic and portion.
- Saleeg, muhallabia and umm Ali made with ordinary milk; other ingredients may also trigger symptoms.

These are suggestions for adapting recipes according to their ingredients. A dish's name alone does not determine whether it suits you.

A temporary trial, then a varied personal diet

No single diet suits everyone. The initial reduction phase usually lasts 2–6 weeks, followed by gradual reintroduction. Then keep the widest variety you tolerate, with guidance from a dietitian. If milk seems to trigger symptoms, try lactose-free milk; persistent symptoms need review. Complete celiac testing before stopping gluten if celiac disease is suspected.

If the diet does not help

Trial the first stage for 2–6 weeks with a dietitian. If you improve, move on to food reintroduction. If symptoms do not improve despite following the plan, do not continue or intensify restriction; review with your dietitian, reintroduce foods and consider other options.

Examples for one serving at a meal, not maximum limits or a guarantee of no symptoms. Use the stated weight and preparation; do not apply an ingredient portion to a whole dish or a different product.

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Food	Portion and preparation	What to check
Plain brown rice	1 cooked cup, about 180 g. Weigh after boiling	Use stock without onion or garlic. This does not classify every kabsa or mandi recipe as low FODMAP.
Plain rolled oats	52 g dry; about half a cup. Weigh before cooking; weight is more reliable than cup volume	Choose plain rolled oats, not a mix with honey or dried fruit. Portions can differ by product and oat type.
Canned chickpeas	Quarter of a cup, about 42 g. Drain and rinse; weigh the chickpeas without the liquid	This is a chickpea portion, not a hummus-dip portion. Garlic, quantity and the rest of the recipe matter.
Fresh cucumber	75 g. Weigh raw	In a salad, check added onion, garlic and dressing.
Fresh carrot	1 medium carrot, about 75 g. Weigh raw after peeling	An example vegetable portion, not a maximum tolerance limit. Increase fiber gradually as tolerated.

Trial the first stage for 2–6 weeks with a dietitian. If you improve, move on to food reintroduction. If symptoms do not improve despite following the plan, do not continue or intensify restriction; review with your dietitian, reintroduce foods and consider other options.

> No single diet suits everyone. Record foods, portions and symptoms. Do not exclude food groups long term without follow-up. This general guidance does not replace a medical assessment.

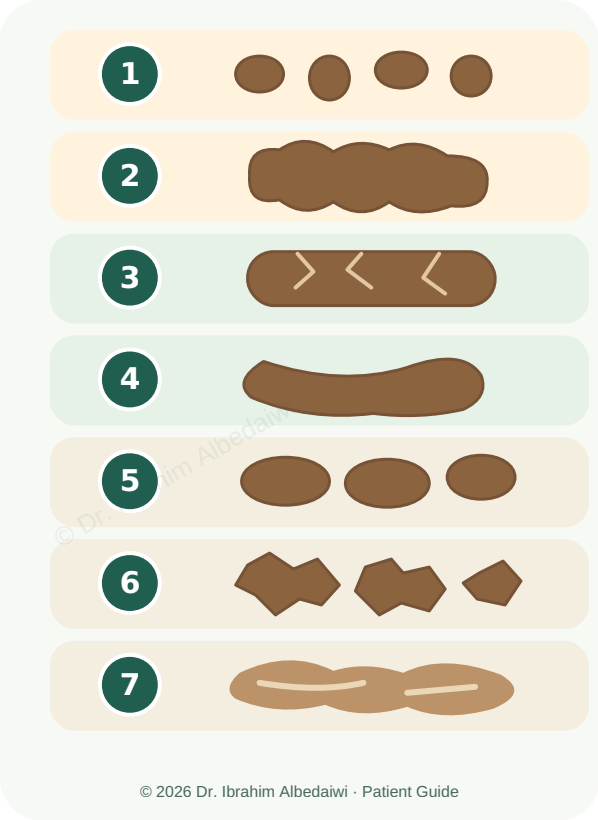
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ILLUSTRATED PATIENT GUIDE

How to describe your stool

Original schematic drawings based on the Bristol stool classification.



1 · Separate hard pellets

Small, firm pieces.

2 · Firm and lumpy

A long piece made up of lumps.

3 · Formed with cracks

A long piece with cracks on the surface.

4 · Smooth and soft

A soft, formed piece.

5 · Separate soft pieces

Soft pieces with clear edges.

6 · Mushy pieces

Loose pieces with uneven edges.

7 · Watery

Liquid without formed pieces.

> Types 1–2 can accompany constipation, 3–4 are usually formed stool, and 6–7 are loose or watery. Shape alone does not diagnose illness; also describe frequency, pain and any blood.

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NHS England: Bristol stool classification

These illustrations support education and do not replace your doctor’s advice or follow-up. Plans vary by patient.

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Medicines for irritable bowel syndrome (IBS)

Last updated: 10 November 2026 · Medicines for irritable bowel syndrome (IBS)

Choose treatment for your main symptom: constipation, diarrhea, or pain. No single medicine suits everyone or permanently cures IBS.

Your next step

Bring a stool and symptom diary plus your medicine list. Agree on one treatment goal, a trial period, and a review date.

What treatment is trying to do

IBS involves altered gut sensitivity and communication between the gut and brain. It is not the same as chronic inflammatory bowel disease. Medicines aim to make daily life easier; steroids and mesalazine are not IBS treatments. Food changes, movement, sleep, and appropriate psychological support remain part of the plan.

Your pattern can change between constipation and diarrhea. Treatment should change with it. Discuss the expected benefit, side effects, cost, and local availability rather than repeatedly adding medicines without review.

Treatment starts with the main symptom

Mostly constipation

Improve stool softness and frequency, while also assessing pain.

Mostly diarrhea

Reduce loose stools and urgency; assess the cause of new changes.

Pain and gut sensitivity

Low-dose medicines and gut–brain therapies may help.

This is an explanation, not a prescription. IBS patterns can change and treatment needs review.

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When constipation dominates (IBS-C)

- Soluble fiber such as psyllium/ispaghula may help. Increase it gradually with suitable fluid intake to limit bloating. Bran can aggravate symptoms in some people.
- PEG/macrogol softens stool and improves bowel frequency, but usually does little for IBS pain or bloating. A bowel improvement does not mean every IBS symptom should disappear.
- If symptoms remain troublesome, a clinician may choose linaclotide. It increases bowel fluid and can improve both constipation and pain. Alvotay is a registered Saudi product. Dose depends on the indication, and diarrhea is an important adverse effect. See the linked medicine card.

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- International guidelines also include tenapanor (Ibsrela), plecanatide and lubiprostone (Amitiza). They increase bowel water or fluid through different mechanisms. The US lubiprostone IBS-C indication is for adult women. Some of these medicines may not be available locally; your doctor and pharmacist will check suitability and availability before prescribing.

When diarrhea dominates (IBS-D)

- Loperamide can reduce loose stools and urgency; it does not reliably treat overall IBS pain. Follow your individual plan and avoid continuing into constipation. New bloody diarrhea or fever needs assessment.
- Rifaximin is a guideline-supported, limited-course option for selected adults with IBS-D. It can improve overall symptoms, but benefit does not prove SIBO. Diagnosed SIBO needs a separate treatment plan and attention to its cause. Do not repeat antibiotics yourself; see the rifaximin card.
- Eluxadoline (Viberzi) is an option for selected IBS-D patients, but is unsuitable without a gallbladder, with pancreatitis history, duct obstruction, substantial alcohol use or severe liver impairment. It is registered in Saudi Arabia but has an official supply-shortage signal; confirm access before relying on it. Cholestyramine may help bile-acid diarrhea, a different diagnosis, rather than routine IBS.
- A specialist may select ondansetron for some people with diarrhea and urgency. It is an anti-nausea medicine used off-label for IBS, not routine first-line treatment. Evidence is stronger for stool consistency and urgency than pain. Constipation and heart-rhythm effects matter: medicines, electrolytes and risk factors need review. Do not copy an anti-nausea dose into an IBS plan.

For cramps and persistent gut pain

- Your clinician may suggest a trial of an antispasmodic, such as mebeverine or hyoscine, for cramps. Benefit varies between people and does not reliably extend to all IBS symptoms. Agree a trial period and continue only if helpful without troublesome adverse effects.
- Enteric-coated peppermint oil may ease cramps and bloating, but can worsen heartburn or reflux. Ask a pharmacist which preparation is appropriate.
- Low-dose amitriptyline may reduce gut sensitivity and pain, particularly with diarrhea, even without depression. Guidelines support clinician-supervised use, but IBS is outside the local product’s approved indications. Alatript 10 mg is registered in Saudi Arabia. Sleepiness, dry mouth and constipation can occur; see the medicine card for use and follow-up.
- Medicines such as SSRIs are not usual treatments for IBS itself; a clinician may choose one for coexisting depression or anxiety. Gut-directed CBT or hypnotherapy can help relieve symptoms. Mental-health follow-up can be helpful when needed: the symptoms are real, and gut-brain communication affects their severity.

Make the plan safe and measurable

- Record stool consistency, pain, and everyday activities. Agree when to adjust, stop, or review a trial; do not use one universal dose or keep escalating an ineffective treatment.
- Ask for a medicine review in pregnancy, while breastfeeding, for children, and when taking several medicines. Adult treatment choices cannot simply be copied for a child.

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Registration does not guarantee pharmacy stock

- Records and references were checked on 10 November 2026. Registration does not establish stock of every strength or pack, or approval for every use. Your clinician and pharmacist should confirm the local leaflet, stock and appropriate alternatives before treatment.

When to get help

Get urgent medical care / go to the emergency department

Seek urgent care for black tarry stool, substantial bleeding, severe worsening pain, fainting, or dehydration. Do not assume these are IBS.

Contact your care team promptly

Arrange prompt reassessment for unexplained weight loss, persistent fever, new bleeding, or persistent nighttime symptoms, especially diarrhea waking you from sleep. Review treatment if symptoms change or the agreed trial does not help.

Related guides: Linaclotide · Low-dose amitriptyline for IBS · Irritable bowel syndrome · Constipation, difficult evacuation and bowel leakage · PEG / macrogol for constipation · Rifaximin · Cholestyramine · Eating with irritable bowel syndrome

Sources and further information NIDDK: Treatment for irritable bowel syndrome NIDDK: Diagnosis and warning signs ACG: Clinical guideline (2021) NICE CG61: Symptom-directed treatment AGA: Medicines for IBS with constipation (2022) AGA: Medicines for IBS with diarrhea (2022) ACG: Peppermint oil SFDA: registered medicines currently unavailable, eluxadoline row SFDA: Alatript 10 mg approval and approved indications SFDA: Zoron 4 mg ondansetron TRITON primary trial and pooled analysis (2023) Ondansetron: official US tablet label SFDA: Alvotay 290 micrograms

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Constipation, difficult evacuation and bowel leakage

Last updated: 10 November 2026 · Constipation, evacuation disorders and fecal incontinence

Constipation, difficult evacuation and bowel leakage are different problems that can overlap. The symptom pattern and pelvic floor function guide treatment.

Your next step

Set a regular toilet time and a gradual plan for fiber and your prescribed laxative.

Understanding the problem: more than infrequent stools

The colon absorbs water from food waste and moves it towards the rectum. When stool moves slowly, it can become hard and dry. Alternatively, colon movement may be adequate but the pelvic and anal muscles may not relax together during emptying, causing a sense of blockage or incomplete emptying even with soft stool.

Constipation therefore includes hard stools, straining or difficulty passing stool, or feeling stool remains, not just frequency. Normal varies between people; daily bowel movements are not necessary if stool is soft and passes comfortably. More than one mechanism may coexist, explaining different treatment responses.

How do we find the cause and choose treatment?

Your doctor reviews when the problem began, stool form, medicines, habits and associated conditions. Some medicines, inactivity or routine changes may contribute, and conditions such as an underactive thyroid may be relevant depending on the context. Constipation does not automatically mean cancer, but bleeding, weight loss or a persistent new change warrants assessment. Not every case is due to insufficient water; do not stop prescribed medicines without review.

We may begin with a practical plan without many tests. If problems persist despite treatment, tests of stool transit or the function of the muscles used for emptying may be needed. Laxatives help some types, while poor muscle coordination may require specialist biofeedback training. The goal is comfortable regular bowel movements suited to you, with less pain and straining, not forcing a fixed daily number.

What is bowel leakage, and can it coexist with constipation?

Fecal incontinence means unintentional stool leakage, with strong urgency or without awareness. Causes include diarrhea, muscle or nerve injury, or severe constipation with liquid stool leaking around an impaction. Leakage and constipation can therefore occur together.

First steps

- Increase fiber gradually from oats, vegetables, fruit and pulses according to tolerance. A common adult target is about 25–30 grams daily, individualized to your situation.
- Drink enough, especially with fiber, but follow any fluid restriction. Do not increase fiber without advice if obstruction or narrowing is suspected.
- Walk regularly and do not delay the urge to open your bowels.

Toilet habits

- Set aside quiet time after breakfast or another meal. Use a small footstool if comfortable, and avoid excessive straining and prolonged sitting.

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- You do not have to pass stool every day if bowel movements are comfortable and regular for you. Record stool form and difficulty passing it, not just frequency.

How is the problem assessed?

- Describe stool consistency, difficulty pushing, urgency, leakage and any need to assist with fingers. Report childbirth injuries, operations, medicines and urinary or nerve symptoms. These are medical details, and examination should respect privacy and consent.
- Assessment may include a rectal examination, pressure and sensation measurements, and a small balloon expulsion test. Imaging during emptying or muscle assessment may be needed. Diagnosis is not based on one isolated test; colonoscopy does not measure muscle coordination.

Why laxatives or tightening exercises may be insufficient

- Laxatives can help hard stool but do not alone correct poor coordination. Specialist biofeedback uses information about muscle activity to teach coordinated pushing and relaxation. Several supervised sessions and directed practice at home may be required.
- Strengthening exercises can help some leakage problems, but they are not appropriate for everyone. Repeated tightening is not the goal when relaxation is difficult. Assessment determines whether relaxation, coordination or strengthening is needed; do not start a random Kegel program.

When are medicines used?

- Your doctor may recommend psyllium or an osmotic laxative such as polyethylene glycol, setting and adjusting the dose according to response.
- Stimulant laxatives or other medicines may be used when needed. Do not repeatedly use enemas, magnesium salts or herbal mixtures without guidance, particularly with kidney disease.
- Regular treatment may take time and adjustment; do not judge it after one day or increase doses randomly.

If constipation does not improve

- We may review medicines and blood tests or request additional investigations. Colonoscopy depends on age, warning signs and preventive screening, and is not needed for every case of constipation.

Improving control and protecting skin

- Treatment addresses the cause and stool consistency, which may involve treating impaction or diarrhea or adjusting fiber. Do not automatically use antidiarrheals for leakage: they can worsen constipation-related impaction.
- Clean skin gently and pat dry rather than rubbing. Ask about a suitable barrier cream for irritation. Absorbent pads, spare clothing and planning toilet access can help, alongside assessment of the underlying cause.

If symptoms continue

- Specialist pelvic floor therapy or further testing may help. Selected persistent incontinence cases may benefit from options such as nerve stimulation or surgery after a specialist team considers less invasive treatments.
- Record symptoms, stool type, leakage, food and medicines before the visit. Embarrassment can delay help, but this is a medical problem that can be discussed respectfully. The aim is easier emptying, better control and improved daily life.

My bowel diary

For a week, record the date, bowel movement frequency, stool form (hard / formed / loose), straining, pain and treatment taken. Bring the diary to your review.

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My follow-up date: ..... | What changed with treatment? .....

When to get help

Get urgent medical care / go to the emergency department

Severe pain with swelling, vomiting or inability to pass gas, heavy bleeding or fainting. Do not take extra laxatives if obstruction is suspected. New leakage with leg weakness, numbness around the saddle area or inability to urinate, or severe abdominal pain with swelling, vomiting and inability to pass gas: seek urgent assessment.

Contact your care team promptly

Persistent new constipation, blood in stool, unintentional weight loss, anemia or no improvement with the plan. Repeated leakage, difficulty passing soft stool, recurrent bleeding, weight loss or a persistent new bowel change.

Related guides: Irritable bowel syndrome · Hemorrhoids and anal fissure · PEG / macrogol for constipation · Medicines for irritable bowel syndrome (IBS) · Linaclotide · Chronic diarrhea

Sources and further information NIDDK: Treatment NIDDK: Nutrition NIDDK: Causes of constipation NIDDK: Diagnosing constipation Clinical guidelines: AGA 2026 ACG: benign anorectal disorders AGA: refractory constipation,2026 NIDDK: fecal incontinence diagnosis NIDDK: fecal incontinence treatment ASCRS: fecal incontinence guideline

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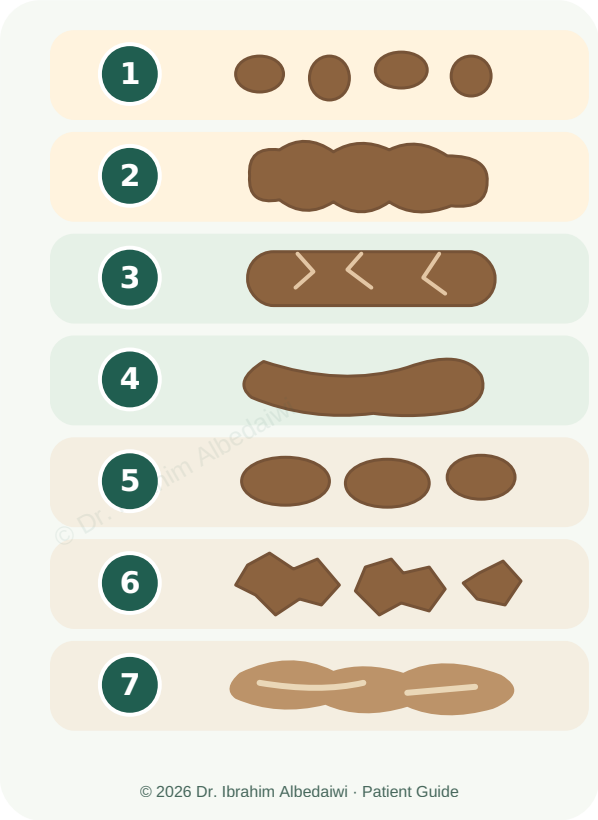
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Soft pieces with clear edges.

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Loose pieces with uneven edges.

7 · Watery

Liquid without formed pieces.

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NHS England: Bristol stool classification

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Helicobacter pylori infection

Last updated: 10 November 2026 · Helicobacter pylori

H. pylori can be treated, but pain improving does not prove the infection has gone. Complete treatment, then have a test of cure at the correct time.

Your next step

Review your dose schedule and book the test of cure at the correct time.

Understanding the infection: where does H. pylori live?

Helicobacter pylori is a bacterium able to live in the mucus layer covering the stomach despite stomach acid. Infection may be acquired in childhood and remain for years without symptoms. In some people it causes chronic lining inflammation and can contribute to an ulcer in the stomach or duodenum, the first part of the small intestine.

An ulcer is a break in the lining, not simply excess acidity. It may cause upper abdominal pain or burning and can bleed, but these symptoms have other causes too. Pain, bad breath or bloating alone cannot diagnose H. pylori, and a lack of symptoms does not exclude infection.

Why treat it and repeat testing?

The infection increases the likelihood of some long-term stomach conditions, including certain tumors, but most infected people do not develop cancer. Once infection is confirmed, your doctor chooses eradication treatment to help ulcers heal, reduce recurrence and lower some future risks.

Breath testing or stool antigen testing detects active infection, which may also be found on endoscopic biopsies. Improvement after medicine does not prove eradication; acid treatment can relieve pain while bacteria remain. Some regimens fail because of antibiotic resistance or difficulty completing treatment, so a timely test of cure and an alternative plan for persistent infection are necessary.

How is it detected?

- By a breath test or stool test for the bacterium, or biopsies during endoscopy when needed.
- Blood antibodies may remain positive after cure, so they are generally unsuitable for confirming eradication.

How can I make treatment successful?

- Treatment usually combines several medicines, including antibiotics and an acid-reducing medicine, sometimes with bismuth, often for 14 days according to the prescription.
- Tell your doctor about drug allergies, pregnancy and any antibiotics previously taken. Do not repeat an old prescription or use a family member’s treatment.
- Use a dose schedule. If a problem occurs or you miss a dose, check the medicine instructions or ask your pharmacist; do not double doses yourself.

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The test of cure

- This is usually performed at least 4 weeks after finishing antibiotics and bismuth, with proton pump inhibitors or potassium-competitive acid blockers stopped for about 2 weeks as directed by your doctor.
- Do not stop acid treatment without a plan if you have a complicated ulcer or another important reason to continue. Your doctor may prescribe a temporary alternative; also follow the laboratory instructions.
- If the test stays positive, we choose another plan based on previous treatment and may need antibiotic susceptibility testing.

Food and prevention

- No food or herb eradicates the infection instead of treatment. Choose foods you tolerate and avoid smoking.
- Wash your hands and use safe food and water. Isolation or separate dishes are not necessary. Discuss testing household contacts with your doctor when appropriate.
- Bismuth can darken the tongue or stool. However, black, tarry or unusually sticky stool may indicate bleeding and needs urgent assessment even without dizziness or weakness; do not automatically attribute it to the medicine.

Before testing for H. pylori

- PPIs can cause a false-negative H. pylori test, including stomach biopsy tests. For planned testing, they are usually paused for 14 days with medical approval, with 4 weeks without antibiotics or bismuth. Do not interrupt essential treatment yourself; not every gastroscopy requires stopping PPIs. A negative result during treatment may need confirmation by a breath or stool test after an appropriate interval. See My medicines before endoscopy.

When to get help

Get urgent medical care / go to the emergency department

Vomiting blood, black tarry or unusually sticky stools even without dizziness, sudden severe abdominal pain, or swelling of the face or tongue or breathing difficulty after medicine.

Contact your care team promptly

Vomiting preventing completion of treatment, a rash or severe diarrhea during antibiotics; contact the team promptly to adjust treatment safely.

Related guides: Gastroscopy · Stomach and duodenal ulcers · Acid medicines: proton pump inhibitors (PPIs) · Vonoprazan · My medicines before endoscopy

Sources and further information AGA: Patient guide ACG: Treatment guidelines 2024 NIDDK: H. pylori and ulcers NIDDK: Understanding ulcers Saudi H. pylori Working Group recommendations ACG 2024: H. pylori testing and treatment

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Hepatitis B

Last updated: 10 November 2026 · Hepatitis B · HBV

Follow-up matters even without symptoms. You may need treatment or regular monitoring; the decision depends on the virus, liver health and other factors.

Your next step

Confirm your viral test result and follow-up date, and discuss household testing and vaccination.

What does the virus do in the body?

Hepatitis B is an infection with a virus that lives and multiplies inside liver cells. The immune response may cause inflammation and cell injury. “Hepatitis” does not mean scarring or liver failure; these may develop in some people with ongoing injury but are not inevitable after every infection.

Infection may be acute—recent and short-term—or chronic if it persists for six months or more. Many adults clear a new infection, while persistence is more likely when acquired in childhood. The date a test first identifies infection does not by itself show when it began.

Does having the virus mean my liver is being damaged now?

Infection may remain for years without symptoms. Some people develop tiredness, reduced appetite, nausea or jaundice. How you feel or the color of your eyes cannot alone establish disease activity. We therefore assess viral load together with liver enzymes, scarring and risk factors; the picture may change over time.

When treatment is needed, it aims to suppress viral replication and reduce inflammation and complications. A viral load too low to detect usually does not mean the virus has been permanently eliminated, so treatment may continue long term. Even if you do not need medicine now, regular monitoring is part of care, not neglect of the condition.

How do we assess the liver?

- We measure viral load and liver enzymes and assess scarring. People with hepatitis B should also be tested for hepatitis D at least once, with repeat testing depending on risk factors. No single result determines the whole plan.

Treatment and follow-up

- Oral medicines may be used to suppress viral replication and protect the liver. Not everyone needs the same treatment, but everyone needs a follow-up plan.
- Do not stop medicine when tests improve; stopping can cause a severe hepatitis flare. Tell the team before you run out.
- Specifically ask for your viral DNA result; a result that has not appeared is not the same as a negative result.

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Who needs liver cancer surveillance?

- People with cirrhosis and some people with hepatitis B may need ultrasound and an alpha-fetoprotein blood test every 6 months, as assessed by their doctor.
- This surveillance may continue even when the virus is suppressed; keep your next appointment.

Protecting your family without isolation

- Transmission occurs through blood, sexual contact and from mother to baby. It does not spread through handshakes, hugs or ordinary food sharing.
- Arrange testing for your spouse and household members and discuss vaccination for those not immune. Do not share razors, toothbrushes or items that may be contaminated with blood, and cover wounds.
- Do not donate blood. Use protection during sex until you have discussed your partner's immunity with the doctor.

Pregnancy and other medicines

- Tell your obstetrician early. Viral load is measured, and treatment during pregnancy may be needed to reduce transmission. A baby born to an infected mother needs hepatitis B vaccine and hepatitis B immunoglobulin within 12 hours of birth, followed by completion of vaccination and response testing at the specified time. Arrange the plan with the maternity team beforehand.
- Tell any doctor you have hepatitis B before steroids, biologics or chemotherapy, as preventive treatment may be needed against viral reactivation.
- Avoid alcohol and herbal mixtures, and review kidney, bone and other medicines as appropriate to your treatment.

When to get help

Get urgent medical care / go to the emergency department

Vomiting blood, black, tarry stools even without dizziness, confusion or unusual drowsiness, or severe jaundice with general deterioration.

Contact your care team promptly

New jaundice, abdominal or leg swelling, or interrupted treatment; contact the team promptly if medicine runs out or stops.

Related guides: Liver cirrhosis (F4) · Understanding hepatitis B blood tests · Liver cancer surveillance · Pregnancy and breastfeeding with bowel and liver disease · Hepatitis D (delta) · Entecavir for hepatitis B · Tenofovir disoproxil (TDF) for hepatitis B · Tenofovir alafenamide (TAF) for hepatitis B · Peginterferon alfa-2a for selected hepatitis B cases

Sources and further information NIDDK: Hepatitis B AASLD: Liver cancer surveillance EASL HBV CPG · 2025-05-09 AASLD/IDSA chronic HBV guideline · 2025-11-04 CDC perinatal HBV · current accessed 2026-11-08

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Hepatitis C

Last updated: 10 November 2026 · Hepatitis C · HCV

Most people can be cured with oral medicines. We confirm active infection with an RNA test, then confirm cure after treatment finishes.

Your next step

Confirm your post-treatment test-of-cure appointment; antibodies alone do not establish active infection.

What is hepatitis C?

This is an infection with a virus that reaches the liver through blood and can remain there, causing inflammation that may persist for years. Some people clear a new infection naturally, but persistent virus may lead to chronic infection. Liver scars can develop over time and progress to cirrhosis in some patients.

Many people have no symptoms, and infection may be found incidentally. Symptoms, if present, may include tiredness, nausea, mild upper abdominal pain or jaundice. These are not specific to hepatitis C, and their absence does not exclude infection or damage.

What is the difference between treating the virus and its effects?

Modern tablets target steps in viral replication until the virus is eliminated from the body. Cure means the viral test remains negative at the specified time after treatment, not simply improved liver enzymes. Antibodies may remain positive because they record the body’s previous exposure.

After cure, liver injury falls and fibrosis may regress over time. Cirrhosis (F4) can also improve, but this does not guarantee a normal liver or remove the need for follow-up. Assessment before treatment guides care after cure; do not stop attending when tablets finish. Cure does not prevent a new infection after exposure to infected blood.

The hepatitis C treatment journey

Antibody test
May show past exposure; it does not prove active infection on its own.

HCV RNA test
Identifies the virus. Tests and interactions are reviewed before treatment.

Prescribed treatment
Daily tablets on your plan. Do not stop just because you feel better.

Confirm cure
HCV RNA testing at least 12 weeks after treatment finishes.

Cure does not prevent reinfection. People with established cirrhosis continue liver and cancer surveillance on their clinician’s plan.

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Antibodies or the virus itself?

- An antibody test shows previous exposure and may remain positive after cure. A viral RNA test identifies active infection.
- If the viral test result has not been issued, we cannot treat it as negative or use it to confirm cure.

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Before treatment

- We assess scarring and liver and kidney function and review hepatitis B status and drug interactions.
- Bring a list of all medicines and supplements, particularly medicines for acidity, cholesterol, heart conditions or epilepsy. Tell the team about pregnancy or plans for pregnancy.

What is treatment like?

- Usually daily tablets for 8–12 weeks, although duration varies in some situations. With adherence, these treatments cure more than 95% of suitable patients.
- In our clinic, a usual first choice for suitable patients is sofosbuvir plus daclatasvir once daily for 12 weeks, particularly if previously untreated and without cirrhosis. Cirrhosis or previous treatment failure may require a different regimen or duration. The linked medicine card explains use, monitoring and precautions.
- Take doses as prescribed and do not stop because symptoms improve. If you miss a dose or start a new medicine, ask your pharmacist or team for instructions specific to your treatment.

When can I say I am cured?

- We usually request a viral test 12 weeks or more after treatment ends to confirm the virus remains undetectable. An undetectable virus during treatment alone does not establish a lasting cure.
- If cirrhosis (stage 4 scarring, F4) was established before treatment, liver cancer surveillance usually continues every 6 months after cure. Do not stop it because liver enzymes or a stiffness measurement improve; your specialist reviews the follow-up plan.

Protecting yourself and others

- Transmission is mainly through blood. Do not share shaving equipment, toothbrushes or needles, and do not donate blood. It does not spread through hugs or ordinary food sharing.
- Cure does not provide immunity to a new infection, and there is no hepatitis C vaccine. Discuss hepatitis A and B vaccines if you are not immune.
- Avoid alcohol and unknown supplements, maintain a healthy weight and manage blood glucose; curing the virus does not prevent other liver diseases.

If exposure risk continues after cure

- Ask about repeat HCV RNA testing, usually annually when exposure risk continues. The antibody may remain positive after cure and cannot by itself identify reinfection.

For readers who would like more detail



Hepatitis C Virus (C) — Arabic-language book

By Prof. Ibrahim bin Hamad Altraif and Dr. Ibrahim bin Saleh Albedaiwi

Arabic-language publication · First edition, 2023

This Arabic-language book covers history, characteristics, diagnosis, symptoms, prevention and treatment, as shown on its original cover. It offers further reading for those who would like to learn more about hepatitis C.

Ask the clinic how to obtain the book.

The book is an additional reference from the 2023 edition. For current treatment and testing decisions, follow your doctor’s plan and the updated information in this guide.

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When to get help

Get urgent medical care / go to the emergency department

Vomiting blood, black, tarry stools even without dizziness, new confusion, or severe jaundice with general deterioration.

Contact your care team promptly

Difficulty obtaining or completing medicine, starting a new medicine, or abdominal swelling and new jaundice.

Related guides: Sofosbuvir + daclatasvir for hepatitis C · Liver cirrhosis (F4) · Liver cancer surveillance · Sofosbuvir/velpatasvir for hepatitis C · Glecaprevir/pibrentasvir for hepatitis C · Ledipasvir/sofosbuvir for hepatitis C · Sofosbuvir/velpatasvir/voxilaprevir (Vosevi) for hepatitis C · Ribavirin for hepatitis C

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Liver cirrhosis (F4)

Last updated: 10 November 2026 · Cirrhosis

Treating the cause and monitoring complications can help keep the liver stable. Good nutrition and knowing warning signs are essential parts of care.

Your next step

Review prescribed medicines for ascites or confusion and the date of your next liver scan.

How does cirrhosis differ from earlier fibrosis?

Persistent liver injury can produce scar tissue, called fibrosis. In the F0–F4 staging system, F1–F3 are fibrosis before cirrhosis; F3 is already advanced fibrosis. F4 is cirrhosis: scarring alters the liver’s structure and may affect blood flow and liver function.

It can result from viruses, steatohepatitis, autoimmune conditions or bile duct diseases. Treating the cause may improve health and reduce complications; the diagnosis alone does not mean a transplant is immediately needed.

Why do symptoms differ between people?

In compensated cirrhosis, the liver is still coping and these major complications have not developed; there may be no obvious symptoms. When complications such as abdominal fluid buildup, bleeding varices or confusion develop, this is called decompensated cirrhosis. It needs closer follow-up and a revised plan. Symptoms alone cannot determine the stage.

Pressure may rise in vessels carrying blood from the intestines to the liver, forming enlarged veins called varices, particularly in the esophagus and stomach. Reduced clearance of substances that affect the brain may cause confusion. Follow-up aims to detect and treat these problems early. Treating the cause can improve stability and reduce complications despite scarring. Cirrhosis does not mean an immediate transplant; specialist assessment determines timing if one is needed.

Can liver scarring improve?

Fibrosis at stages F1–F3 can regress when its cause is treated, particularly at earlier stages. Improvement is not guaranteed, and F3 is advanced scarring that still needs careful follow-up.

Cirrhosis (F4) can also improve in some people, but this does not necessarily restore a normal liver. Follow-up and any prescribed surveillance for liver cancer and varices remain important, even if blood tests or a stiffness measurement improve.

Follow-up not to postpone

- Treat the cause, such as viral infection, autoimmune disease or metabolic problems. Many patients need liver imaging and an alpha-fetoprotein blood test every 6 months for early cancer detection.
- You may need medicine to lower pressure in the portal vein, the vein carrying blood to the liver, or an endoscopy to assess varices, according to your doctor’s plan. Bring your medicine list to every visit.

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If you have abdominal fluid or swelling

- Your doctor may recommend limiting sodium to about 2 grams daily, equivalent to around 5 grams of salt from all sources. Reduce pickles, canned foods and very salty meals.
- Weigh yourself regularly as planned. Do not change diuretic doses or restrict fluids yourself; fluid restriction is not necessary for everyone.

Food to maintain muscle

- Eat small frequent meals with a bedtime snack, and include protein such as eggs, pasteurized yogurt, chicken or pulses as tolerated.
- Do not avoid protein because of confusion; the cause needs treatment alongside appropriate nutrition. Avoid prolonged fasting without discussing it with your doctor.
- Avoid raw seafood and meat and unpasteurized milk, and abstain from alcohol.

Medicines and confusion

- Avoid ibuprofen, diclofenac, sleeping medicines and herbs without approval. Even paracetamol requires an appropriate dose for your condition.
- If lactulose is prescribed, the usual aim is 2–3 soft stools daily according to your plan, not severe diarrhea. Do not stop it or raise the dose randomly.
- Ask family to watch for changes in sleep or concentration. Discuss vaccinations and transplant assessment if complications develop.

When to get help

Get urgent medical care / go to the emergency department

Vomiting blood or black stools, new confusion or drowsiness, fever or abdominal pain with ascites, markedly reduced urine, or breathlessness.

Contact your care team promptly

Rapid weight gain or increasing abdominal size, worsening swelling, new jaundice or difficulty eating; contact the team early.

Related guides: Care after liver transplantation · A family guide to cirrhosis · Liver cancer surveillance · My cirrhosis monitoring plan · Lactulose · Rifaximin · Gastrointestinal bleeding · Liver transplantation: when is evaluation needed? · Ascites: abdominal fluid and drainage · Hepatic encephalopathy: confusion and altered awareness · Portal hypertension and esophageal or gastric varices · Alcohol-related liver disease · Herbs, mixtures and supplements: benefits and risks · Eating well with cirrhosis · Portal vein thrombosis · Spironolactone for ascites · Furosemide for ascites · Carvedilol for portal hypertension

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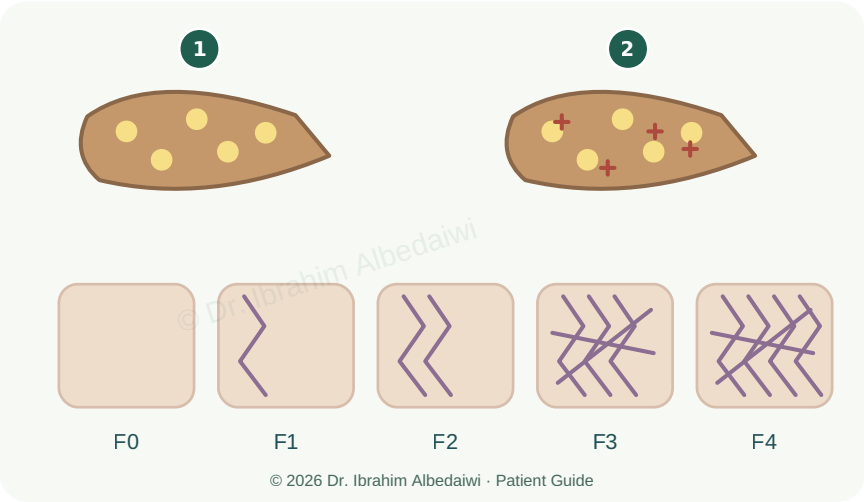
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ILLUSTRATED PATIENT GUIDE

Fat, fibrosis and cirrhosis: what is the difference?

Fat in the liver does not automatically mean fibrosis or cirrhosis. Not everyone develops these stages.



1 · Fat accumulation: MASLD

Fat builds up inside liver cells.

2 · Steatohepatitis: MASH

Fat accompanies liver-cell injury and inflammation; scars may develop.

F0 · No fibrosis

This staging system describes scarring, not the amount of liver fat.

F1–F3 · Fibrosis before cirrhosis

F1: mild · F2: moderate · F3: advanced bridging fibrosis, before F4.

F4 · Cirrhosis

Extensive scarring alters liver structure and may affect blood flow and function.

> Fibrosis can regress when its cause is treated, especially earlier stages. F4 can also improve, but this does not guarantee a normal liver or remove the need for follow-up. Progression is not inevitable; enzymes or stiffness alone cannot establish the stage.

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AASLD: fibrosis stages
AASLD: regression of fibrosis and cirrhosis (2026)

These illustrations support education and do not replace your doctor’s advice or follow-up. Plans vary by patient.

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Autoimmune hepatitis

Last updated: 10 November 2026 · Autoimmune hepatitis · AIH

Treatment calms the immune attack on the liver. Normal blood tests are a good sign, but do not mean it is safe to stop treatment without supervision.

Your next step

Confirm your dose plan and treatment-safety blood test appointment before medicine runs out.

Why does the immune system attack the liver?

The immune system protects the body from infection. In this condition it mistakenly recognizes some liver cells as foreign, causing ongoing inflammation. The precise cause is unknown, and genetic susceptibility and other factors may interact. It is not caused by poor hygiene or an infection that can spread to your family.

It can affect women and men at different ages and may coexist with other autoimmune conditions, such as some thyroid diseases. Another autoimmune condition does not automatically establish autoimmune hepatitis; the liver needs its own assessment.

Understanding active disease and remission

It may be discovered through elevated blood tests without symptoms, or cause tiredness, joint pain, nausea or jaundice; occasionally it starts severely. Persistent inflammation may lead to scarring and fibrosis, so few symptoms do not always reflect little activity inside the liver.

Medicine aims to stop the immune attack, bring tests to target levels and protect liver tissue. Control of disease activity is called remission, which does not necessarily remove susceptibility to the disease. Your doctor therefore balances the lowest effective dose against treatment effects and monitors tests even when you feel better. Disease can reactivate after stopping treatment; this does not mean previous treatment was pointless.

How is it diagnosed?

- We combine blood tests, antibodies and immune proteins in the blood while ruling out other causes. A biopsy may be needed to confirm the diagnosis and assess inflammation.
- One positive test alone is not enough to confirm the condition.

How is it treated?

- Treatment often begins with corticosteroids and another immune-suppressing medicine, such as azathioprine or mycophenolate mofetil, according to your situation. Mycophenolate is unsuitable for pregnancy and requires contraception planning and a supervised switch before pregnancy.
- Doses are reduced gradually according to response and side effects. Do not stop steroids suddenly or change the dose yourself.
- Treatment may continue for years or lifelong. A trial of withdrawal suits only a small selected group after sustained remission and specialist assessment, with close follow-up.

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Safe medicine monitoring

- Keep appointments for liver tests, blood counts and other tests required for your medicine. Special tests may be needed before some treatments.
- Report fever, severe sore throat, mouth ulcers, unusual bruising or severe abdominal pain.
- Discuss vaccinations, sun protection and preventive screening appropriate to your age and treatment. Do not receive a live vaccine without your team’s approval.

Bones, pregnancy and lifestyle

- Steroids can affect blood glucose, blood pressure, bones and mood. Depending on assessment, you may need vitamin D, calcium or bone-density testing.
- Eat a balanced diet, remain active within your ability, and avoid alcohol and unknown supplements. No special diet replaces treatment.
- If planning pregnancy, discuss it early with your doctor; some medicines are unsuitable and need to be changed beforehand. Do not stop medicines yourself if you become pregnant.

When to get help

Get urgent medical care / go to the emergency department

Severe jaundice with confusion, gastrointestinal bleeding, breathing difficulty or rapid general deterioration.

Contact your care team promptly

Fever during immunosuppression, new jaundice, bruising or mouth ulcers, or difficulty obtaining treatment; contact the team the same day for fever.

Related guides: Liver cirrhosis (F4) · Pregnancy and breastfeeding with bowel and liver disease · Azathioprine / Imuran

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Sources and further information NIDDK: Definition and diagnosis NIDDK: Treatment NIDDK: Nutrition and bones NIDDK: Understanding autoimmune hepatitis EASL AIH CPG · 2025-05

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Primary biliary cholangitis

Last updated: 10 November 2026 · Primary biliary cholangitis · PBC

A chronic disease affecting the small bile ducts inside the liver. Early treatment and follow-up help protect the liver, even without symptoms.

Your next step

Review your treatment dose against your weight and record how itching affects sleep.

What are bile ducts, and what happens to them?

The liver makes bile, a fluid that helps digest fat and eliminate certain substances. Bile travels through a network of small ducts inside the liver, then larger ducts, to reach the intestine. An immune reaction in this condition damages the small ducts, disrupting bile flow and potentially injuring liver tissue over time.

“Primary” is part of the disease name, not its severity grade. It does not mean a stone or bacterial infection is present and does not spread to family members. Diagnosis also does not mean cirrhosis is already present; it can be detected early, before advanced scars form.

Why monitor tests even if itching improves?

Itching and tiredness may be the first symptoms, sometimes with dry eyes or mouth, or the disease may be found on routine tests without symptoms. Itch or fatigue severity alone does not show how much liver damage exists. Some symptoms may continue despite improvement in the markers used to monitor the disease.

Tests showing impaired bile flow and disease-specific antibodies, together with exclusion of duct obstruction, help establish the diagnosis. Treatment aims to improve bile flow, reduce injury and slow disease progression. Response must be monitored over time to determine whether treatment is sufficient, with separate treatment for itching, vitamin deficiencies or bone problems when present.

Symptoms and diagnosis

- It may cause itching, tiredness or a raised alkaline phosphatase level, or no symptoms.
- Diagnosis uses liver tests, antibodies and imaging, with biopsy in some cases. We may assess thyroid function, bones and problems with dryness.

Treatment and follow-up

- Ursodeoxycholic acid is a main treatment for many patients, with a dose calculated by weight. Continue it as prescribed.
- If response is inadequate or the medicine is not tolerated, newer options include seladelpar and elafibranor. A specialist selects treatment according to disease stage, other medicines, regulatory approval and local availability. They are not suitable for every situation, particularly with complications of cirrhosis. Itching sometimes needs separate treatment from the disease itself.

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- We monitor liver enzymes, bilirubin, response and scarring. Improved itching alone does not establish disease control.

Managing itching and tiredness

- Use moisturizer, reduce hot-water bathing and keep nails short. Tell your doctor if itching affects sleep.
- Itch treatments differ from treatment of the underlying condition. Some bile-acid-binding medicines must be separated in time from other medicines; ask your pharmacist for a schedule.
- Tiredness has many causes, and we may investigate anemia, thyroid problems or sleep. Increasing liver medicine is not always the answer.

Bones and nutrition

- Eat a balanced diet and exercise to maintain muscles and bones. Bone-density testing and vitamin D or other tests may be needed according to your situation.
- Do not take high-dose vitamins or herbs without advice. Discuss dry eyes or mouth and dental care if these problems occur.
- Your doctor determines the need for variceal and liver cancer surveillance according to disease stage and risk factors. Men with this condition may need liver cancer surveillance even without cirrhosis; monitoring should not be linked to cirrhosis alone.

When to get help

Get urgent medical care / go to the emergency department

Vomiting blood, black tarry stools, new confusion, sudden severe abdominal pain, or jaundice with fever or chills need urgent assessment. Do not wait for fever, jaundice and pain to occur together.

Contact your care team promptly

Itching that disrupts sleep, worsening jaundice, abdominal or leg swelling, or unintentional weight loss.

Related guides: Primary sclerosing cholangitis (PSC) · Ursodeoxycholic acid (UDCA) · Cholestyramine

Sources and further information NIDDK: Definition NIDDK: Treatment NIDDK: Overview NIDDK: Diagnosis AASLD/AGA PBC guideline · 2026-10 AASLD PBC guidance · 2018 AASLD current PBC guideline index · current accessed2026-11-08

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Wilson disease

Last updated: 10 November 2026 · Wilson disease

An inherited condition causing copper buildup. Regular lifelong treatment protects the liver and brain; diet alone is not enough.

Your next step

Ensure an uninterrupted medicine supply and confirm required copper test appointments.

How does copper build up?

Copper is a mineral the body needs in small amounts from food. The liver normally processes excess copper and excretes it in bile. In Wilson disease an inherited defect disrupts this process, allowing copper to build up in the liver and then potentially affect the brain, eyes and other organs. It is not simply the result of eating a copper-rich meal.

The defect is present from birth, but symptoms may be delayed until copper accumulates. People usually inherit an altered gene copy from each parent, who may carry the trait without symptoms. Family screening is therefore useful even when relatives appear healthy.

Why do cases differ?

One person may have liver problems alone, while another has tremor, difficulty speaking or moving, or behavioral and mood changes. These symptoms require assessment and do not alone establish Wilson disease. A special slit-lamp eye examination may reveal copper deposits that cannot be assessed by ordinary inspection.

Several test results are combined to confirm diagnosis; blood copper can be low despite copper buildup inside organs. Treatment removes excess copper or reduces absorption, then prevents renewed buildup. Improvement may be gradual and varies with the organ involved and disease duration. Diet supports treatment but cannot alone correct the inherited defect or replace medicine.

How is the diagnosis confirmed?

- We may use blood tests, urine copper, an eye examination and sometimes genetic testing, biopsy or imaging. Diagnosis does not rely on one test alone.
- First-degree relatives need assessment according to the doctor’s plan; early detection allows treatment before damage develops.

Treatment is ongoing

- Some medicines bind excess copper and help the body remove it; zinc may reduce its absorption in appropriate situations. A specialist chooses the medicine, and these options are not automatically interchangeable.
- Do not stop treatment when tests improve; interruption can cause serious deterioration or liver failure.
- Medicines may need different timing in relation to food or each other. Ask for a clear schedule rather than combining them randomly.

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Food and supplements

- You may be asked to reduce high-copper foods, especially early in treatment, such as liver, shellfish, nuts and chocolate; your dietitian determines suitable amounts.
- Do not use supplements containing copper. Check vitamin ingredients, and do not start zinc yourself as a replacement for medicine.
- If water comes from a well or flows through copper pipes, discuss whether its copper content should be tested. Do not exclude all foods without a nutrition plan.

How should I monitor myself?

- Keep blood and urine test appointments; accurate 24-hour urine collection may be needed. These tests monitor treatment effectiveness and safety, not just symptoms.
- Report tremor, changes in speech, walking or mood, or a rash, bruising or urinary changes during treatment.
- If planning pregnancy, see your specialist and do not stop treatment; doses and monitoring may change. Arrange enough medicine before travel or before it runs out.

When to get help

Get urgent medical care / go to the emergency department

Rapid severe jaundice, confusion, gastrointestinal bleeding, sudden severe weakness or acute neurological deterioration.

Contact your care team promptly

Any interruption or difficulty obtaining medicine, or new worsening of movement or speech; contact the team promptly.

Related guides: Liver cirrhosis (F4)

Sources and further information NIDDK: Treatment NIDDK: Food NIDDK: Disease NIDDK: Diagnosis NIDDK: Causes and inheritance of Wilson disease EASL–ERN Wilson CPG · 2025

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Gallbladder and bile duct stones

Last updated: 10 November 2026 · Gallstones

A stone does not always require intervention, but persistent pain, fever or jaundice may indicate obstruction or inflammation needing urgent treatment.

Your next step

Confirm the stone treatment plan and date of surgery or stent follow-up if needed.

Understanding the condition: what do the gallbladder and bile do?

The liver makes bile, a fluid that helps digest fat. The gallbladder stores it in a small sac beneath the liver, then releases it into the intestine through narrow ducts. Some bile components, such as cholesterol or pigments, can collect to form small or large solid stones.

A stone inside the gallbladder without obstruction or inflammation may cause no symptoms. Problems occur when it temporarily blocks the gallbladder outlet, causing pain, or the blockage persists and inflammation develops. If it moves into the main bile duct, it can cause jaundice or a duct infection and may contribute to pancreatitis. Gas and bloating alone do not prove a stone is responsible.

Why do treatment plans differ?

Decisions depend on the stone’s location and effects, not size alone. Ultrasound helps identify gallbladder stones, while blood tests look for inflammation or obstruction. MRCP or endoscopic ultrasound may be needed for a suspected duct stone not clearly seen on initial imaging.

A silent gallbladder stone usually does not require surgery. A stone in the main bile duct may need removal even without symptoms, if the person’s condition allows, to prevent obstruction and infection. Repeated pain or complications may require gallbladder removal or duct treatment. You can live without a gallbladder because the liver continues making bile, which reaches the intestine without the same storage step. Dietary changes may reduce some attacks but do not guarantee stone removal or prevent blockage.

What is an attack like?

- Upper abdominal pain, particularly on the right, may spread to the back or shoulder and last from minutes to hours, sometimes after a fatty meal.
- We assess symptoms and use ultrasound and liver tests, sometimes with additional bile duct imaging.

What are the treatment options?

- Silent stones within the gallbladder usually do not need treatment. Stones causing pain or complications may require laparoscopic gallbladder removal.
- A bile duct stone may be removed by an endoscopic bile duct procedure, which differs from gallbladder removal; you may need both procedures.

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- Stone-dissolving medicines suit only a few cases and are not a general alternative to surgery.

Until treatment is complete

- Reduce meals you have noticed trigger pain, especially large or fatty meals. Choose moderate meals without eliminating fat completely.
- Avoid rapid weight loss and crash diets. Do not use oil-and-lemon mixtures or “gallbladder cleanses”; they have not been shown to remove stones and may delay treatment.
- Use only the painkiller chosen by your doctor, and do not treat ongoing pain or fever as an ordinary attack.

After gallbladder removal

- You can live normally without a gallbladder. Smaller, lower-fat meals may be better tolerated initially, followed by a balanced diet as tolerated.
- A temporary change in stools may occur. Persistent diarrhea deserves review; there are possible causes and treatments.
- Follow your surgeon’s wound, activity and medicine instructions. If a bile duct stent was placed, confirm its removal or replacement date and do not neglect follow-up.

When to get help

Get urgent medical care / go to the emergency department

Severe pain or pain lasting several hours, fever or chills, jaundice, repeated vomiting, or dark urine with pale stool; do not wait for all these signs to occur together.

Contact your care team promptly

Repeated attacks, an unclear surgical plan, or an unclear stent follow-up date if a stent is present.

Related guides: Gastroscopy · Bile duct stones and obstructive jaundice · Bile and pancreatic duct endoscopy (ERCP)

Sources and further information NIDDK: Symptoms NIDDK: Treatment NIDDK: Diet NIDDK: Gallstones Clinical guidelines: ESGE 2019

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Diverticulosis and diverticulitis

Last updated: 10 November 2026 · Diverticulosis / diverticulitis

Having diverticula is different from having inflamed diverticula. Most do not cause problems, but new pain with fever needs medical assessment.

Your next step

Ask about food during the attack and your follow-up appointment after recovery.

Understanding the condition: a pouch is not a polyp

Diverticula are small pouches that bulge out through weak points in the colon wall. They resemble side pockets, whereas a polyp grows into the inside of the colon. Diverticula become more common with age. Many people have no symptoms and discover them during a scan or colonoscopy performed for another reason.

Having these pouches is called diverticulosis; inflammation of a pouch is called diverticulitis. Some diverticula can bleed without obvious inflammation. These are different conditions, so everyone with diverticula on a report does not need the same treatment, and not every episode of bloating or pain is automatically due to them.

Recognizing an attack and what to expect afterwards

Diverticulitis usually causes persistent lower abdominal pain, often on the left, sometimes with fever or a change in bowel habits. Examination, blood tests and imaging when needed help distinguish localized inflammation from complications such as an abscess, perforation or blockage.

Many uncomplicated attacks improve without surgery. Antibiotics are selected according to severity, immune function and other factors. Pouches may remain after recovery; that does not mean inflammation is continuing. The focus is on suitable food, regular activity, and deciding whether follow-up colonoscopy or surgery is needed for your situation.

How is severity assessed?

- Assessment uses examination and tests; a CT scan may be needed to confirm the diagnosis and look for an abscess or complications.
- Not every pain in someone with diverticula is diverticulitis. Colonoscopy is not usually performed during an acute attack to diagnose it.

Treatment depends on severity

- Some uncomplicated attacks can be treated outside hospital with monitoring, appropriate food and prescribed pain relief. Not everyone needs antibiotics.
- Antibiotics or hospital care may be needed for severe illness, weakened immunity or complications. An abscess or perforation may require a procedure or surgery.

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During an attack and after improvement

- Your doctor may temporarily recommend clear fluids or light food as tolerated, followed by gradually returning to food as you improve. Do not continue on fluids alone for days without review.
- Contact the team if pain is not improving or you cannot gradually resume usual food or drink fluids. Do not restart leftover antibiotics yourself.
- After recovery, increase fiber gradually within a balanced diet, stay active, maintain a suitable weight and stop smoking.

Common questions

- You do not usually need to avoid nuts, seeds or popcorn simply because you have diverticula; adjust them if they personally disagree with you.
- Avoid repeated use of painkillers such as ibuprofen without advice.
- Colonoscopy is recommended after recovery from complicated diverticulitis. After an uncomplicated attack, the decision depends on warning symptoms, whether screening is due and the quality of previous colonoscopies. It is usually delayed for 6–8 weeks or until symptoms have fully resolved, whichever is longer. Surgery is not decided by the number of attacks alone.

When to get help

Get urgent medical care / go to the emergency department

Severe or worsening pain with fever, a rigid or markedly swollen abdomen, vomiting that prevents drinking, fainting or heavy bleeding. Diverticular bleeding can be painless.

Contact your care team promptly

Failure to improve with the plan, returning pain, or uncertainty about whether you need colonoscopy after recovery.

Related guides: Colonoscopy

Sources and further information NIDDK: treatment NIDDK: eating and nutrition AGA: diverticulitis guidance NIDDK: definition and facts NIDDK: diverticular disease Clinical guideline: July 2026

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IBD medicine safety

Last updated: 10 November 2026 · Biologics & immunosuppressive treatment

Biologic and targeted medicines and immunomodulators help control inflammation. Their risks and instructions differ; keep a plan specific to your medicine.

Your next step

Write down your medicine’s name and dose date, and check whom to contact for fever or infection.

Why do I need an immune treatment?

In Crohn’s disease and ulcerative colitis, uncontrolled immune activity in the bowel damages its lining. Medicines calm this activity: some target particular inflammatory signals and others act more broadly. The aim is to heal inflammation, prevent flares and reduce the need for steroids and surgery, not simply mask pain.

Medicines differ in how they are given, how quickly they work and which safety tests they require. Continuing maintenance treatment after improvement helps keep the disease in remission. Your doctor balances medicine risks against uncontrolled inflammation; ask for your medicine’s name, purpose and monitoring plan.

Before the first dose

- You may need tests for tuberculosis, hepatitis B and C and other infections, along with a blood count and liver tests. Tell the team about previous infections, travel or exposure to tuberculosis.
- Review your vaccination record, pregnancy or pregnancy plans, other illnesses and all medicines and supplements. Additional tests depend on the treatment.

What happens at an infusion?

- An infusion alone usually does not require fasting. Staff review your health and tests, then give medicine slowly through a small tube in a vein while monitoring you. Tell the nurse immediately about new symptoms; observation afterwards may be needed.
- Infusion time varies from around half an hour to two hours or more. Read the linked “Biologic infusions: what to expect” guide for preparation, medicine-specific times and aftercare.

Vaccines and pregnancy

- Ideally, complete appropriate vaccinations before treatment. Many non-live vaccines can be given during treatment, but the team decides which and when.
- Do not receive a live vaccine without specialist advice; it may be unsuitable during immunosuppression. Tell the travel clinic your medicine’s name.
- Some IBD medicines are suitable in pregnancy and others are not. Plan early and do not stop treatment yourself. Tell your baby’s doctor about medicines used during pregnancy before vaccination.

Do not rely on symptoms alone

- Attend blood tests for medicine safety and inflammation monitoring even when you feel better. Endoscopy, stool tests or levels of some medicines may be needed.
- If you miss a dose, contact the team for instructions. Do not double a dose or change the interval between doses yourself.

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When should I call before a dose?

- If you have fever, a significant infection, are taking antibiotics or have been exposed to a serious infection, contact the team before your next dose so they can decide its timing. Do not delay infection treatment or stop your IBD medicine for a long period without a plan.
- Tell the team before surgery or a major procedure, and about a new rash, bruising or unusual changes.
- Do not stop steroids suddenly even if you develop an infection; seek prompt assessment.

Storage and prevention

- For home injections, learn the injection and storage instructions for your product. Do not freeze it; ask the pharmacist about travel, refrigeration and safe needle disposal.
- Wash your hands, care for your teeth and skin, and use sun protection. Keep up with appropriate preventive screening, including cervical screening when needed.
- Side effects differ between medicines. Read your own medicine's leaflet; this page does not cover every treatment or risk.

Prevention suited to your treatment

- Discuss annual influenza, pneumococcal and hepatitis B vaccination, and the non-live shingles vaccine when appropriate, based on your age, treatment and local schedule.
- Some immunosuppressive, biologic or targeted treatments may require annual skin checks. Bone density testing may be needed with risk factors such as repeated steroid use. Tell the team about anxiety or depression; psychological support is part of your care.

When to get help

Get urgent medical care / go to the emergency department

Breathing difficulty or facial swelling, fainting or a severe rash after a dose, fever with severe illness, or sudden chest pain and shortness of breath.

Contact your care team promptly

A new fever or infection during treatment, incorrect medicine storage or a missed dose. Contact the team the same day for an infection.

Related guides: Biologic infusions: what to expect · Crohn's disease · Ulcerative colitis · Nutrition with Crohn's disease and ulcerative colitis · Pregnancy and breastfeeding with bowel and liver disease · Infliximab medicine card · Adalimumab medicine card · Vedolizumab medicine card · Ustekinumab medicine card · Risankizumab medicine card · Mesalazine / mesalamine medicine card · Corticosteroid medicine card · Budesonide MMX 9 mg / Cortiment · Azathioprine / Imuran

Sources and further information Crohn's & Colitis UK: targeted medicines BSG: IBD guidelines 2025 AGA: screening and vaccinations 2025

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Hemorrhoids and anal fissure

Last updated: 10 November 2026 · Hemorrhoids & anal fissure

Rectal bleeding or anal pain does not automatically mean hemorrhoids. The correct diagnosis helps select treatment and avoid missing another cause.

Your next step

Start a plan to keep stool soft and arrange assessment if bleeding recurs.

Understanding the difference

Hemorrhoids are vascular tissues around the anus that may enlarge and cause symptoms. Internal hemorrhoids lie inside the anal canal and may cause bright red bleeding or protrude during a bowel movement. External hemorrhoids near the skin may cause a lump or discomfort; a clot inside one can cause sudden pain.

An anal fissure is a small tear in the lining of the anus, not an enlarged blood vessel. It often starts after hard stool but can also occur with diarrhea. It typically causes sharp pain during a bowel movement that continues afterwards, with a small amount of blood. Pain may cause the surrounding muscle to tighten, reducing blood flow to the wound and delaying healing.

Why examination matters and what treatment aims to do

Symptoms can overlap and both conditions may occur together, but their treatments differ. Examination helps identify the cause and rule out an abscess or other problem. Bleeding should not automatically be attributed to hemorrhoids, particularly with changed bowel habits, anemia or other risk factors.

The first aim is soft, easy-to-pass stool to reduce repeated injury and straining. A fissure may need treatment that relaxes the muscle to help healing. Persistent haemorrhoidal bleeding or prolapse may need a specific procedure. Many cases improve without surgery, but continuing pain or bleeding needs a review of the diagnosis and plan rather than simply repeating creams.

When do I need an examination?

- The doctor assesses where pain and bleeding occur and may examine the anus. Having hemorrhoids does not rule out another illness; colonoscopy may be needed depending on age, symptoms and family history.
- Report changed bowel habits, weight loss or anemia. Persistent pain with fever or swelling may be an abscess rather than simple hemorrhoids.

Treatment depends on the diagnosis

- Softening stool and reducing excessive straining are first steps for both conditions. Some hemorrhoid products give short-term relief; avoid prolonged steroid cream use without review.
- A chronic fissure may need a prescribed muscle-relaxing ointment, and sometimes botulinum toxin injections or surgery. Bleeding or prolapsing hemorrhoids may need banding or another procedure.

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Everyday steps

- Increase fiber gradually and drink an amount appropriate for your health. Use a prescribed laxative for hard stool without causing diarrhea.
- Do not delay bowel movements or spend long periods on the toilet. Sitting in warm water may ease pain. Clean gently and avoid rubbing and fragranced products.
- Do not puncture or tie off a painful lump yourself. Do not keep using suppositories if they worsen pain.

If the problem continues

- Improvement takes time, and constipation may cause a fissure to recur. Maintain habits that keep stool soft after pain improves.
- See your doctor if bleeding or pain fails to improve, or a fissure recurs or does not heal. Other causes should be considered before repeating treatment.
- Before surgery, discuss possible effects on bowel control and tell the surgeon about previous anal muscle injuries or a difficult childbirth.

When to get help

Get urgent medical care / go to the emergency department

Heavy bleeding, dizziness or fainting, or severe persistent anal pain with fever, swelling or pus.

Contact your care team promptly

Repeated bleeding, pain that does not improve, a lasting change in bowel habits or unintentional weight loss. Severe persistent or worsening anal pain needs same-day assessment even without fever or a visible swelling; an abscess may be deep. Seek urgent care if fever or general deterioration occurs.

Related guides: Constipation, difficult evacuation and bowel leakage · Gastrointestinal bleeding

Sources and further information NIDDK: haemorrhoids ASCRS: anal fissure ASCRS: understanding anal fissure NIDDK: haemorrhoids Clinical guidelines: ASCRS 2024 haemorrhoids / 2023 fissure

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Functional dyspepsia

Last updated: 10 November 2026 · Functional dyspepsia

Symptoms can be distressing despite normal tests. After other causes are assessed, treatment targets stomach sensitivity, movement and its interaction with the brain.

Your next step

Choose smaller meals and record the symptom you most want to improve before your review.

What does “functional” mean?

The stomach does more than hold food: it stretches to receive a meal, mixes it and gradually moves it into the bowel. In functional dyspepsia, sensitivity or adaptation to food may differ, causing uncomfortable fullness, feeling full after only a few bites, pain or burning in the upper abdomen without a structural illness explaining the symptoms after appropriate assessment.

“Functional” describes how the system works and interacts with the brain. It does not mean the pain is imagined or everything is caused by anxiety. Food, sleep and stress may influence symptoms, and in some people symptoms start after an infection. IBS or reflux can coexist, but these are not different names for the same condition.

How do we confirm the diagnosis and measure improvement?

Your doctor distinguishes this pattern from an ulcer, H. pylori, medicine effects or other causes. Age, symptoms and medical history determine whether tests or endoscopy are needed; not every patient needs every test. Dyspepsia is a general symptom, while “functional dyspepsia” follows an assessment supporting that diagnosis.

Symptoms may fluctuate, and one treatment does not work for everyone. The plan targets the main symptom—fullness, pain or burning—with meal changes and medicines when appropriate. Success means being able to eat and stay active more comfortably, not necessarily eliminating every sensation after every meal. A new symptom or clear change needs reassessment.

How is it assessed?

- We review medicines, including painkillers, and test for H. pylori when appropriate. Endoscopy depends on age, risk factors and warning signs.
- Not every case needs every test. Repeated vomiting, swallowing difficulty or weight loss may change the assessment plan.

How is it treated?

- Confirmed H. pylori is treated. Depending on symptoms, an acid-reducing medicine or a medicine that regulates pain sensitivity or stomach movement may help.
- Some medicines that modify pain signals are used at low doses; prescribing them does not mean the problem is only psychological.

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- Relaxation exercises or treatment directed at the brain–gut interaction may help. Review response with your doctor rather than changing several treatments at once.

Try simple adjustments

- Eat smaller amounts regularly and chew slowly. Reduce fried or fatty meals if they increase fullness.
- Record foods linked to your symptoms. Coffee and fizzy drinks bother some people but are not prohibited for everyone.
- Do not automatically exclude gluten or milk. See a dietitian if you become afraid of most foods or lose weight.

Monitor what matters to you

- Choose a goal such as finishing a small meal comfortably or reducing pain episodes. Record symptoms and treatment timing for two weeks.
- Improvement may be gradual. If treatment does not help, we review the diagnosis, adherence and side effects rather than increasing medicines at random.
- Tell your doctor about new symptoms; do not attribute new chest pain or bleeding to dyspepsia.

When to get help

Get urgent medical care / go to the emergency department

Pressure-like chest pain with breathlessness or sweating, vomiting blood, black, tarry stool even without dizziness, or sudden severe abdominal pain.

Contact your care team promptly

Swallowing difficulty, repeated vomiting, anemia, unintentional weight loss or worsening despite treatment.

Related guides: Gastroesophageal reflux disease · Gastroscopy

Sources and further information NIDDK: indigestion NIDDK: treatment NIDDK: causes of indigestion Clinical guideline: BSG 2022

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Gastroparesis: delayed stomach emptying

Last updated: 10 November 2026 · Gastroparesis

Food leaves the stomach more slowly without a blockage. Changing meal size and texture and treating the cause can support nutrition and reduce nausea.

Your next step

Divide meals into smaller portions, adjust their texture, and review your glucose and vomiting plans.

Delayed movement, not a blockage

Normally, stomach nerves and muscles coordinate grinding food and moving it into the small bowel. In gastroparesis this movement is delayed without a physical blockage preventing passage. Food may therefore remain in the stomach longer than usual.

It can result from nerve damage associated with diabetes, some operations or certain medicines; sometimes no clear cause is found. Not every feeling of slow digestion or fullness is gastroparesis. Functional dyspepsia and other conditions can cause similar symptoms and need a different plan.

How is it confirmed, and why does nutrition matter?

Symptoms include feeling full after a few bites, fullness lasting hours, nausea, vomiting and sometimes pain. Markedly reduced intake can cause dehydration, weight loss and nutritional deficiencies. In diabetes, unpredictable food absorption may make glucose control harder.

After ruling out blockage and reviewing medicines, a test that measures the emptying of a standard meal may be used. Food residue seen at endoscopy alone does not establish the diagnosis. Treatment aims to maintain nutrition and fluids, reduce nausea, improve movement and address treatable causes. Response varies: food texture, medicines and follow-up may need adjustment, while specialist procedures or additional nutritional support are reserved for more severe cases.

Confirming the cause

- First, blockage is excluded. Delayed emptying is usually confirmed using a standardized four-hour solid-meal gastric emptying test; shorter tests may miss some cases. The team will explain which medicines to adjust beforehand and how to manage glucose if you have diabetes.
- Tell your doctor about diabetes or weight-loss medicines such as semaglutide and tirzepatide, and opioid painkillers, which may affect stomach emptying. Do not stop them yourself.

Treatment options

- Medicines may be prescribed to improve stomach movement or reduce vomiting. Your doctor chooses the medicine and duration according to benefits and side effects.

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- If involuntary movements or facial or neck spasms occur while taking a medicine for stomach movement, seek prompt assessment and do not take another dose before receiving advice.
- Severe cases may need nutritional support or specialist procedures. Preventing dehydration and malnutrition matters as much as relieving nausea.

Planning meals

- Divide food into five or six small meals. Choose soft or finely chopped foods such as smooth soup, soft rice, mashed potato and tender protein.
- Reduce fat and coarse fiber if these worsen symptoms. Avoid hard vegetable pieces, skins and large portions. Do not impose a low-calorie diet without a dietitian.
- Nourishing liquids or puréed foods may be easier to tolerate. Take a gentle walk after eating and avoid lying down immediately.

If you have diabetes

- Irregular stomach emptying can make glucose fluctuate. Ask for a glucose-monitoring and insulin plan for reduced intake or vomiting; do not change doses at random.
- Record weight, vomiting and food and fluid intake. Contact the team if urine output falls or you cannot keep medicines and fluids down.
- Do not use herbs or motility medicines yourself; some can affect heart rhythm or the nervous system.

When to get help

Get urgent medical care / go to the emergency department

Vomiting that prevents fluid intake with dehydration or fainting, vomiting blood, severe pain and swelling, or a major glucose disturbance with significant illness.

Contact your care team promptly

Repeated vomiting, weight loss, reduced food intake or side effects from a motility medicine.

Related guides: Gastroscopy

Sources and further information NIDDK: treatment NIDDK: eating and nutrition NIDDK: understanding gastroparesis NIDDK: diagnosing gastroparesis Clinical guideline: AGA September 2025

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Pancreatitis and pancreatic enzyme insufficiency

Last updated: 10 November 2026 · Pancreatitis and exocrine pancreatic insufficiency

Pancreatitis can be acute or chronic. Some conditions reduce digestive enzyme production and cause malabsorption; understanding the cause, nutrition and treatment plan supports recovery and follow-up.

Your next step

Write down the cause of your attack and its treatment plan. Do not miss gallbladder treatment if gallstones were the cause.

What does the pancreas do?

The pancreas is a gland behind the stomach with two important jobs: making enzymes that help the bowel digest food, and hormones such as insulin that regulate glucose. Pancreatitis occurs when the gland is injured and inflammation develops inside it; digestive enzymes can contribute to the damage.

Acute pancreatitis begins suddenly, usually with strong upper abdominal pain that may spread to the back, with nausea or vomiting. Many cases improve with treatment, but some require a prolonged hospital stay because of complications. Chronic pancreatitis involves continuing damage and scarring that may reduce enzyme or insulin production, causing poor digestion or diabetes.

Understanding the type and cause

Diagnosis combines symptoms, examination and tests such as lipase, with imaging when needed. Gallbladder imaging, triglyceride testing and a review of medicines and medical history help identify the cause. A single abnormal test is not interpreted in isolation, and not everyone needs the same scan or procedure.

During an acute attack, treatment supports the body, relieves pain, monitors organ function and addresses the cause. Afterwards, the aim is to prevent recurrence. In chronic disease, nutrition, stool, weight and glucose are monitored; enzymes with meals or diabetes and pain treatment may be needed. Disappearance of pain does not always mean pancreatic function has returned to normal, so follow-up is individualized.

Acute or chronic?

- Acute pancreatitis is a sudden attack that can be mild or severe. Chronic pancreatitis causes ongoing damage and may lead to poor food digestion or diabetes.
- Gallstones, alcohol, high triglycerides and some medicines can cause pancreatitis; other causes also exist.

During an acute attack

- Hospital care may be needed for fluids, pain relief and monitoring complications. Antibiotics are not required for every attack, only for infection or another specific medical reason.

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- In mild cases, food is restarted early as tolerated according to the team’s plan. Do not impose prolonged fasting on yourself after discharge.
- Gallstones may require gallbladder treatment and sometimes ERCP if there is bile duct obstruction or infection. Not every episode of pancreatitis needs ERCP.

After discharge

- Understand the likely cause and treatment plan, including scan or surgery appointments if needed. Some collections around the pancreas are monitored; others require intervention.
- Bring your medicine list. Do not stop or restart a suspected medicine without agreeing this with your doctor.

When should enzyme insufficiency be suspected?

- It can follow chronic or severe pancreatitis, pancreatic surgery or other pancreatic and digestive conditions. Signs include oily stools that are difficult to flush, diarrhea, bloating, weight loss and vitamin deficiencies. Floating stool alone does not establish the diagnosis.

Checking the cause

- Assessment reviews nutrition, weight, symptoms, illnesses and operations. Fecal elastase may be measured using a solid or semisolid stool sample. A watery sample may produce a misleading low result requiring repeat testing or interpretation alongside other findings.
- Blood tests may assess deficiencies and imaging may investigate pancreatic disease. Imaging alone does not measure digestive function, and improvement with an enzyme trial alone does not confirm the diagnosis. Testing depends on your individual likelihood of disease.

Taking pancreatic enzymes

- Prescribed enzymes are taken during meals and nourishing snacks so they mix with food. Do not take the whole day’s dose together or rely on taking them well away from food. Dose depends on meals, response and the product prescribed.
- Do not chew or crush the granules. If swallowing capsules is difficult, ask the pharmacist whether and how your specific product can be opened. General digestive-enzyme supplements are not substitutes for prescribed treatment; do not change the dose randomly.

Food and vitamins

- Avoid imposing a severely fat-restricted diet yourself; this can worsen calorie intake and weight loss. A dietitian can help maintain adequate energy and protein and spread meals, with enzymes matched to food and the clinical plan.
- Fat-soluble vitamins A, D, E and K and bone health may need assessment, with suitable replacement for deficiencies. Avoid unsupervised high-dose vitamins and review glucose management if you have diabetes.

Checking whether treatment works

- Follow-up considers weight, muscle, stool, food intake and blood tests rather than diarrhea frequency alone. Persistent problems prompt a review of enzyme timing, dose and adherence and investigation of other causes before changing treatment.

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Reducing repeat attacks

- Avoid alcohol and stop smoking. Manage triglycerides and diabetes according to the plan.
- If gallstones caused a mild attack, gallbladder removal is usually recommended during the same admission, before discharge, if your condition allows. Severe attacks or collections around the pancreas may require delaying surgery according to the team's assessment. Monitor weight, glucose and new symptoms.
- New persistent pain or weight loss needs review; do not assume it is simply an old effect of pancreatitis.

When to get help

Get urgent medical care / go to the emergency department

Severe upper abdominal pain spreading to the back, particularly with vomiting or fever; or jaundice, breathlessness, fainting or deterioration after discharge.

Contact your care team promptly

Repeated greasy stool, weight loss, recurring pain or new glucose fluctuations.

Related guides: Gallbladder and bile duct stones · Endoscopic ultrasound · Bile duct stones and obstructive jaundice · Pancreatic cancer · Chronic diarrhea · Pancreatic enzymes: pancreatin / Creon · Pancreatic cysts · Alcohol-related liver disease

Sources and further information NIDDK: treatment ACG: acute pancreatitis NIDDK: definition of pancreatitis NIDDK: diagnosing pancreatitis Clinical guideline: IAP 2025, endorsed by APA/EPC/IPC/JPS AGA: EPI clinical practice update NIDDK: diagnosis NIDDK: treatment NIDDK: nutrition UEG and collaborating societies: PEI guideline

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Colorectal cancer screening

Last updated: 10 November 2026 · Colorectal cancer screening

Screening is performed before symptoms develop. Blood in stool, anemia or a persistent change in bowel habits requires diagnostic assessment rather than waiting for routine screening.

Your next step

Clarify your risk and screening date, and follow every positive result through to the required colonoscopy.

Why screen when I feel well?

Colorectal cancer is uncontrolled growth of cells in the large bowel lining. Many cancers begin as certain polyps that change gradually over time, although most polyps are not cancerous when discovered. Polyps and early cancers may cause no obvious symptoms.

Screening before symptoms can detect an early cancer that is easier to treat, or find and remove a polyp before it changes. Feeling well or having no affected relatives does not remove the benefit of screening when due. Family or personal history may mean starting earlier or having closer follow-up.

Stool testing versus colonoscopy

FIT detects small amounts of blood in stool that you cannot see. It does not show the colon or remove polyps. Colonoscopy examines the lining, takes samples and can remove many polyps during the same procedure. Each option has different preparation, repetition and advantages; the choice depends on risk and health.

A positive stool test does not diagnose cancer. It signals the need for further investigation, usually colonoscopy. A negative test does not provide permanent protection or explain visible bleeding or weight loss. Symptoms change the task from screening to diagnostic assessment, and the required tests may differ regardless of age or the last screening date.

Who should start screening?

- The Saudi program generally targets symptom-free adults at average risk aged 45–75. Your doctor discusses timing according to your health and previous tests. Average risk means there are no factors requiring earlier assessment, such as a significant family history or previous polyps.
- Family history, previous polyps, chronic colitis or inherited syndromes may require an earlier, different plan.

What are the options?

- The fecal immunochemical test (FIT) uses a stool sample collected at home and is usually repeated yearly after a negative result in average-risk people.
- Colonoscopy examines the lining and allows polyp removal. After a normal, high-quality examination, the interval may be ten years for average-risk people, but findings may require a shorter interval.

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- Choose the appropriate test with your doctor. Do not assume these intervals apply if you have symptoms or risk factors.

What does the result mean?

- A positive FIT does not necessarily mean cancer, but usually needs colonoscopy. Repeating FIT to obtain a negative result does not replace the required colonoscopy.
- A negative FIT does not rule out every tumor or explain symptoms. Continue assessment if worrying signs persist.

Collecting the stool sample

- Follow the kit instructions and do not mix the sample with urine or toilet water. Label it and return it within the specified time.
- If you have visible bleeding, are menstruating or think the sample may be contaminated, contact the service before collecting it. Do not stop blood thinners or other medicines yourself.

Prevention and follow-up

- Tell your doctor which relative was affected and their age at diagnosis. Keep colonoscopy and polyp pathology reports.
- Be physically active, avoid smoking and limit processed meat within a balanced diet. Lifestyle does not replace screening when due.
- Arrange follow-up of the result. If the test is positive, do not delay colonoscopy because you feel well or assume the blood comes from hemorrhoids.

When to get help

Get urgent medical care / go to the emergency department

Heavy bleeding, fainting, severe pain with swelling and vomiting or inability to pass gas, or black, tarry stool even without dizziness.

Contact your care team promptly

Recurring blood in stool, anemia, weight loss, persistent changes in bowel habits, or a positive FIT requiring colonoscopy arrangements.

Related guides: Colonoscopy · Colon polyps · Colon and rectal cancer

Sources and further information Saudi Ministry of Health: early detection NIDDK: colonoscopy NCI: colorectal cancer screening

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Primary sclerosing cholangitis (PSC)

Last updated: 10 November 2026 · Primary sclerosing cholangitis · PSC

A chronic disease causing bile duct narrowing. Organized follow-up and treatment of obstruction and infection are important even when symptoms are mild.

Your next step

Record your bile duct imaging, colonoscopy and any stent follow-up appointments.

What does bile duct scarring mean?

Bile ducts carry bile made by the liver to the bowel. In PSC, the duct walls become inflamed and scarred, creating narrowed areas that impede bile flow. Ducts inside and outside the liver may be affected, potentially leading to liver injury and fibrosis over time.

The exact cause is unknown; immune activity, genetic susceptibility and other factors are thought to contribute. It is not an infection spread by contact. Narrowed ducts may develop a bacterial infection as a complication. This infection is separate from the underlying chronic disease and needs prompt treatment when symptoms appear.

Why does follow-up involve several areas?

There may initially be no symptoms, or itching, fatigue, abdominal discomfort or jaundice may occur. Abnormal bile-related blood tests may draw attention, but duct imaging helps show the location and nature of narrowing. Sometimes the large ducts are normal and small-duct disease requires a different assessment.

We monitor the liver, ducts and bowel because PSC may coexist with inflammatory bowel disease, and complications can start without clear symptoms. Imaging or a biopsy does not mean cancer is present; the aim is to exclude important causes of narrowing and monitor risk according to your situation. Progression varies, and treatment depends on symptoms, obstruction and liver function, not the disease name alone.

How is it related to other diseases?

- PSC differs from primary biliary cholangitis (PBC), which generally affects small ducts inside the liver. PSC may coexist with ulcerative colitis or Crohn’s disease, sometimes without obvious bowel symptoms.

Tests and follow-up

- MRI of the bile ducts (MRCP) is commonly used, alongside liver blood tests and fibrosis assessment. A biopsy may be needed in selected cases.
- Colonoscopy and biopsies may be requested to look for inflammatory bowel disease. If present, closer colon surveillance is needed, often every one to two years according to the plan.
- The specialist determines surveillance for bile duct and gallbladder cancers. This may include yearly imaging for adults with large-duct disease; plans differ in other situations.

Treatment

- No medicine guarantees that disease progression will stop in everyone. We treat itching, infection and important strictures. A specialist may select medicines or clinical studies for some patients.
- ERCP is used for treatment when needed, not routinely at every visit. Samples may be taken from an important stricture, or a temporary stent inserted.

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IBD can be present without bowel symptoms

- A colonoscopy with biopsies is generally recommended when PSC is diagnosed to check for associated inflammatory bowel disease, even if bowel symptoms are absent. Your specialist sets repeat examination intervals according to the findings.

If a stent is inserted

- Obtain a written date for its removal or exchange. Do not leave it without follow-up even if blood tests improve.
- Fever or chills with jaundice or pain may indicate bile duct infection and requires urgent assessment. Do not wait for a routine appointment.

Long-term care

- Monitor itching, fatigue, nutrition and bone health; vitamin tests may be needed. Do not start high-dose vitamins or bile-related medicines yourself.
- Avoid alcohol, smoking and unknown supplements. Advanced liver fibrosis requires additional monitoring for its complications.
- Liver transplantation may be discussed for liver failure, severe complications or repeated infections. This is a specialist decision, not one based on a single blood test.

When to get help

Get urgent medical care / go to the emergency department

Fever or chills with jaundice or upper abdominal pain, confusion, vomiting blood or rapid deterioration.

Contact your care team promptly

Increasing itching or jaundice, unexplained weight loss or an unclear stent follow-up date.

Related guides: Ulcerative colitis · Primary biliary cholangitis · Bile duct stones and obstructive jaundice · Bile and pancreatic duct endoscopy (ERCP) · Liver transplantation: when is evaluation needed?

Sources and further information NIDDK: treatment AASLD: disease guidance NIDDK: primary sclerosing cholangitis NIDDK: disease and complications AASLD: PSC diagnosis and follow-up AASLD PSC/CCA guidance · 2022

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Care after liver transplantation

Last updated: 10 November 2026 · Liver transplant aftercare

Taking anti-rejection medicines consistently and attending blood tests are central to protecting the transplanted liver. Problems may appear in tests before you feel symptoms.

Your next step

Check your anti-rejection medicine supply, blood-level testing instructions and transplant-team contact number.

What has changed after transplantation?

Transplantation replaces a diseased liver with a donor liver or part of one. The transplanted liver performs important bodily functions, but the immune system may recognize it as foreign tissue and attack it: this is rejection. Anti-rejection medicines reduce that response and are therefore usually continued for life under transplant-team supervision.

Rejection may be detected on blood tests before symptoms develop, but abnormal tests can also have causes other than rejection. Symptoms alone do not diagnose it, and rejection does not automatically mean transplant failure. Regular monitoring helps identify it early, and it can often be treated successfully.

Anti-rejection medicines

- Take them at consistent times and follow the instructions about food. Do not stop them because tests are normal, or change the formulation or strength yourself.
- If you miss a dose or vomit after it, call the team for instructions. Do not automatically repeat the dose or double the next one.

Medicine level blood tests

- A level may need to be taken immediately before the next dose. Obtain written instructions for your last dose and blood draw, and bring the medicine to take afterwards if instructed.
- Do not delay doses all day yourself. Record dose and sample times, because interpreting the level depends on both.

Interactions and monitoring

- Check with your transplant team or pharmacist before any new medicine, including antibiotics, herbs or painkillers. Avoid grapefruit and its juice, and review the food-interaction list for your own medicine.
- Monitor liver and kidney function, blood counts, blood pressure, glucose and lipids. Rejection is not diagnosed by symptoms alone; further assessment or biopsy may be necessary.

Prevention and nutrition

- Wash your hands and avoid exposure to infections where possible. Eat thoroughly cooked food and pasteurized dairy, and follow your transplant center’s food-safety advice.

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- Review vaccinations with the team; do not receive live vaccines without their approval. Use sun protection and attend skin checks and cancer screening according to your plan.
- Increase activity gradually as your surgeon advises, and maintain a healthy weight without extreme dieting.

Prepare before travel or pregnancy

- Arrange an adequate medicine supply, reports and contact details. Discuss travel, returning to work and exercise according to your recovery stage.
- Plan pregnancy with the team in advance. Some transplant medicines can harm a developing baby and require a planned switch. Do not stop them yourself.
- Contact the team the same day for vomiting, diarrhea or difficulty obtaining medicine, as absorption or medicine levels may change.

When to get help

Get urgent medical care / go to the emergency department

Fever with significant illness, breathing difficulty, confusion, severe pain, bleeding or markedly reduced urine. Follow your center’s temperature threshold and emergency instructions.

Contact your care team promptly

Any new fever, jaundice, persistent vomiting or diarrhea, missed dose or shortage of medicine: contact the transplant team the same day.

Related guides: Liver cirrhosis (F4) · Liver biopsy and FibroScan · Pregnancy and breastfeeding with bowel and liver disease · Fasting, travel and medicine planning · Azathioprine / Imuran · Liver transplantation: when is evaluation needed? · Living liver donation: a guide for donors and families · Anti-rejection medicines after liver transplantation: a practical guide · Tacrolimus: preventing transplant rejection · Mycophenolate: CellCept and Myfortic

Sources and further information NIDDK: life after transplantation NHSBT: transplant medicines NHS: liver transplant rejection AASLD/AST LT non-graft complications · 2026 AASLD/AST LT graft complications · March 2026

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Herbs, mixtures and supplements: benefits and risks

Last updated: 10 November 2026 · Herbs, mixtures and supplements: benefits and risks

A practical guide to common herbs and postpartum, weight-loss and sports products. Natural does not necessarily mean safe; risk depends on the product, exposure and your health.

Your next step

Photograph all herb and supplement packages and record doses and dates. Ask whether you need them and whether they suit your health.

How can the liver be affected?

A herb or supplement may inflame liver cells or interfere with bile flow. Injury may start without symptoms or cause fatigue, nausea, itching or jaundice. Many cases improve when the cause is stopped, but some become severe and need hospital treatment, occasionally including liver transplantation.

A reaction can occur even at the labelled dose. Concentrated extracts, multiple or unknown ingredients, contamination and undeclared drugs complicate assessment. Symptoms starting after a product do not prove it caused them; other causes must be excluded.



Ordinary food amounts | **Concentrated extracts and capsules** | **Mixtures with unknown ingredients**

Illustrative categories, not a guide to identifying plants or a guarantee of product safety.

Before you start

- What is the product intended to do? Is benefit established for your condition? Could it interact with your medicine? Ask your doctor or pharmacist.
- Bring the product name and a photograph of its ingredient list. The herb’s name alone is not enough, as concentrations and mixtures vary.
- Avoid mixtures of unknown composition and claims of “liver cleansing” or rapid weight loss. You do not need a supplement to cleanse your liver.

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Ordinary food differs from a concentrated extract

- Cooking amounts of turmeric and brewed green tea are different from curcumin capsules or concentrated green tea extract. More is not necessarily better, and none should replace liver treatment.
- Reports of liver injury do not mean every user will be affected, while a lack of reports does not prove complete safety. Brands, manufacturing methods and ingredients can differ despite similar names.

Bodybuilding and weight-loss products

- Anabolic steroids and some products marketed as SARMs, such as ostarine and ligandrol, can cause serious liver injury with prolonged jaundice and itching. Some products contain undeclared steroids. A label saying “for research only” is not a safety assurance.
- Marked jaundice and itching need assessment even when liver enzyme elevations are modest. A lower enzyme level alone does not mean mild disease.
- Whey protein and creatine monohydrate are not anabolic hormones and are not established major causes of liver injury with conventional use of reliable products. This does not guarantee every product or mixture is safe. People with liver or kidney disease need individual advice.
- “Detox” mixtures and laxatives can cause water loss and dehydration; this is not sustainable fat loss.

Traditional postpartum herbal mixtures

- These may include fenugreek, garden cress, cinnamon, black seed, ginger, fennel or anise. They are not all established liver toxins in ordinary food amounts. Unknown mixtures, high doses and concentrated extracts are more concerning; do not use Teucrium polium as a postpartum remedy.
- Fenugreek is not a common or well-established cause of liver injury, but limited reports describe harm during supplement use, sometimes in mixtures. They cannot establish that fenugreek alone caused every case. Allergy, low blood sugar and medicine interactions are also possible.
- Safety in food amounts does not establish safety at medicinal doses during pregnancy or breastfeeding. Avoid amounts of fenugreek above food levels in pregnancy, and seek advice before milk-supply supplements. Assessment of feeding and nutrition comes before an unknown mixture.

Transplantation, pregnancy and medicine interactions

- After liver transplantation, check every herb or supplement with the transplant team, even if it is not known to injure the liver: it may alter anti-rejection medicine levels. For example, St John’s wort can reduce cyclosporine effectiveness. Pregnancy, breastfeeding, and planned procedures also require review. Bring the container or a label photograph, and disclose every ingredient and when you started it.

Ashwagandha

- It may help some people with sleep or stress, but liver benefits are unproven and rare liver injury has been reported.
- Avoid ashwagandha products if you have liver disease, and during pregnancy or breastfeeding. Consult your doctor if you have thyroid disease or take sedatives or immunosuppressants.

Milk thistle (silymarin)

- A clear treatment benefit for fatty liver or viral hepatitis has not been established. Lower liver enzymes alone do not prove that fibrosis has improved.
- It may cause digestive upset or allergy, and product quality varies. Discuss whether you need it rather than assuming it is harmless.

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Peppermint oil and IBS

- Enteric-coated capsules may help some patients with pain in the short term, but can worsen heartburn and reflux.
- Choose an appropriate product with your doctor or pharmacist. Do not drink concentrated essential oils or substitute them for capsules intended for medical use.

Apple cider vinegar and black seed

- Using them in food does not mean that drinking vinegar or taking oils or capsules treats fatty liver. Do not replace diabetes or liver medicines with them.
- Concentrated vinegar can irritate the esophagus and damage teeth. Concentrated products need review of ingredients and interactions, especially with diabetes and blood pressure medicines.

What should I tell my doctor?

- Include every product, even one sold as food, tea or a sports powder: name, packaging and ingredient photos, dose, and start and stop dates. Mention weight-loss, bodybuilding and postpartum products, including those used in the preceding months.
- If symptoms suggest a reaction, do not take another dose of a non-essential supplement before assessment; keep the packaging. Do not stop all prescribed medicines, especially transplant medicines, yourself. Do not retry a product suspected of causing liver injury without a specialist decision.

How is it assessed and followed up?

- Liver and clotting tests and imaging may be needed to exclude blocked ducts, infection and other causes. No single test proves a herb caused the problem. Your doctor determines whether hospital care is needed and arranges monitoring and adverse-event reporting.
- Tests may take weeks or months to return to normal. Do not substitute a “liver cleanse”. Bring your product list to each visit, including after recovery.
- Vitamins prescribed for a proven deficiency differ from unsupervised use; do not stop them merely because they are called supplements.

Herb directory

Open the group you need. This is not an exhaustive list: an unlisted product is not necessarily safe, and an unknown mixture cannot be assessed without its ingredients.

Products linked to important liver injury

Ingredient or product	What should I know?
Concentrated turmeric / curcumin	Can cause liver-cell inflammation, occasionally severe; cooking amounts differ. Some products enhance absorption.
Green tea extract	A recognized cause of liver injury, including in some weight-loss products; not equivalent to ordinary brewed tea.
Ashwagandha	Rare injury may combine inflammation and impaired bile flow. Avoid products containing it if you have liver disease.
Garcinia cambogia	Marketed for weight loss; linked to hepatitis, occasionally severe.
Kratom	May cause impaired bile flow or mixed injury with itching and jaundice; not a liver treatment.
Teucrium polium (germander)	Linked to serious injury, with reported cases requiring transplantation; avoid medicinal use.

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Ingredient or product	What should I know?
Khat	May cause acute or chronic hepatitis, sometimes with autoimmune-like features.

Risks that depend on exposure and strength of evidence

Ingredient or product	What should I know?
Cinnamon	Concern is greater with coumarin-rich cassia cinnamon in large or prolonged amounts; moderate food use differs from concentrated supplements.
Senna	Liver injury is rare, particularly reported with high doses or prolonged excessive use; follow your prescribed laxative plan.
Oral aloe vera	Rare hepatitis cases have been reported with products taken by mouth; this differs from topical skin gel.
Moringa	Very rare reports; not an established major liver toxin. Sparse reports do not guarantee high-dose or mixed products are safe.

Common herbs: other important risks and interactions

Ingredient or product	What should I know?
Licorice	It is not a recognised major cause of liver injury, but it can raise blood pressure, lower potassium, and cause fluid retention or abnormal heart rhythms. Avoid medicinal or repeated use without clinical advice, particularly with ascites, heart or kidney disease, diuretics, or other interacting medicines.
Indian costus (Saussurea costus)	It is not a proven treatment for liver disease. Product quality and mistaken plant identity matter: some substitute herbs may contain kidney-toxic aristolochic acids. This does not mean authentic costus always contains them. Avoid unidentified mixtures and show the packaging to your clinician or pharmacist.
Myrrh	Traditional use of certain topical or mouth-rinse products does not establish the safety of swallowing homemade mixtures or a benefit for liver disease. Medicinal use is not recommended during pregnancy or breastfeeding because safety data are insufficient. Discuss oral preparations with your clinician, especially when taking other medicines.
Harmal (Peganum harmala)	Ingestion can cause serious poisoning affecting consciousness, the nervous system, and the heart; severe cases may also injure the kidneys and liver. Do not use it for self-treatment, particularly during pregnancy. Common names may refer to different plants, so a name or picture alone cannot confirm plant identity.

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Culinary and postpartum herbs: what do we know about safety?

Ingredient or product	What should I know?
Ginger	It is not an established major cause of liver injury and may help some types of nausea, but it does not treat liver disease. It can worsen heartburn or cause diarrhoea. Food amounts differ from concentrated supplements, which should be reviewed during pregnancy, breastfeeding, or use of other medicines.
Fennel and anise	Culinary flavouring differs from frequent large amounts of herbal tea or extracts. Evidence for increasing breast-milk supply is limited. Harm has been reported with excessive use of some multi-herb lactation teas; those reports do not prove fennel or anise alone caused it. Mixtures cannot replace assessment of feeding problems.
Black seed / black cumin (Nigella sativa)	It is not a recognised common cause of liver injury, but this does not prove a benefit for viral hepatitis or cirrhosis, or guarantee every oil, capsule, or mixture is safe. Allergy can occur and product quality and concentration vary. Do not replace prescribed treatment; have concentrated products reviewed.
Garden cress (Lepidium sativum)	It is commonly included in postpartum mixtures. Food use does not establish the safety of medicinal doses or concentrated mixtures, or prove a liver benefit. It should not be labelled an established hepatotoxin, nor should all products be assumed safe. Review mixtures during pregnancy, breastfeeding, or liver disease.

These examples are not a precise risk ranking. Case reports alone cannot compare injury rates between ingredients.

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When to get help

Get urgent medical care / go to the emergency department

Jaundice with confusion or unusual drowsiness, bleeding, persistent vomiting, fainting or rapid deterioration: go to emergency care immediately; do not wait for WhatsApp.

Contact your care team promptly

New jaundice, dark urine, severe itching or abnormal liver tests during or after a supplement: seek same-day assessment. Do not take another dose of a non-essential supplement before assessment.

Related guides: Fatty liver and steatohepatitis · Food guide for fatty liver · Irritable bowel syndrome · Care after liver transplantation · Drug-induced liver injury · Raised liver enzymes: what do they mean? · Pregnancy and breastfeeding with bowel and liver disease · Liver transplantation: when is evaluation needed? · Eating well with cirrhosis

Sources and further information NIH: ashwagandha NIH: turmeric NIH: green tea NIH: milk thistle NIH: peppermint oil FDA: bodybuilding supplement risks Complete sources in the online herb guide

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Gilbert’s syndrome

Last updated: 10 November 2026 · Gilbert syndrome

A benign inherited condition in which the liver processes bilirubin more slowly. It does not damage the liver and usually needs no treatment once the diagnosis is confirmed.

Your next step

Keep the test results confirming your diagnosis and understand your usual pattern of jaundice.

What does benign mean?

The issue is how quickly the bilirubin pigment is processed, not inflammation attacking liver cells or a bile duct blockage. Bilirubin may be mildly raised while other liver tests are normal. “Benign” means Gilbert’s syndrome itself does not damage the liver or progress to advanced fibrosis.

You may only discover it after a test for another reason, or notice brief episodes of mildly yellow eyes. However, new jaundice should not be attributed to Gilbert’s without assessment, especially with dark urine, pale stool, marked itching or pain, which are not its usual pattern.

Why does yellowing occur?

- Bilirubin is a pigment produced as red blood cells are renewed. In Gilbert’s syndrome it is processed more slowly, causing mild, intermittent rises in unconjugated (indirect) bilirubin.
- Mild yellowing of the eyes can appear with illness, dehydration, reduced food intake, fasting or stress. Not every episode of jaundice means you have Gilbert’s syndrome.

How is it diagnosed?

- Your doctor reviews the bilirubin type and other liver tests, and may rule out red blood cell breakdown or other causes. Other liver tests are usually normal.
- Biopsy or genetic testing is usually unnecessary. Additional tests depend on whether results or symptoms are unusual.

A normal life without a special diet

- Eat regularly and drink an appropriate amount of fluid. Avoid dehydration and prolonged fasting that triggers symptoms for you.
- You do not need herbs or supplements to lower bilirubin. It is not infectious, does not cause advanced liver fibrosis and does not shorten life.

Medicines and follow-up

- Tell your doctor about Gilbert’s syndrome before new treatment. Some medicines, such as irinotecan, require particular attention. Do not stop prescribed medicine yourself.
- Once the diagnosis is confirmed, extensive repeat testing is usually unnecessary for a familiar mild elevation unless symptoms or results change.

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When to get help

Get urgent medical care / go to the emergency department

Jaundice with confusion, severe pain, fever, repeated vomiting or significant illness needs urgent assessment; do not attribute it to Gilbert’s syndrome.

Contact your care team promptly

First-time, unusually severe or persistent jaundice, particularly with dark urine, pale stool or new itching.

Related guides: Herbs, mixtures and supplements: benefits and risks

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Sources and further information NHS: Gilbert’s syndrome

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Liver biopsy and FibroScan

Last updated: 10 November 2026 · Liver biopsy and FibroScan

FibroScan estimates liver stiffness without a needle, while biopsy examines a small tissue sample. Each has a role; you may need one or both.

Your next step

Confirm which test you need and obtain preparation instructions from the unit performing it.

Why might the doctor request these tests?

We may need to identify why blood tests are abnormal, how much scarring is present or how active inflammation is. Each test answers a different question: FibroScan estimates tissue stiffness, whereas biopsy allows a sample to be examined under a microscope. Neither completely replaces the other, and not every patient needs a biopsy.

What do F0–F4 mean?

F0 means no fibrosis. F1 is mild fibrosis, F2 moderate fibrosis and F3 advanced fibrosis; F4 is cirrhosis. These describe scarring, not the amount of liver fat. FibroScan measures stiffness to help estimate the likelihood of fibrosis; it does not directly measure scar tissue or determine an exact stage in every person.

A lower stiffness reading after treatment may partly reflect less inflammation. It does not by itself prove that scarring has disappeared or that previously established cirrhosis has resolved. Your doctor reviews the full assessment before changing follow-up.

What is the difference?

- FibroScan is a quick test through the skin that estimates stiffness to help assess fibrosis and may also measure fat. It does not establish the cause of disease by itself.
- Biopsy takes a small sample using local anesthetic, sometimes with sedation, to assess inflammation, the type of disease and fibrosis when the result could change treatment.

Understanding a FibroScan result

- Greater stiffness does not always mean advanced fibrosis; inflammation and recent food intake can affect the result. Your doctor interprets it with blood tests, measurement quality and the underlying disease.
- Do not compare your number with internet cut-offs or another patient’s result. Its meaning may vary with the situation.

Before your appointment

- For FibroScan, follow the center’s food and drink restrictions; many centres request around three hours. Ask beforehand about diabetes medicines and permitted fluids.

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- For biopsy, bring all medicines and supplements, particularly blood thinners, aspirin and diabetes medicines. Get written instructions about fasting and stopping or restarting medicines; do not change them yourself.

During and after biopsy

- The sample may be taken through the skin or through a vein in the neck, depending on your condition. Before consent, the team explains the method and risks, particularly pain and bleeding.
- You will remain under observation according to unit instructions. Arrange a companion and transport home, and follow advice about driving, work, exercise and heavy lifting.

Before leaving the unit

- Obtain a contact number, a painkiller and blood-thinner plan, and a date to discuss the result. The report may take several days or longer.
- Not being contacted does not mean the result is normal. Check with the team if the report is later than expected.

When to get help

Get urgent medical care / go to the emergency department

After biopsy, severe or worsening abdominal, shoulder or chest pain, breathlessness, dizziness or fainting, bleeding, fever or black stool requires urgent assessment.

Contact your care team promptly

Unclear fasting, blood-thinner or diabetes medicine instructions, or a delayed biopsy result.

Related guides: Fatty liver and steatohepatitis · Liver cirrhosis (F4) · Raised liver enzymes: what do they mean? · Hereditary iron overload (hemochromatosis)

Sources and further information NIDDK: liver biopsy NHS: FibroScan SingHealth: interpreting FibroScan BSG/RCR/RCPath liver biopsy guideline · 2020; validity reviewed December 2024; next review 2028 AASLD EXPO: liver biopsy (expert opinion document) · October 2026 AASLD: fibrosis stages AASLD: regression of fibrosis and cirrhosis (2026)

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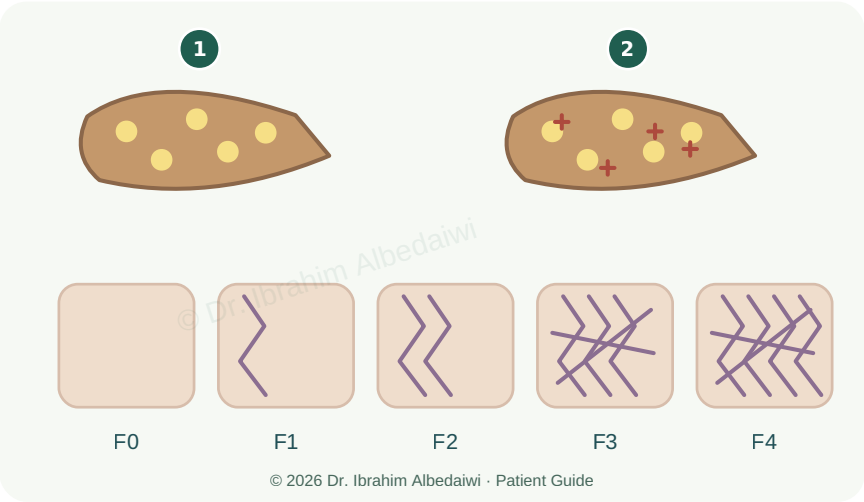
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ILLUSTRATED PATIENT GUIDE

Fat, fibrosis and cirrhosis: what is the difference?

Fat in the liver does not automatically mean fibrosis or cirrhosis. Not everyone develops these stages.



1 · Fat accumulation: MASLD

Fat builds up inside liver cells.

2 · Steatohepatitis: MASH

Fat accompanies liver-cell injury and inflammation; scars may develop.

F0 · No fibrosis

This staging system describes scarring, not the amount of liver fat.

F1–F3 · Fibrosis before cirrhosis

F1: mild · F2: moderate · F3: advanced bridging fibrosis, before F4.

F4 · Cirrhosis

Extensive scarring alters liver structure and may affect blood flow and function.

> Fibrosis can regress when its cause is treated, especially earlier stages. F4 can also improve, but this does not guarantee a normal liver or remove the need for follow-up. Progression is not inevitable; enzymes or stiffness alone cannot establish the stage.

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AASLD: fibrosis stages
AASLD: regression of fibrosis and cirrhosis (2026)

These illustrations support education and do not replace your doctor’s advice or follow-up. Plans vary by patient.

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Understanding hepatitis B blood tests

Last updated: 10 November 2026 · Understanding hepatitis B tests

Some tests detect infection; others indicate immunity or previous exposure. Treatment decisions depend on the combination of results and your situation, not a single number.

Your next step

Bring the complete report with test dates, treatment list and previous vaccination record.

Three different questions behind the tests:

Some tests ask whether infection or immunity is present. Others measure the amount of virus, while further tests assess its effect on the liver. “Positive” or “negative” is not enough without the test name and date. Results may need repeating or combining with imaging and fibrosis assessment to reach a clear decision.

Test	What it means
HBsAg — surface antigen	A positive result usually indicates current infection and is interpreted with other results. Persistence for six months or longer supports chronic infection.
Anti-HBs — surface antibody	May indicate immunity after vaccination or recovery. Interpretation depends on test timing, vaccination history and health.
Total Anti-HBc — core antibody	Usually indicates previous exposure or current infection; vaccination alone does not produce it. An isolated positive result needs further interpretation.
HBeAg and Anti-HBe	Help assess the phase of infection. Negative HBeAg does not rule out viral replication.
HBV DNA — viral genetic material	Measures the amount of virus in the blood and monitors treatment. An undetectable result during treatment does not mean complete cure or permission to stop medicine.
ALT and AST	Markers of cell injury. They can rise for other reasons, and normal levels do not exclude fibrosis.

Three points to prevent confusion

- A result that has not been reported or is marked “pending” is not a negative result.
- Positive Anti-HBc alone does not mean active infection now, but matters before immunosuppressive treatment because of possible reactivation.
- Do not stop treatment when blood tests improve. Liver cancer surveillance may still be needed despite a low viral level.

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Ask at your appointment

Is the infection current or past? Do I need treatment now? When should tests be repeated? Do I need regular liver imaging?

When to get help

Get urgent medical care / go to the emergency department

Severe jaundice with significant illness, confusion or bleeding needs urgent assessment, regardless of your last viral result.

Contact your care team promptly

Before prolonged steroids, biologics or chemotherapy, tell the team about any previous infection even if HBsAg is negative.

Related guides: Hepatitis B · Liver biopsy and FibroScan · Liver cancer surveillance

Sources and further information CDC: interpreting hepatitis B tests EASL HBV CPG · 9 May 2025 AASLD/IDSA chronic HBV guideline · 4 November 2025

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A family guide to cirrhosis

Last updated: 10 November 2026 · Cirrhosis caregiver guide

Family observations of everyday changes can help detect complications early. Keep a written plan for medicines, monitoring and contacting the team.

Your next step

Choose a family member who knows the medicine plan, warning signs and treatment-team contact number.

Why family observations help:

Cirrhosis (stage 4 liver scarring, F4) can affect the control of body fluids, removal of harmful substances from the blood and nutrition. Complications may begin with a small change in sleep, concentration or appetite, or increased abdominal swelling. Recognizing and reporting these changes early helps the team find the cause before the problem worsens.

Not every change in alertness is caused by the liver. Infection, bleeding, glucose or electrolyte problems, or a new medicine may be responsible. The family's role is to recognize changes and seek assessment, not diagnose the cause or adjust treatment at random.

Watch three areas:

- Alertness and behavior: new changes in concentration, speech, sleep or personality may indicate a problem needing assessment. Confusion is not simply tiredness or aging.
- Fluids: record weight according to the plan, at roughly the same time each day on the same scale. Watch abdominal and leg swelling and urine output.
- Food and medicines: monitor the ability to eat and take doses, particularly with vomiting, diarrhea or running out of medicine.

When lactulose is prescribed:

- The usual target is two to three soft stools daily according to the team's plan, not frequent watery diarrhea.
- Follow the written dose-adjustment plan. Contact the team for persistent constipation or severe diarrhea, because dehydration can worsen the problem. Do not manage new confusion only by increasing doses and delaying assessment.

Protect muscles and kidneys:

- Offer small, frequent meals with suitable protein and a bedtime snack. Do not restrict protein because of confusion.
- Reduce salt if advised, but do not restrict water or change diuretics without a plan. Fluid needs differ between patients.
- Do not add painkillers such as ibuprofen or diclofenac, sleeping medicines or herbs without checking with the team.

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Confusion or difficulty waking:

- Do not allow the patient to drive or remain alone. If they are hard to wake or cannot swallow, do not give food, drink or oral medicines; call emergency medical services.
- Bring the medicine list and latest reports. Explain when the change began and any fever, bleeding or missed doses.

Home monitoring sheet:

- Record as instructed: date, weight, number of stools, changes in alertness and new symptoms.
- Keep liver imaging and follow-up dates, and the weight-change thresholds for contacting the team.

When to get help

Get urgent medical care / go to the emergency department

Vomiting blood or black stool, new confusion or sleepiness, fever or abdominal pain with ascites, markedly reduced urine or breathlessness: seek urgent assessment.

Contact your care team promptly

Rapid weight gain or swelling, poor intake, persistent constipation or diarrhea, or difficulty obtaining medicines.

Related guides: Liver cirrhosis (F4) · Liver cancer surveillance · My treatment and follow-up plan · My cirrhosis monitoring plan · Lactulose · Rifaximin · Ascites: abdominal fluid and drainage · Hepatic encephalopathy: confusion and altered awareness · Portal hypertension and esophageal or gastric varices · Liver transplantation: when is evaluation needed? · Eating well with cirrhosis

Sources and further information AASLD: cirrhosis (advanced liver scarring) care AASLD: hepatic encephalopathy

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Hepatitis A and protecting close contacts

Last updated: 10 November 2026 · Hepatitis A and close contacts

An infection usually spread by contaminated food or water or close contact. It does not become chronic, but some cases can be severe.

Your next step

If recently exposed, prepare the exposure date and vaccination record and contact the team about prevention.

Is it the same as hepatitis B or C?

These viruses can all inflame the liver, but their transmission and course differ. Hepatitis A causes an acute, time-limited infection and does not become chronic. Most patients recover completely, and past infection usually provides protection against getting it again.

Symptoms can begin weeks after exposure, so the source may not be remembered. Young children may spread the virus without jaundice or obvious symptoms, while adults more often have symptoms. Assessment is especially important with pre-existing chronic liver disease, because infection may be more severe.

Fatigue may persist or return temporarily during recovery without meaning the infection has become chronic. We monitor symptoms, tests and liver function and advise when usual activity can resume. Eye color or symptoms cannot identify the virus; the appropriate blood test helps establish the diagnosis.

How does it spread?

- The virus passes from an infected person’s stool to another person’s mouth, usually through hands, food or water. Wash your hands with soap and water after using the toilet and before preparing food.
- Transmission can occur before symptoms. If infected, do not prepare food for others; ask the team how long precautions are needed and when to return to work or school.

Symptoms and tests:

- Fatigue, nausea, loss of appetite, jaundice and dark urine may occur. Liver enzyme levels alone do not determine severity.
- Anti-HAV IgM helps diagnose recent infection when suspected. IgG usually indicates immunity after past infection or vaccination.

Treatment and recovery:

- Treatment is usually supportive: fluids, food as tolerated and appropriate rest. An antiviral is not routinely used for this infection.
- Fatigue may last weeks, and symptoms can be prolonged or return temporarily. Attend scheduled blood tests; some patients need hospital care.

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- Review medicines and painkillers with your doctor, and avoid alcohol and herbs. Do not start a strict diet or “liver cleansing” mixtures.

After exposure: do not wait for symptoms:

- Seek prompt assessment for preventive treatment, preferably the same day. Vaccine or immune globulin is given as soon as possible within two weeks of exposure.
- The choice depends on age, vaccinations, immunity and liver disease. For exposure within the past two weeks, an unprotected person with chronic liver disease or weakened immunity is generally advised to receive both vaccine and immune globulin after medical assessment.
- Tell the doctor when contact occurred and whether you live with or provide daily care to the infected person. Do not select preventive treatment yourself.

Future prevention:

- Discuss hepatitis A vaccination if you are not immune, especially with chronic liver disease or travel to areas where it is common.
- Complete doses according to the center’s schedule and vaccine type. Preventive doses and options differ for children and some special situations.

When to get help

Get urgent medical care / go to the emergency department

Confusion or difficulty waking, bleeding, vomiting that prevents drinking, reduced urine, severe dizziness or rapid deterioration: seek urgent assessment.

Contact your care team promptly

New jaundice, symptoms after exposure or persistent symptoms. Follow-up should be closer with existing liver disease.

Related guides: Herbs, mixtures and supplements: benefits and risks · Liver cirrhosis (F4)

Sources and further information CDC: hepatitis A care and post-exposure prevention CDC: vaccine and protecting contacts CDC: hepatitis A overview CDC: hepatitis A symptoms CDC: disease basics CDC HAV clinical care · accessed 8 November 2026

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Liver cancer surveillance

Last updated: 10 November 2026 · Liver cancer surveillance

Early liver cancer may cause no symptoms. Regular screening for those who need it can find disease at a stage with more treatment options.

Your next step

Ask whether you need liver cancer surveillance, and record your next scan date and how the result will be reviewed.

Which liver cancer does this refer to?

This usually means hepatocellular carcinoma: uncontrolled growth starting in liver cells, with increased risk in people with cirrhosis (F4) and some people with hepatitis B. It differs from cancer that began elsewhere and spread to the liver. Many spots found on imaging are benign, not cancer.

Surveillance means scheduled checks before symptoms for people expected to benefit. Finding a small tumor may provide more treatment options. It does not mean every test will find a tumor or every person with liver disease will develop cancer.

Who needs surveillance?

- It is recommended for many people with cirrhosis (stage 4 scarring, F4) and some with hepatitis B, according to risk and expected benefit from treatment. Stage 3 fibrosis (F3) is not the same as cirrhosis; your specialist decides whether surveillance is needed based on the cause, risk factors and applicable guidance.
- Not everyone with fatty liver needs this program. Your doctor determines whether it is needed and the best method for your situation.

What is the usual test?

- Usually liver ultrasound with AFP blood testing every six months. If ultrasound quality is insufficient, your doctor may choose another method.
- AFP measures a protein called alpha-fetoprotein; it is not a liver enzyme. An elevated result does not prove cancer by itself, and a normal result does not exclude it.

Why continue after blood tests improve?

- Treating the virus or curing hepatitis C lowers cancer risk, but surveillance continues when cirrhosis (F4) has been established. Do not stop surveillance merely because liver enzymes or a stiffness measurement improve; your specialist sets the plan.
- Do not substitute liver enzyme blood tests for imaging or postpone screening because you feel well.

If imaging shows a spot:

- A spot does not automatically mean cancer. Contrast-enhanced CT or MRI may be required depending on its pattern and size.

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- Some very small spots need repeat imaging sooner, often in three to six months. Follow the specified date rather than waiting for routine screening.
- In certain circumstances, the imaging pattern can diagnose liver cancer; in others, biopsy is needed.

If cancer is confirmed:

- A specialist team discusses options based on tumor size and spread, liver function and overall health. Options may include surgery, ablation, catheter-based treatment, medicines or transplantation.
- Treatment cannot be selected from tumor size alone or another patient’s experience. Ask about the treatment goal and next step.

Before leaving the clinic:

- Know the next test date, how you will receive the result and whom to contact if it is delayed.
- Routine surveillance does not replace assessment of new symptoms between appointments.

When to get help

Get urgent medical care / go to the emergency department

Sudden severe abdominal pain, severe dizziness or fainting, vomiting blood, or new confusion: seek urgent assessment.

Contact your care team promptly

A new spot or unclear result without a follow-up plan, unintentional weight loss or new jaundice.

Related guides: Liver cirrhosis (F4) · Hepatitis B · Hepatitis C · Benign liver lesions and cysts · Liver cancer: diagnosis and treatment

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Sources and further information AASLD: liver cancer guidance AASLD: surveillance and diagnosis AASLD/IDSA chronic HBV guideline · 4 November 2025

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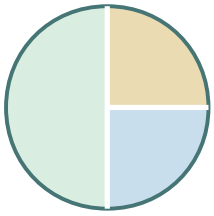
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Food guide for fatty liver

Last updated: 10 November 2026 · Food guide · MASLD / MASH

Sustainable everyday choices. The amounts below are starting points, not a fixed calorie prescription; a dietitian tailors them to weight, diabetes and activity.



A balanced plate
Half non-starchy vegetables
One quarter protein: fish, chicken or legumes
One quarter starch: rice, bread or grains
The diagram shows the area of the plate, not the proportion of calories.

From our table	A practical adjustment	Approximate starting portion
Kabsa or mandi	Use less rice and fat; choose skinless chicken with salad	Half to one cup of cooked rice; a palm-sized portion of protein
Jareesh or qursan	Reduce ghee and fat and add vegetables and protein	A small bowl; do not automatically add bread or rice
Breakfast	Eggs or unsweetened laban with wholegrain bread and vegetables	Choose a bread portion that fits your goal
Dates and fruit	A measured alternative to sweets; whole fruit is preferable to juice	One small fruit or 1–2 small dates
Drinks	Water, tea or coffee without sugar, as tolerated	Gradually reduce juices and sweetened drinks

You do not have to ban rice or dates
Portion size, reducing liquid sugar and consistency matter most. Nuts and oils can be useful in small amounts but are high in calories.

This week’s goal

Choose one goal: replace a sweetened drink, reduce the rice portion or walk regularly. Do not use “liver cleansing” mixtures. If you have advanced liver fibrosis or are underweight, do not start a weight-loss diet without assessment.

My first change: ..... | Weight review date: .....

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An example of a balanced day

- Breakfast: eggs or unsweetened laban with wholegrain bread and cucumber or tomato.
- Lunch: grilled fish or chicken, salad and a moderate amount of rice or bulgur.
- Dinner: lentil soup or fava beans with a little oil, vegetables and a suitable bread portion.
- If a snack is needed: whole fruit or a small amount of unsalted nuts. These are examples, not a compulsory calorie plan.

Three common questions

- **Should I avoid fruit?** Whole fruit does not need to be excluded; account for portions in your diet. Limit juice even if fresh and without added sugar. Honey is not an unlimited substitute for sugar.
- **Does coffee treat the liver?** Studies associate it with lower risks of some liver diseases, but it does not replace treatment. If you already drink and tolerate it, limit sugar and additions; do not start it as a medicine. Caffeine may worsen insomnia, palpitations and reflux.
- **Is intermittent fasting necessary?** It is not required for improvement; choose a pattern you can sustain. Consult the team before fasting if you take diabetes medicines. Do not start it yourself with advanced fibrosis, malnutrition or an eating disorder.

Related guides: Fatty liver and steatohepatitis · Herbs, mixtures and supplements: benefits and risks

Sources and further information EASL: nutrition and lifestyle NIH: fatty liver EASL: diet and lifestyle for fatty liver

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Mediterranean-style eating for fatty liver

Mediterranean-style eating for fatty liver

A balanced eating pattern you can maintain. Choose simple foods and adjust portions to your weight and health needs.

Choose less often

Sugary drinks and sweets

Reduce sweetened drinks, juices, frequent sweets and pastries.



Saturated fat and fried meals

Reduce fried meals and large amounts of ghee or butter. Watch rich pastries.

Processed and fatty meat

Reduce sausages, mortadella, fatty red meat and highly processed meals.

Choose more often

Vegetables and whole fruit

A variety of vegetables daily. Choose whole fruit instead of juice.



Whole grains

Oats, bulgur and wholegrain bread, in portions that suit your needs.



Legumes

Lentils, broad beans, other beans and chickpeas, as tolerated. Replace some meat meals with legumes.



Healthy fats

Measured olive oil instead of ghee or butter. Small portions of unsalted nuts.



Protein

Fish, skinless chicken and legumes. Grill or bake instead of frying.



Drinks and dairy

Water, unsweetened tea or coffee, and unsweetened laban or yogurt as tolerated.



A practical plate

Half non-starchy vegetables, one quarter protein and one quarter starchy food. These are proportions of plate space, not calories. For kabsa or mandi, reduce rice and fat, add salad and choose a suitable protein. Rice and dates do not need to be cut out completely.

Portions still matter

If overweight, aim for gradual weight loss with regular activity and a plan suited to you. Avoid alcohol. Do not start a weight-loss diet if underweight or malnourished without professional advice.

Nuts and oils are high in calories despite their benefits. Tailor portions to your weight, diabetes and activity. If you have cirrhosis (stage 4 liver scarring, F4) or are underweight, do not start a weight-loss diet without assessment. This diet is different from the low-FODMAP diet.

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Patient Guide · English edition

Enlarge the chart to read it. The complete diet guidance follows on the next page.

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Mediterranean-style eating for fatty liver

A balanced eating pattern you can maintain. Choose simple foods and adjust portions to your weight and health needs.

Choose more often

- A variety of vegetables and whole fruit rather than juice.
- Whole grains such as oats, bulgur and wholegrain bread, in portions that suit your needs.
- Legumes such as lentils, broad beans, other beans and chickpeas, as tolerated; use them to replace some meat meals.
- Fish, skinless chicken and a variety of protein sources, including legumes. Grill or bake instead of frying.
- Measured amounts of olive oil instead of ghee and butter.
- Small portions of unsalted nuts.
- Water, unsweetened tea or coffee, and unsweetened laban or yogurt as tolerated.

Reduce gradually

- Sweetened drinks and juices.
- Frequent sweets and pastries.
- Processed meat, such as sausages and mortadella, fatty red meat and highly processed meals.
- Fried meals and large amounts of ghee.
- Large portions of rice and bread.

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A practical plate

Fill half the plate with non-starchy vegetables, one quarter with protein and one quarter with starchy foods. These proportions refer to plate space, not calories.

For kabsa or mandi, reduce the rice and fat, add salad and choose a suitable protein. You do not need to cut out rice or dates completely.

Portions matter, even with healthy choices

If you are overweight, aim for gradual weight loss with regular activity and a plan suited to you. Avoid alcohol. Do not start a weight-loss diet if you are underweight or malnourished without professional advice.

Nuts and oils are high in calories despite their benefits. Tailor portions to your weight, diabetes and activity. If you have cirrhosis (stage 4 liver scarring, F4) or are underweight, do not start a weight-loss diet without assessment. This diet is different from the low-FODMAP diet.

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Everyday eating with reflux

Last updated: 10 November 2026 · Food guide · GERD

Meal timing and size matter. Do not eliminate many foods at once; reduce what triggers your own symptoms and then assess the result.

Situation	Try this	Watch for
A large kabsa or mandi meal	A smaller portion, less fat and slower chewing	Becoming very full and then lying down
Shawarma or fried food	A smaller grilled option with a lighter sauce	Fat and spicy sauces if they trigger heartburn
Frequent coffee or tea	Reduce the amount or strength if you notice a link	There is no need to stop them if they do not cause symptoms
Tomatoes, citrus fruit or mint	Try reducing one item, then reassess	Triggers are individual, not a universal banned-food list
Suhoor or a late meal	A lighter meal and about three hours before lying down	Discuss sleep and medicine timing during Ramadan

A simple trial diary

Record food, portions, bedtime and heartburn severity for one or two weeks. If nothing changes, do not continue excluding food without benefit. Review medicine timing with your team.

Day / meal	Possible trigger	What changed? Did symptoms improve?
.....	.....	.....
.....	.....	.....
.....	.....	.....

A useful rule
If you are overweight, gradual weight loss helps. For night-time symptoms, discuss raising the head of the bed or using a wedge that supports the upper body, not just the neck.

Do not dismiss these as simple heartburn
Swallowing difficulty or weight loss needs review. New chest pain with breathlessness or sweating, or bleeding, needs urgent assessment.

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Raising the head of the bed for night-time symptoms

This is particularly helpful for heartburn or fluid coming back up at night or when lying down. Raising the chest and head above the abdomen lets gravity help reduce reflux into the esophagus. It supports treatment rather than replacing it.

Raise the head end of the bed about 15–20 cm using purpose-made stable bed risers under the legs at that end, or use an adjustable bed. A long wedge pillow that supports the back, shoulders and head together on a gradual slope is another option.

Stacking ordinary pillows under the head alone does not produce the same incline and may bend the neck or increase pressure on the abdomen. Ensure the bed is stable and your back comfortable; get help to set it up safely. Continue leaving about three hours between the last meal and lying down.

Smoking and reflux

Smoking can weaken the muscular barrier between stomach and esophagus, making acid reflux easier. Stopping is important for reducing reflux and protecting health, particularly if symptoms persist despite medicine.

The goal is to stop completely. If that is difficult now, reduce smoking within a clear plan to quit and seek support from your doctor or a smoking cessation clinic to choose suitable aids. Cutting down is a transitional step and does not remove the harm.

Related guides: Gastroesophageal reflux disease

Sources and further information NIDDK: eating and nutrition NIDDK: treatment NHS: raising the head of the bed NIDDK: eating and nutrition for acid reflux NIDDK: treatment of acid reflux

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Eating with acid reflux

Eating with acid reflux

Meal size and timing matter. There is no single list of foods that everyone must avoid.

Options to try

Lighter meals

Moderate portions of rice, oats or bread, with grilled or baked chicken or fish instead of fried food.

Vegetables and fruit as tolerated

Try cooked or fresh vegetables, bananas, melon or pears. You do not need to avoid all fruit.

Drinks and dairy

Choose water instead of drinks that trigger symptoms, and lower-fat dairy if you tolerate it. Watch the portion and preparation method.

Reduce your own triggers

Fat and heavy meals

Fried and fatty meals and large portions may worsen reflux, especially before bed.

Triggers for some people

Coffee, caffeine, chocolate, mint and spicy foods. Reduce the items you notice trigger your symptoms.

Acidic foods and drinks

Tomatoes and citrus fruit may bother some people. Reduce them if they trigger symptoms; they are not forbidden for everyone.

Leave time before bed

Finish your last meal three hours before lying down or going to sleep, and avoid lying down after eating.

Try one clear change

Record food, portion size, timing and symptoms, then assess the effect of the change. Lose weight gradually if you are overweight.



Diet can help but does not replace treatment. Difficulty swallowing, bleeding or unintentional weight loss needs medical assessment.

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A gluten-free table

Last updated: 10 November 2026 · Food guide · Celiac disease

A lifelong gluten-free diet is required after celiac disease is confirmed. Do not start it before diagnostic testing is complete unless your doctor advises it.

Food	A suitable choice	What should I check?
Kabsa or mandi	Rice and protein without a flour coating	Stock cubes, spices, additions and preparation
Jareesh, qursan and marqooq	A rice or corn alternative, or a certified gluten-free product	The traditional versions usually contain wheat; changing the sauce does not make them suitable
Bread and pasta	A product labeled gluten-free	Wheat, barley, rye, semolina and their derivatives
Oats	Certified gluten-free oats if suitable for you	Wheat contamination is common; review tolerance with the dietitian
Grilled meat and potatoes	Meat without flour coating and safely prepared potatoes	Marinade, sauce and shared frying oil
Milk, laban and fruit	Plain varieties without additions are usually suitable	Additives and flavourings; lactose intolerance is a separate issue

Cross-contact matters
A shared toaster, breadcrumbs in butter, oil used for flour-coated foods or unclean utensils can transfer gluten. Clean utensils and surfaces and keep separate items that are difficult to clean. Use a dedicated gluten-free toaster or protective toaster bags.

At a restaurant or with relatives

Say: “I have celiac disease and need gluten-free food, with no cross-contact during preparation.” Ask about ingredients and the kitchen, and carry a safe alternative if uncertain.

Do not replace gluten with nutritional deficiency

Include protein, vegetables, fruit and suitable starches. Monitor iron and vitamins according to your plan, and do not rely only on gluten-free baked products.

A food I need to check: ..... | Dietitian appointment: .....

Related guides: Celiac disease

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Celiac disease: a gluten-free diet

Celiac disease: a gluten-free diet

After the diagnosis is confirmed, the diet must continue even when symptoms disappear.

Choose safe alternatives	Avoid gluten
Naturally gluten-free starches Rice, corn, potatoes and quinoa. Choose bread and pasta labeled “gluten-free”.	**Grains that contain gluten** Wheat, barley and rye, including bulgur, semolina, freekeh and wheat-based jareesh.
Simple, varied foods Vegetables, fruit, legumes, eggs, fish and meat without flour coatings or sauces containing gluten.	**Their usual products** Bread, pasta, biscuits and cakes, unless they are reliable gluten-free alternatives.
Dairy and oats Plain dairy as tolerated. Use oats only if labeled “gluten-free”, in consultation with your dietitian.	**Hidden sources** Check for barley malt and check sauces, soups and marinades. Read the label every time.

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Prevent cross-contact from crumbs

Clean surfaces and utensils. Use a separate toaster and avoid frying oil shared with flour-coated foods.

Ask at restaurants

Explain that you have celiac disease and ask about ingredients and preparation. “Wheat-free” does not always mean “gluten-free”.



Do not start the diet before completing celiac testing. Improvement in symptoms does not mean the disease has gone away; continue follow-up.

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Celiac disease: a gluten-free diet

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Choose safe alternatives

Naturally gluten-free starches

Rice, corn, potatoes and quinoa. Choose bread and pasta labeled “gluten-free”.

Simple, varied foods

Vegetables, fruit, legumes, eggs, fish and meat without flour coatings or sauces containing gluten.

Dairy and oats

Plain dairy as tolerated. Use oats only if labeled “gluten-free”, in consultation with your dietitian.

Avoid gluten

Grains that contain gluten

Wheat, barley and rye, including bulgur, semolina, freekeh and wheat-based jareesh.

Their usual products

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Sources and further information NIDDK: eating and nutrition NIDDK: follow-up NIDDK: eating and nutrition for coeliac disease NIDDK: treatment of coeliac disease

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Eating with irritable bowel syndrome

Last updated: 10 November 2026 · Food guide · IBS / low FODMAP

A low-FODMAP diet is a short therapeutic trial for some patients, not a permanent diet for everyone. Both food type and portion size matter.

Stage	What should I do?
1 · Temporary reduction	Usually 2–6 weeks with dietitian guidance. Substitute foods that cause gas without broad deprivation.
2 · Reintroduction	If symptoms improved, test one FODMAP group at a time with your dietitian, usually over three days with increasing portions while keeping the rest of the diet stable. Record amounts and symptoms; allow two to three days between challenges, or until symptoms settle.
3 · Long-term personalization	Keep the widest variety you tolerate. Limit only foods shown to trouble you and the amounts that trigger symptoms.

From our table	An adjustment to try
Kabsa or mandi	Reduce onion and garlic; choose a suitable rice portion and protein not seasoned with them.
Saleeg or coffee with milk	Try lactose-free milk if milk has been linked to your symptoms.
Fava beans or chickpeas	Try a smaller amount. Some canned legumes, drained and rinsed, may be better tolerated.
Bread, qursan and jareesh	Wheat fructans may be the problem; this does not establish gluten sensitivity.
Fruit and juice	Test a small portion of a tolerated fruit instead of juice or large mixed portions.
Sugar-free gum and sweets	Check for sweeteners such as sorbitol and mannitol, which may increase gas and diarrhea.

Amount changes the outcome
These are examples of adjustments, not laboratory-tested portion classifications. The dietitian sets portions using current resources and your tolerance. Do not eliminate food groups without reintroduction.

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Before starting
If celiac disease is suspected, complete testing before stopping gluten. Blood in stool, weight loss or night-time diarrhea needs assessment and should not automatically be attributed to IBS.

Trial start: ..... | Reintroduction date: ..... | Symptom I am tracking: .....

Related guides: Irritable bowel syndrome · Medicines for irritable bowel syndrome (IBS)

Sources and further information Monash University: diet stages NIDDK: IBS nutrition Monash: food and portion examples Monash: the three phases of the diet Published food portions Food portion examples

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Low-FODMAP diet for IBS

Low-FODMAP diet for IBS

An expanded guide to foods and portions, including Saudi and Arab dishes. A food may contain more than one type of FODMAP. These lists do not mean permanent bans or unlimited portions.

Reduce temporarily

Potential triggers during the trial - not permanent bans.

Choose alternatives

Suitable portions and your tolerance guide the choice.

A food can contain more than one FODMAP. These lists do not mean unlimited portions.

Excess fructose

Apples, pears and mangoes. Honey, agave syrup and high-fructose corn syrup. Concentrated juices and large amounts of dried fruit may trigger symptoms. Read drink and dessert ingredients.



Lactose

Cow, goat, sheep and camel milk are not lactose-free. Condensed milk, ordinary ice cream and ordinary yogurt may cause symptoms. Ricotta and cottage cheese vary with portion size. Not all cheese or dairy is high in lactose.

Fructans

Onion, garlic, asparagus and the white part of spring onions. Large portions of wheat, barley and rye; ordinary bread, pasta, biscuits, cakes and pastries. Check onion and garlic powders in stock, sauces and seasonings. The trigger may be fructans rather than gluten.

Legumes and nuts

Large portions of beans, chickpeas, lentils and peas may cause symptoms, as may cashews and pistachios. Drained, rinsed canned legumes may be tolerated in smaller portions; do not exclude all legumes.



Polyols and sweeteners

Sorbitol, mannitol, xylitol, maltitol and isomalt may occur in sugar-free gum, sweets and other products. Read names and ingredients; “sugar-free” does not mean suitable. Larger amounts may increase gas or diarrhea.

Type and portion matter

Mushrooms, cauliflower, peaches, apricots, plums, cherries and blackberries vary by type and portion. Avocado, celery, sweet potato, hazelnuts and grapes need portion control; they are not automatically banned.

Fruit

Oranges, mandarins, kiwifruit, pineapple and papaya. Choose less-ripe bananas; very ripe bananas need a smaller portion. Cantaloupe, passion fruit, strawberries, blueberries and raspberries can be options in suitable portions. Fresh cranberries differ from dried sweetened ones. Grapes and grapefruit need defined portions. Use lemon in normal cooking amounts. Spread fruit portions through the day.



Vegetables

Carrots, cucumber, lettuce and potatoes. Spinach, eggplant, green beans and zucchini in suitable portions. Green sweet peppers differ from red peppers; tomatoes depend on variety and portion. Olives, parsley and ginger. Check portions for parsnip and fennel. Broccoli heads differ from stalks. Green spring-onion leaves can replace the white part. Celery and sweet potatoes need specific portions.



Grains and fiber

Rice, oats, quinoa and millet; rice or corn pasta. Check bread ingredients and portions, and do the same for tapioca, arrowroot and sorghum. Psyllium is a fiber supplement; increase gradually with fluids. Barley contains gluten. Gluten-free does not automatically mean low-FODMAP.

Dairy and alternatives

Lactose-free milk and yogurt; almond or rice milk depending on product and portion. Soy-protein milk differs from whole-soybean milk. Cheddar, Gouda, Brie and Camembert in suitable portions. Check lactose and sweeteners in ice-cream alternatives. Choose calcium-fortified alternatives.



Saudi and Arab dishes: reduce or adapt

Large portions of wheat-based jareesh, qursan, matazeez and ordinary Arabic bread. Kabsa and shawarma containing onion or garlic. Large portions of ful medames, hummus and lentil soup. Falafel depends on legumes, onion, garlic and portion. Saleeg, muhallabia and umm Ali made with ordinary milk may cause symptoms; other ingredients matter too.

Saudi and Arab alternatives to try

Adapted kabsa or mandi: rice with meat or chicken, without onion, garlic or raisins; check stock and spices. Saleeg with lactose-free milk and no onion or garlic. Grilled fish or chicken with a suitable marinade; plain eggs or omelette. Cucumber, carrot and lettuce salad without onion or garlic. A dish’s name alone does not determine suitability.



Protein, fats and sweetening

Plain eggs, meat, chicken and fish; check marinades. Moderate olive oil or butter. Fat can trigger symptoms despite low FODMAPs. Small amounts of sugar, glucose or maple syrup; molasses and dark syrups depend on product and portion.

Dates, milk and probiotics

Date size, variety and number matter; no fixed number suits everyone. Lactose intolerance is not milk allergy. Try lactose-free milk if appropriate; persistent symptoms need review. Probiotic benefits vary by strain and person; discuss a trial and duration with your doctor.

A temporary trial, then variety

Usually 2-6 weeks, then gradual reintroduction and a personal diet with the widest variety tolerated, guided by a dietitian. Complete celiac testing before stopping gluten if celiac disease is suspected.

No single diet suits everyone. Record foods, portions and symptoms. Do not exclude food groups long term without follow-up. This general guidance does not replace a medical assessment.

Dr. Ibrahim Albedaiwi Clinic

Patient Guide · English edition

Dr. Ibrahim Albedaiwi

Enlarge the chart to read it. The complete diet guidance follows on the next page.

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Low-FODMAP diet for IBS

An expanded guide to foods and portions, including Saudi and Arab dishes. A food may contain more than one type of FODMAP. These lists do not mean permanent bans or unlimited portions.

Choose alternatives: the food and portion both matter

Use suitable portions and choose foods according to their ingredients and your tolerance. Foods listed as alternatives are not unlimited. Foods listed for temporary reduction are not permanently forbidden.

Fruit: type and portion matter

Oranges, mandarins, kiwifruit, pineapple and papaya. Choose less-ripe bananas; very ripe bananas need a smaller portion. Cantaloupe, passion fruit, strawberries, blueberries and raspberries can be options in suitable portions. Fresh cranberries differ from dried, sweetened cranberries. Grapes and grapefruit need a defined portion; use lemon in normal culinary amounts. Spread fruit portions through the day rather than eating several large portions at once.

Vegetables in detail

Carrots, cucumber, lettuce and potatoes. Spinach, eggplant, green beans and zucchini in suitable portions. Green sweet peppers differ from red peppers, which need portion control; tomatoes depend on the variety and portion. Olives, parsley and ginger. Check portions for parsnips and fennel. Broccoli heads differ from the stalks. The green leaves of spring onions can replace the white part. Celery and sweet potatoes need specific portions. Type, quantity and preparation all matter.

Grains and fiber

Rice, oats, quinoa and millet; rice or corn pasta. Check bread ingredients and portion size, and do the same for tapioca, arrowroot and sorghum. Psyllium is a fiber supplement, not a type of bread; increase it gradually with fluids. Barley contains gluten; ordinary barley bread is not gluten-free. A gluten-free product is not automatically low in FODMAPs.

Dairy and alternatives

Lactose-free milk and yogurt; almond or rice milk depending on the product and portion. Soy milk made from soy protein differs from milk made from whole soybeans. Cheddar, Gouda, Brie and Camembert in suitable portions. Check lactose and sweeteners in ice-cream alternatives and choose calcium-fortified alternatives. Cow, goat, sheep and camel milk are not lactose-free. Condensed milk, ordinary ice cream and ordinary yogurt may cause symptoms. Some soft cheeses, such as ricotta and cottage cheese, vary in tolerance with portion size. Not all cheeses or dairy products are high in lactose. Lactose intolerance is not the same as a milk allergy.

Excess fructose and hidden ingredients

Apples, pears and mangoes are examples of fruit that may cause symptoms. Excess fructose in some fruits, honey, agave syrup and high-fructose corn syrup can trigger symptoms. Watch concentrated juices and large amounts of dried fruit. Read drink and dessert ingredients.

Polyols and sweeteners

Sorbitol, mannitol, xylitol, maltitol and isomalt may be present in sugar-free gum, sweets and other products. Sweeteners are not all the same: read the name and ingredients rather than relying on an unclear number or name on the packet. Larger amounts can increase gas or diarrhea. Small amounts of sugar, glucose and maple syrup may be used. Molasses and dark syrups are not guaranteed substitutes: their suitability depends on the product and portion.

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Fructans, legumes and nuts

Watch onion, garlic, asparagus and the white part of spring onions, as well as large portions of wheat, barley, rye and their products. Ordinary bread, pasta, biscuits, cakes and pastries may contain these ingredients. Check onion and garlic powders in sauces, stock and seasonings. The trigger may be fructans rather than gluten. Large portions of beans, chickpeas, lentils and peas may cause symptoms, as may cashews and pistachios. Canned legumes that have been drained and rinsed may be tolerated in smaller portions; do not exclude all legumes automatically.

Foods that are not automatically banned

Avocado, celery, sweet potato, hazelnuts and grapes require portion control. Mushrooms, cauliflower, peaches, apricots, plums, cherries and blackberries vary by type and portion. The size, variety and number of dates matter: there is no rule that three dates suit everyone. A dietitian can help you choose the amount.

Protein, fats and probiotics

Plain eggs, meat, chicken and fish are suitable options; check marinades and seasonings. Use olive oil and butter in moderate amounts. Fat may trigger symptoms even when a food is low in FODMAPs. The benefit of probiotics varies by strain and person; they are not a reliable treatment for everyone. Discuss whether to try one, and for how long, with your doctor.

Saudi and Arab dishes: adapted alternatives to try

- Adapted kabsa or mandi: rice with meat or chicken, without onion, garlic or raisins, in a suitable portion. Check stock and spice ingredients.
- Saleeg made with lactose-free milk and without onion or garlic.
- Grilled fish or chicken with a suitable marinade that contains no onion or garlic; boiled eggs or a plain omelette.
- Cucumber, carrot and lettuce salad without onion or garlic.

Examples to reduce temporarily, depending on portions and ingredients

- Large portions of wheat-based jareesh, qursan and matazeez, and ordinary Arabic bread.
- Kabsa and shawarma when they contain onion or garlic.
- Large portions of ful medames, hummus and lentil soup. Falafel may cause symptoms depending on the legumes, onion, garlic and portion.
- Saleeg, muhallabia and umm Ali made with ordinary milk; other ingredients may also trigger symptoms.

These are suggestions for adapting recipes according to their ingredients. A dish's name alone does not determine whether it suits you.

A temporary trial, then a varied personal diet

No single diet suits everyone. The initial reduction phase usually lasts 2–6 weeks, followed by gradual reintroduction. Then keep the widest variety you tolerate, with guidance from a dietitian. If milk seems to trigger symptoms, try lactose-free milk; persistent symptoms need review. Complete celiac testing before stopping gluten if celiac disease is suspected.

If the diet does not help

Trial the first stage for 2–6 weeks with a dietitian. If you improve, move on to food reintroduction. If symptoms do not improve despite following the plan, do not continue or intensify restriction; review with your dietitian, reintroduce foods and consider other options.

Examples for one serving at a meal, not maximum limits or a guarantee of no symptoms. Use the stated weight and preparation; do not apply an ingredient portion to a whole dish or a different product.

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Food	Portion and preparation	What to check
Plain brown rice	1 cooked cup, about 180 g. Weigh after boiling	Use stock without onion or garlic. This does not classify every kabsa or mandi recipe as low FODMAP.
Plain rolled oats	52 g dry; about half a cup. Weigh before cooking; weight is more reliable than cup volume	Choose plain rolled oats, not a mix with honey or dried fruit. Portions can differ by product and oat type.
Canned chickpeas	Quarter of a cup, about 42 g. Drain and rinse; weigh the chickpeas without the liquid	This is a chickpea portion, not a hummus-dip portion. Garlic, quantity and the rest of the recipe matter.
Fresh cucumber	75 g. Weigh raw	In a salad, check added onion, garlic and dressing.
Fresh carrot	1 medium carrot, about 75 g. Weigh raw after peeling	An example vegetable portion, not a maximum tolerance limit. Increase fiber gradually as tolerated.

Trial the first stage for 2–6 weeks with a dietitian. If you improve, move on to food reintroduction. If symptoms do not improve despite following the plan, do not continue or intensify restriction; review with your dietitian, reintroduce foods and consider other options.

> No single diet suits everyone. Record foods, portions and symptoms. Do not exclude food groups long term without follow-up. This general guidance does not replace a medical assessment.

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Nutrition with Crohn’s disease and ulcerative colitis

Last updated: 10 November 2026 · Food guide · Inflammatory bowel disease

There is no single list of forbidden foods for everyone with inflammatory bowel disease. Food supports recovery, but does not replace treatment for inflammation or follow-up tests.

Your current situation	What often helps	When is an individual plan needed?
Remission without a stricture	A varied diet: protein, vegetables, fruit and starchy foods as tolerated	Do not automatically avoid fiber, milk or gluten.
A flare with diarrhea or poor appetite	Small meals, foods that are easier to tolerate and suitable fluids	Contact the team to treat the flare and check for infection if needed.
A known stricture without acute blockage symptoms	A soft diet low in coarse fiber may be needed under your team’s plan	Pain and bloating with vomiting or inability to pass gas need emergency care; do not rely on changing food.
Weight loss or malnutrition	Enough protein and energy; nutritional supplements may be prescribed	You need assessment, not further food restrictions.
Milk makes symptoms worse	Try lactose-free products while maintaining calcium intake	Lactose intolerance does not mean you must avoid all dairy.

A balanced eating pattern

During remission, without a stricture that limits eating, a Mediterranean-style diet is often recommended for general health: varied foods, olive oil, enough protein and fewer highly processed foods. Texture and portions are adjusted to your situation. No single eating pattern guarantees prevention of every flare.

Flexible examples using everyday foods

A portion of rice you tolerate with tender chicken or fish, mashed potatoes with eggs, or a yogurt drink that suits you. Add cooked or peeled vegetables when needed, then expand your choices after the flare improves. With a stricture, food types and amounts need an individual plan.

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What should I monitor?

Your weight, food intake, ability to drink and number of bowel movements. Agree a plan with your team to monitor iron and vitamin D deficiency. Vitamin B12 testing is especially important with extensive disease or previous surgery involving the end of the small bowel. Your team sets the schedule; do not start high doses yourself.

Therapeutic diets need supervision

Liquid nutrition or exclusion diets may help selected people with Crohn’s disease, but require a nutritional plan and monitoring. Do not replace prescribed treatment with them yourself.

My disease phase: ..... | Do I have a stricture? ..... | Weight / nutrition goal: .....

Related guides: Crohn’s disease · Ulcerative colitis · IBD medicine safety

Sources and further information NIDDK: Crohn’s disease treatment Crohn’s & Colitis UK: Food AGA: Diet and nutrition in IBD, 2024

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Gastroscopy preparation checklist

Complete with your care team. Your unit’s instructions and individual plan take priority.

Name / record number: .....

Procedure date / actual start time / arrival time: .....

Last approved meal / stop all fluids at: .....

Eating and drinking before gastroscopy

- Stop light meals at least 6 hours before the procedure; fatty meals or meat need at least 8 hours. Your condition may require longer.
- For an afternoon procedure, a light dinner the previous evening is allowed according to your unit’s timetable. Once food fasting starts, this clinic’s plan permits water only; stop water 3 hours before the procedure.
- Milk, yoghurt drinks, juice with pulp and milky coffee are not water and are not allowed during that period.

Medicines, escort and recovery

- Get a plan for regular medicines, especially diabetes medicines and blood thinners. Do not stop them yourself. Acid medicines are stopped only when instructed for H. pylori testing, usually 14 days after clinician agreement. Other medicines may be taken with a sip of water as directed.
- Arrange an adult escort after sedation and do not drive for 24 hours. When the team allows and swallowing is normal, start with fluids and a light meal, then advance as tolerated and instructed.

> Contact the endoscopy unit for repeated vomiting or inability to finish preparation. Do not rush doses to catch up. Severe pain, fainting or heavy bleeding needs urgent assessment.

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Colonoscopy preparation instructions

Complete with your care team. Your unit’s instructions and individual plan take priority.

Name / record number: .....

Procedure date / actual start time / arrival time: .....

Last approved meal / stop all fluids at: .....

First sachet time / finish its follow-up fluids at: .....

Second sachet time / finish its follow-up fluids at: .....

Your prescribed Picoprep plan

- Take the two sachets at the times written by your unit or its approved calculator. Mix each sachet according to the pack and prescription. Do not substitute products yourself.
- Bisacodyl 10 mg once only with the first dose (two 5 mg tablets), if included in your prescription. Do not repeat it with the second sachet.
- After each sachet: 2 litres of varied clear fluids as prescribed by this clinic; about 250 mL every 20 minutes, or 8 cups over 2 hours 40 minutes. Finish before the stop-fluid time, 3 hours before the procedure.
- Eat low-fibre food before fasting as instructed. A light dinner the evening before an afternoon procedure may be allowed if your plan says so. No solid food on procedure day. Clear fluids include water, strained clear broth, pulp-free apple juice, tea or black coffee without milk or grounds; avoid red and purple drinks.

Medicines, escort and recovery

- Get a plan for regular medicines, especially diabetes medicines and blood thinners. Do not stop them yourself. Acid medicines are stopped only when instructed for H. pylori testing, usually 14 days after clinician agreement. Other medicines may be taken with a sip of water as directed.
- Arrange an adult escort after sedation and do not drive for 24 hours. When the team allows and swallowing is normal, start with fluids and a light meal, then advance as tolerated and instructed.

> Contact the endoscopy unit for repeated vomiting or inability to finish preparation. Do not rush doses to catch up. Severe pain, fainting or heavy bleeding needs urgent assessment.

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My treatment and follow-up plan

Complete with your care team. Your unit’s instructions and individual plan take priority.

Name / record number: .....

Date / diagnosis / allergies: .....

Two main goals or questions for this visit: .....

Medicines agreed with your clinician

Medicine / dose	How and when	Duration / review
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

Tests and due dates: .....

Who reviews results? When do I follow up if none arrive?: .....

Next appointment / treating hospital: .....

My warning signs and who to contact

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Plain-language medical glossary

Last updated: 10 November 2026 · Patient glossary

Short explanations of terms you may hear in the clinic or read in your results. Select a term within a topic to open its explanation here.

Biopsy

A small sample of tissue from an organ that a pathologist (a doctor who examines tissue) examines under a microscope. It may help diagnose inflammation or other conditions. Having a biopsy does not necessarily mean cancer is suspected. Depending on the organ, the sample may be taken during endoscopy or with a needle.

Remission (inactive disease)

A period when disease activity settles. Clinical remission means symptoms of active disease are absent or minimal according to your doctor’s assessment. Some improvement alone does not necessarily mean remission. Few symptoms do not prove inflammation has gone; stool and blood tests or endoscopy may be needed. Remission does not mean you should stop maintenance treatment on your own.

Ascites

Fluid collecting in the abdominal cavity, rather than simply gas. Liver disease and other conditions can cause it. Fever or abdominal pain in someone with ascites needs urgent assessment because the fluid may be infected.

Varices

In liver disease, this usually means enlarged veins in the esophagus or stomach caused by increased pressure in the portal vein. They are different from varicose veins in the legs. Vomiting blood or passing black, tarry stools requires emergency care, even without dizziness.

AFP — alpha-fetoprotein

A blood test measuring the protein alpha-fetoprotein. It is used with imaging to check for tumors in some people with liver disease. Non-cancerous conditions can also raise it, and a normal result does not rule out a tumor. The test alone cannot diagnose cancer. It has a different use during pregnancy.

PCR — testing genetic material

A laboratory technique that detects genetic material. When monitoring viruses, it may detect HBV DNA or HCV RNA and measure viral load, depending on the test. It is different from an antibody test. “Undetectable” means the level is below the test’s detection limit in that sample; it does not always mean a permanent cure or complete absence of the virus from the body.

Liver fibrosis and cirrhosis

Fibrosis means scar tissue following liver injury. In the F0–F4 system, F0 means no fibrosis; F1 is mild, F2 moderate and F3 advanced fibrosis; F4 is cirrhosis, with altered liver structure. F1–F3 can regress with treatment of the cause, especially earlier stages, but improvement is not guaranteed. F4 can also improve, without necessarily restoring a normal liver. Follow-up and prescribed surveillance remain important. Liver stiffness is a measurement, not a diagnosis or proof of an exact fibrosis stage.

ERCP — bile and pancreatic duct endoscopy

A procedure combining a scope passed through the mouth with X-rays to access the bile or pancreatic ducts. It is mainly used for treatment, such as removing a stone or placing a stent, and differs from routine gastroscopy.

MRCP — MRI of the bile and pancreatic ducts

An MRI examination showing the bile and pancreatic ducts without inserting a scope into them. It helps assess stones and narrowing, but cannot remove stones or place a stent. Tell the imaging team about implanted devices or metal.

Ferritin — iron stores

Ferritin is a protein that stores iron. A low level may indicate depleted stores, but a high result can occur with inflammation or liver disease and does not by itself prove iron overload. It is interpreted with other tests.

Transferrin saturation (TSAT)

Transferrin carries iron in the blood. This test estimates how much of its iron-carrying capacity is being used. Alongside ferritin, it helps assess iron deficiency or overload; one result is not a diagnosis on its own.

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INR — a blood-clotting test

A result calculated from a test of how long a blood sample takes to clot. It is used to monitor warfarin and may contribute to liver assessment. Medicines and other factors affect it; do not adjust blood thinners yourself.

Biologic treatment

A complex medicine produced using living cells or systems. Many IBD biologics target particular inflammatory signals or cells. Administration, monitoring and storage differ between medicines; follow your own prescription and medicine card.

Biosimilar medicine

An approved biologic with no clinically meaningful difference in safety or effectiveness from its reference medicine. Packaging, injection devices or storage instructions can differ. Follow the instructions for the product dispensed to you.

Fecal calprotectin

A protein measured in stool to help assess bowel inflammation and treatment response. Other conditions can also raise it. Your doctor interprets it with symptoms and other tests; a single result is not enough to diagnose disease or change treatment.

Stricture

A narrowed area that may limit the passage of food or fluid. Inflammation, scarring and other causes need different treatments. Severe pain with swelling, vomiting or inability to pass gas needs urgent assessment.

Fistula

An abnormal channel between the bowel and another organ or the skin. It differs from a fissure, a small tear, and an abscess, a collection of pus. A fistula can coexist with an abscess; increasing pain or fever needs prompt assessment.

Portal vein

A large vein that brings blood from the digestive tract to the liver. Raised pressure here can contribute to varices and ascites. Portal pressure is different from the blood pressure measured with a cuff on your arm.

Stent

A small tube placed in a narrowed duct or passage to help fluid or food pass. Some stents are temporary and need removal or replacement. Obtain a written follow-up date; feeling better does not mean the stent can be forgotten.

Hepatic encephalopathy

Liver disease can allow substances to affect brain function, causing confusion, altered sleep or drowsiness. New confusion or unusual difficulty waking needs urgent assessment; do not assume it is ordinary tiredness.

Related guides: Liver cirrhosis (F4) · Crohn’s disease · Ulcerative colitis

Sources and further information NIDDK: Liver biopsy NIDDK: Cirrhosis complications MedlinePlus: AFP MedlinePlus: PCR AASLD: fibrosis stages AASLD: regression of fibrosis and cirrhosis (2026)

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Gastrointestinal bleeding

Last updated: 10 November 2026 · Gastrointestinal bleeding

Bleeding may be obvious or hidden. The priorities are assessing its severity, finding the cause and preventing further bleeding.

Your next step

Go to the emergency department now for vomiting blood, black tarry stool or heavy bleeding, especially with dizziness or weakness. Do not wait for WhatsApp or delay care for a home test.

Where does bleeding come from?

Upper gastrointestinal (GI) bleeding comes from the oesophagus, stomach or duodenum. Lower bleeding comes from the colon, rectum or anus. The small intestine can also bleed. GI bleeding is a sign of an underlying problem, not a diagnosis by itself.

What might I notice?

- Vomit may contain red blood or material resembling coffee grounds. Stool may be black, sticky and tar-like, or contain red or maroon blood. Colour alone cannot locate the source. Slow, hidden bleeding can cause iron-deficiency anaemia, with tiredness, pallor or breathlessness, even without visible blood. Anaemia can also have causes unrelated to GI bleeding.

What can cause bleeding?

- Causes include ulcers, inflammation, a tear after forceful vomiting, or enlarged veins associated with advanced liver disease. Other causes include diverticula (small pouches in the bowel wall), fragile blood vessels, bowel inflammation, haemorrhoids, anal fissures, polyps or cancer. Blood does not automatically mean cancer, and should not automatically be blamed on haemorrhoids.

What happens at hospital?

- The team checks your circulation and takes blood tests to assess blood loss and clotting. You may need an intravenous line, fluids or blood. Tell staff about previous bleeding, ulcers, liver disease and every medicine you take. Stabilising your condition comes before choosing the next test.
- Upper endoscopy, colonoscopy or a CT angiogram may identify the source. Tests and timing depend on your stability and the suspected site; major ongoing bleeding may need CT angiography first. Endoscopy can also stop bleeding using clips, heat or other treatments. Some patients need a radiology procedure to block a bleeding vessel, or surgery if other treatment fails.

Medicines need an individual plan

- Anti-inflammatory painkillers such as ibuprofen or naproxen can cause bleeding. Aspirin and anticoagulants may increase bleeding risk. Tell the emergency team their names and when

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you last took them. Do not delay care while seeking medicine advice, or independently stop, restart or change prescribed blood-thinning treatment.

After the bleeding is controlled

- Keep follow-up appointments even if the bleeding stops. Ask about the cause, test results, repeat blood tests and any further endoscopy. Follow the prescribed treatment and iron plan if needed. If an ulcer is found, ask about H. pylori testing and treatment, and a later test to confirm clearance. Get written instructions for your medicines and for returning if bleeding recurs.

When to get help

Get urgent medical care / go to the emergency department

Go to the emergency department now for vomiting blood or coffee-ground material, black tarry stool, heavy or continuing bleeding, or bleeding with faintness, confusion, severe pain, chest pain or breathlessness. Do not wait for WhatsApp. If weak or dizzy, do not drive; call an ambulance.

Contact your care team promptly

Small or intermittent amounts of red blood, unexplained anaemia or persistent tiredness need prompt clinical assessment. Do not wait for bleeding to become heavy; any emergency sign above takes priority.

Related guides: Gastroscopy · Colonoscopy · Helicobacter pylori infection · Liver cirrhosis (F4) · Hemorrhoids and anal fissure · Acid medicines: proton pump inhibitors (PPIs) · Safe use of blood thinners (anticoagulants)

Sources and further information NIDDK: GI bleeding symptoms and causes NIDDK: diagnosing GI bleeding NIDDK: treating and preventing GI bleeding MedlinePlus: GI bleeding and when to seek help NHS: vomiting blood ACG: acute lower GI bleeding guideline (2023) ESGE: peptic ulcer bleeding guideline (2026)

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Biologic infusions: what to expect

Last updated: 10 November 2026 · Biologic infusions: what to expect

Medicine is given slowly through a small tube in a vein while you remain awake and nurses monitor you. Treatment and observation times depend on the medicine and your health.

Your next step

Confirm your medicine and appointment. Contact the unit beforehand if you develop a fever or infection, or start an antibiotic.

Infusion or injection under the skin?

Some medicines are given through a vein in a treatment unit; others are injected under the skin after training. Treatment may start intravenously and later change to injections to keep the disease settled. Your clinician selects the product, dose and schedule; do not switch routes yourself.

Before your appointment

- Report fever, persistent cough, infection, antibiotics or a previous reaction. The team may postpone treatment after assessing you. Bring a medicine list, complete requested tests, and disclose pregnancy or pregnancy plans.
- An infusion alone usually does not require fasting. Eat and drink within your usual medical restrictions unless the unit gives different instructions. Wear clothes allowing access to your arm and bring something to read. Allow time for preparation and observation.

On arrival

- Staff review your health, prescription and tests, check blood pressure, pulse and temperature, and may weigh you. A cannula—a small plastic tube—is placed in a hand or arm vein after a brief needle prick. Preparing the medicine may take time.
- Premedication may be prescribed to reduce reactions, but is not required for everyone. Do not add steroids or antihistamines yourself.

While the medicine is running

- You sit in a chair or bed while the medicine runs through tubing at the prescribed rate. You may read or use your phone, and usually eat or drink if the unit permits. Ask for help before walking or using the toilet.
- You may feel nothing unusual. Tell the nurse immediately about itching, rash, flushing, headache, nausea or chills, or pain, burning or swelling around the cannula. Do not silently tolerate symptoms or adjust the pump. Staff may slow or pause treatment and assess you.

After the infusion and at home

- The line may be flushed with saline, followed by observation according to the product, unit policy and previous reactions. Infusion time is not total visit time. Stay until staff say you can leave.
- Mild fatigue or headache may occur. Do not drive if dizzy or sleepy, or after medication that makes you drowsy. Plan suitable transport, especially for the first visit. Before leaving, confirm the next dose, blood tests and contact details.
- Delayed reactions can occur after leaving, sometimes days later, especially with infliximab. Report new rash, fever or joint pains. Breathing difficulty, facial swelling or fainting requires emergency care.

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If treatment changes to home injections

- Train with your exact pen or syringe. Wash your hands, check the name, strength and expiry, rotate sites as instructed and avoid inflamed or bruised skin. Devices and permitted time out of the refrigerator differ. Do not heat the medicine or copy another device’s instructions. Use a sharps container.
- Improvement may take weeks and varies by medicine. Lack of improvement after one infusion does not automatically mean failure; do not stop when symptoms improve. Contact the team if a dose is missed or instructions are unclear.

How long does the medicine take?

Adult examples below describe infusion time only. Preparation and observation add to the visit.

Medicine	Time for the intravenous dose
Infliximab	Usually at least two hours initially. A shorter infusion may later be allowed for selected products and suitable patients under the unit protocol.
Vedolizumab	About 30 minutes. The referenced leaflet specifies about two hours of observation after the first two infusions and about one hour after later infusions. Follow your unit’s instructions.
Ustekinumab	At least one hour for the initial intravenous dose, usually followed by injections under the skin.
Risankizumab, when intravenous induction is prescribed	At least one hour for the Crohn’s intravenous dose, or at least two hours for the ulcerative-colitis intravenous dose.

Ask your unit about the expected total visit time. Observation may be longer if symptoms occur; plans vary by product and individual circumstances.

When to get help

Get urgent medical care / go to the emergency department

During treatment, tell the nurse immediately about breathing difficulty, facial or throat swelling, chest pain or fainting. After leaving, seek emergency care for these symptoms; do not wait for WhatsApp.

Contact your care team promptly

Contact the team promptly for fever or infection before a dose, or rash, joint pains or persistent symptoms afterwards. Fever with severe illness needs urgent assessment.

Related guides: IBD medicine safety · Infliximab medicine card · Adalimumab medicine card · Vedolizumab medicine card · Ustekinumab medicine card · Risankizumab medicine card

Sources and further information Royal Free London: starting a biologic Infliximab: official prescribing information Flixabi: official prescribing information Vedolizumab: patient leaflet Ustekinumab: official prescribing information Risankizumab: official prescribing information Adalimumab: injection-pen instructions

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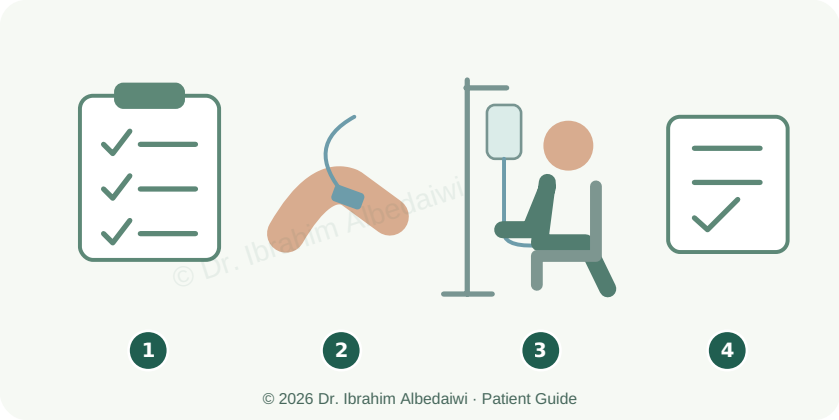
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ILLUSTRATED PATIENT GUIDE

Your intravenous biologic infusion

What to expect before, during and after treatment.



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1 · Before starting

The team asks about symptoms, infections and medicines, checks vital signs and reviews required tests.

2 · Placing a cannula

A small needle places a thin plastic tube in a hand or arm vein. The needle is removed; the tube stays in place.

3 · Medicine and monitoring

Medicine runs gradually through the tube while you are awake. Session length varies by drug and dose; extra medicines may be given when needed.

4 · After the infusion

You may stay for observation, then receive home-care instructions and your next appointment.

> Tell the nurse immediately about itching, a rash, sudden flushing, dizziness, chest tightness or breathing difficulty. Not all biologics are intravenous; some use injections under the skin.

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Crohn’s & Colitis UK: Infliximab

These illustrations support education and do not replace your doctor’s advice or follow-up. Plans vary by patient.

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Infliximab medicine card

Last updated: 11 November 2026 · Infliximab

A biologic treatment that blocks the inflammatory signal TNF. It is used for some cases of Crohn’s disease and ulcerative colitis and may help Crohn’s fistulas.

How do I use it?

- The intravenous dose usually takes at least two hours initially. The usual schedule is the first dose, then at weeks two and six from the start, then every eight weeks; your clinician may adjust it. You are monitored during and afterwards. Under-the-skin products also exist; do not switch product or route without a prescription and training.

How do I store it?

- The unit stores and prepares the vials. Unopened vials are usually stored at 2–8°C. If you collect the medicine for transport, ask the pharmacist for instructions for your exact brand and formulation; do not leave it in a car.

What tests do I need?

- Tuberculosis and hepatitis B tests before starting, along with a blood count, liver tests and monitoring set by the team. Drug levels and antibodies to the medicine may be checked if response weakens.

Possible side effects: what to expect

- Not everyone experiences side effects. Headache, nausea or a mild rash may occur. During an infusion, tell the nurse about any new symptom immediately; the team may slow or interrupt treatment and assess you.
- Serious infections or severe allergy can occur. Infection screening, vaccination review and follow-up help reduce risk. Your team also discusses longer-term cancer risks, particularly with combined immune treatments, and weighs these against the benefit of controlling bowel inflammation in your circumstances.

Important points

- Do not stop or restart treatment yourself. Instructions vary between biosimilars and injection forms. Live vaccines and pregnancy need a plan from your team.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Difficulty breathing, facial swelling, chest pain or fainting during or after an infusion: tell the team immediately or seek emergency care.

Contact your care team promptly

Fever, infection or starting an antibiotic before a dose: contact the unit before receiving it. Tell them about new breathlessness, leg swelling, a delayed rash or a missed appointment.

Related guides: Biologic infusions: what to expect · IBD medicine safety · Crohn’s disease · Ulcerative colitis · Pregnancy and breastfeeding with bowel and liver disease

Sources: 1 · 2 · Source details and full guide online

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Adalimumab medicine card

Last updated: 11 November 2026 · Adalimumab

An anti-TNF biologic injection for some cases of Crohn’s disease and ulcerative colitis.

How do I use it?

- Inject under the skin with a pen or syringe after training, usually every two weeks after starting doses; your schedule may differ. Wash your hands and rotate abdomen or thigh sites according to your device instructions, avoiding inflamed or bruised skin. Use a sharps container. Do not double a missed dose; contact the team to arrange a replacement date.

How do I store it?

- Keep in the original packaging at 2–8°C, protected from light. Do not freeze or use after freezing. Permitted time out of the refrigerator differs between brands and biosimilars; record when you remove it and follow your product leaflet and pharmacist’s advice.

What tests do I need?

- Tuberculosis and hepatitis B screening before starting, with blood and liver tests according to the team’s plan. Continue monitoring bowel inflammation even when symptoms improve.

Possible side effects: what to expect

- Not everyone experiences side effects. Limited injection-site soreness or redness, headache or nausea can occur. A wrapped cool compress and rotating injection sites may help; increasing or persistent redness needs review.
- Infections, including serious infections, can occur. Tuberculosis and hepatitis B checks, vaccination review and follow-up help reduce risk. Your team also discusses allergy and cancer risks against the benefit of controlling bowel inflammation, considering your health and other medicines. Report an infection before the next dose.

Important points

- Do not change treatment yourself. Do not receive a live vaccine without the team’s approval. Arrange a plan for pregnancy and breastfeeding.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Difficulty breathing, swelling of the face or throat, fainting, or severe illness with fever: seek emergency care.

Contact your care team promptly

Fever, a new infection or an antibiotic: call before the next injection so the team can decide whether to give or delay it. Also call for a persistent rash, unusual bruising or a storage problem.

Related guides: Biologic infusions: what to expect · IBD medicine safety · Crohn’s disease · Ulcerative colitis · Pregnancy and breastfeeding with bowel and liver disease

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Vedolizumab medicine card

Last updated: 11 November 2026 · Vedolizumab

A biologic treatment targeting the movement of inflammatory cells toward the bowel, for some cases of Crohn's disease and ulcerative colitis.

How do I use it?

- An intravenous dose takes about 30 minutes, plus observation. The usual schedule is the first dose, then at weeks two and six from the start, then every eight weeks; your clinician may adjust it. Under-the-skin injections may later maintain disease control. Do not change the route yourself; receive training before home injections.

How do I store it?

- Keep unopened vials and injections in the original packaging at 2–8°C; do not freeze. Do not shake the pen or syringe. Conditions for storage outside the refrigerator vary by formulation and leaflet; ask the pharmacist about travel or a power outage.

What tests do I need?

- Review of infections and vaccinations before starting, with tuberculosis and viral tests according to the unit's plan. Liver tests, blood tests and disease activity are monitored as needed.

Possible side effects: what to expect

- Not everyone experiences side effects. Headache, joint aches or cold-like symptoms can occur. Tell your team if these persist or bother you, and tell the nurse immediately about new symptoms during an infusion.
- Infections and infusion reactions can occur. The intravenous Entyvio leaflet lists anaphylaxis as very rare: up to 1 in 10,000 people. This figure refers only to severe allergy. The team monitors you during treatment, and reporting symptoms early helps them respond.

Important points

- Being gut-targeted does not eliminate the possibility of infection or allergic reactions. Consult the team about pregnancy, breastfeeding and before vaccination.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

A severe allergic reaction or difficulty breathing. New weakness, changes in vision or speech, confusion or worsening balance also need urgent assessment.

Contact your care team promptly

Fever or infection before a dose, yellow eyes or dark urine: contact the team promptly. Do not delay or stop doses without a plan, and do not double a missed dose.

Related guides: Biologic infusions: what to expect · IBD medicine safety · Crohn's disease · Ulcerative colitis · Pregnancy and breastfeeding with bowel and liver disease

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Ustekinumab medicine card

Last updated: 11 November 2026 · Ustekinumab

A biologic targeting the IL-12 and IL-23 inflammatory pathways in some cases of Crohn’s disease and ulcerative colitis.

How do I use it?

- Crohn’s or ulcerative colitis treatment usually starts with an intravenous dose over at least one hour. The first under-the-skin injection is usually eight weeks later, then repeated on your clinician’s schedule. This differs from psoriasis treatment. Train in injection technique and rotate sites; do not double a missed dose.

How do I store it?

- Store at 2–8°C in the original packaging. Do not freeze or shake. Permitted time outside the refrigerator differs by brand and formulation. Follow your own pack’s leaflet; do not assume a biosimilar has identical instructions.

What tests do I need?

- Tuberculosis screening and a review of infections and vaccinations before starting. Blood and liver tests, viral tests and disease monitoring follow the team’s plan.

Possible side effects: what to expect

- Not everyone experiences side effects. Headache, tiredness, injection-site redness or cold-like symptoms may occur. Tell your team if these persist or bother you; reviewing injection technique may help local discomfort.
- Serious infections or severe allergy can occur. Infection screening, vaccination review and early reporting help the team manage these risks. Report an infection before the next dose. New breathlessness or neurological symptoms, such as altered vision or confusion, need urgent assessment as explained below.

Important points

- Do not stop because symptoms improve without a plan. Avoid live vaccines unless directed by the specialist, and discuss pregnancy and breastfeeding in advance.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

A severe allergic reaction or breathlessness. A new severe headache with altered vision, confusion or a seizure needs urgent assessment.

Contact your care team promptly

Fever, infection or starting an antibiotic before a dose: call the team first. Contact them for persistent cough, a rash or new skin change, or a storage problem.

Related guides: Biologic infusions: what to expect · IBD medicine safety · Crohn’s disease · Ulcerative colitis · Pregnancy and breastfeeding with bowel and liver disease

Sources: 1 · Source details and full guide online

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Risankizumab medicine card

Last updated: 11 November 2026 · Risankizumab

An IL-23-targeting biologic for some cases of Crohn’s disease and ulcerative colitis.

How do I use it?

- Starting doses depend on the disease and locally approved product. Crohn’s induction may be intravenous or under the skin; ulcerative colitis induction is intravenous. An intravenous dose takes at least one hour for Crohn’s or two hours for ulcerative colitis. Later doses are under the skin to maintain control. Follow your schedule, train with your device, and do not switch routes or strengths yourself.

How do I store it?

- Keep in the original packaging at 2–8°C, protected from light. Do not freeze, shake or warm it to speed up preparation. How long to remove it before use depends on the device; follow its leaflet and the pharmacist’s advice.

What tests do I need?

- Liver tests and bilirubin before treatment and during induction through at least week 12, then according to the plan. The team reviews infections, tuberculosis as appropriate to your circumstances, and vaccinations before starting.

Possible side effects: what to expect

- Not everyone experiences side effects. Headache, joint aches, or injection-site redness and soreness may occur. Tell your team if these persist; checking device technique and rotating injection sites may help local discomfort.
- Infections or severe allergy can occur. Serious liver injury has been reported during treatment for bowel disease, so liver tests are monitored, particularly during induction. Keeping these checks even when you feel well, and reporting new symptoms early, helps identify and address problems.

Important points

- Do not stop treatment or double a missed dose yourself. Consult the team about live vaccines, pregnancy and breastfeeding.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Difficulty breathing, swelling of the face or throat, or fainting: seek emergency care.

Contact your care team promptly

Fever or infection before a dose: contact the team before it is given. Yellow eyes, dark urine, persistent nausea or upper abdominal pain need prompt contact, particularly during induction doses.

Related guides: Biologic infusions: what to expect · IBD medicine safety · Crohn’s disease · Ulcerative colitis · Pregnancy and breastfeeding with bowel and liver disease

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Mesalazine / mesalamine medicine card

Last updated: 11 November 2026 · Mesalazine / Mesalamine

An anti-inflammatory medicine that works inside the bowel, mainly for ulcerative colitis. It is not a usual substitute for effective Crohn’s disease treatments.

How do I use it?

- Available as tablets or granules, suppositories or enemas; your doctor may combine oral and rectal forms. Products differ in where they release the medicine and how they should be taken. Do not crush or switch products, open a capsule or dissolve a tablet unless your product leaflet allows it.

How do I store it?

- Keep in the original packaging away from heat and moisture, at the temperature stated on the pack. Instructions differ between tablets, suppositories and enemas. Do not leave it in a car.

What tests do I need?

- Kidney function before starting and regularly afterwards, with blood, liver and urine tests as appropriate. Tell your doctor about kidney disease and painkillers such as ibuprofen or diclofenac.

Possible side effects: what to expect

- Not everyone experiences side effects. Headache, nausea, wind or abdominal discomfort may occur. Report persistent symptoms; sudden worsening diarrhoea and cramps with fever after starting need assessment because a medicine reaction can resemble a flare.
- The Pentasa leaflet lists kidney disorders as very rare: up to 1 in 10,000 people. Kidney monitoring remains important to detect changes early. Other reactions include pancreatitis or allergy; see the warning signs below for when to seek help.

Important points

- Do not stop maintenance treatment when symptoms improve or double a missed dose. Pregnancy and breastfeeding plans are individualized with your doctor.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Severe rash or mouth ulcers, difficulty breathing or chest pain: seek urgent care before taking another dose. A severe headache with changed vision needs urgent assessment.

Contact your care team promptly

Sudden worsening diarrhea and cramps with fever after starting: seek same-day assessment and advice before the next dose; this may be a medicine reaction. Reduced urination needs prompt review, and a severe headache with altered vision needs urgent assessment.

Related guides: IBD medicine safety · Crohn’s disease · Ulcerative colitis · Pregnancy and breastfeeding with bowel and liver disease

Sources: 1 · 2 · Source details and full guide online

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Corticosteroid medicine card

Last updated: 11 November 2026 · Corticosteroids: prednisolone / budesonide

Used to settle inflammation. In Crohn’s disease and ulcerative colitis, treatment is usually short term; some liver diseases need different plans.

How do I use it?

- Follow your written dose and tapering schedule. Oral prednisolone is often taken in the morning with food when prescribed once daily. Budesonide is not identical; its capsules, tablets and foam differ according to disease location. Do not switch between them. A separate card explains how to use Cortiment 9-mg tablets.

How do I store it?

- Keep the product in its packaging away from heat and moisture and follow its leaflet. Storage temperatures and packaging requirements differ between formulations; do not use instructions for another medicine.

What tests do I need?

- Monitoring of blood pressure, blood glucose, weight, infections and mood. Bone, vitamin D, calcium and eye assessments may be needed depending on dose, duration and risk factors.

Possible side effects: what to expect

- Not everyone experiences side effects. Increased appetite, indigestion, sleep difficulties or mood changes may occur. Morning prednisolone with food, when prescribed once daily, may help; report troublesome symptoms rather than changing the dose yourself.
- Risks depend on dose, duration and formulation. Glucose, blood pressure and infection risk may rise; longer courses can affect bones and eyes. Serious mental-health changes can occur and need prompt assessment. Monitoring and your clinician’s prescribed taper help reduce risk.

Important points

- Do not stop steroids suddenly or change your taper yourself. Tell the team before surgery or severe illness; you may need a special plan. Avoid grapefruit with budesonide.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Fainting or severe weakness with vomiting, black stools or vomiting blood, severe mental health changes or difficulty breathing: seek emergency care.

Contact your care team promptly

Fever or infection, markedly raised blood glucose, major mood changes, or contact with chickenpox: contact the team promptly. If vomiting prevents you taking a dose, seek same-day advice.

Related guides: IBD medicine safety · Crohn’s disease · Ulcerative colitis · Pregnancy and breastfeeding with bowel and liver disease · Autoimmune hepatitis · Budesonide MMX 9 mg / Cortiment · Anti-rejection medicines after liver transplantation: a practical guide

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Budesonide MMX 9 mg / Cortiment

Last updated: 11 November 2026 · Budesonide MMX 9 mg / Cortiment

A corticosteroid released in the colon to settle mild-to-moderate active ulcerative colitis. Some products are also prescribed for microscopic colitis, according to their approved use and your clinician's plan.

How do I use it?

- The usual prescribed adult course is one 9-mg tablet in the morning, with or without food, generally for up to eight weeks. Swallow whole with water: do not split, crush or chew. Follow your leaflet for missed doses; never double. Your clinician decides when and how to stop, particularly when changing from another steroid.

How do I store it?

- Follow your own pack's temperature limit; the referenced Cortiment leaflet specifies below 30°C. Keep away from children, heat and moisture. Do not leave it in a car.

What tests do I need?

- Symptoms, blood pressure, glucose, infections and mood are reviewed as appropriate. Other tests may be needed for new symptoms or longer steroid exposure. Disclose liver disease, diabetes or eye problems.

Possible side effects: what to expect

- Not everyone experiences side effects. Headache, nausea, bloating, abdominal pain or sleep difficulties may occur. Report persistent or troublesome symptoms. It acts mainly in the bowel and generally has fewer whole-body steroid effects than prednisolone, but these are not absent.
- The body's cortisol production may be suppressed, and steroid effects such as glucose or mood changes and increased infection susceptibility can occur. Duration, liver disease and other medicines affect risk. Interaction checks, monitoring and a planned stopping schedule help reduce it.

Important points

- MMX tablets are not automatically interchangeable with 3-mg budesonide capsules or rectal foam: their release site and uses differ. This is not usual long-term maintenance treatment for ulcerative colitis. Avoid grapefruit and check new medicines, particularly clarithromycin or some antifungals, with the pharmacist. If you have a soya or peanut allergy, do not start Cortiment until your pharmacist or doctor checks it; the referenced formulation contains a soya-derived ingredient. Tell the team about pregnancy or breastfeeding.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Breathing difficulty or facial swelling, or fainting and profound weakness with repeated vomiting: seek urgent care.

Contact your care team promptly

Contact the team promptly for fever or infection, chickenpox exposure, blurred vision or significant mood changes. Review the plan if symptoms do not improve.

Related guides: Ulcerative colitis · Microscopic colitis · Corticosteroid medicine card · IBD medicine safety

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Azathioprine / Imuran

Last updated: 11 November 2026 · Azathioprine / Imuran

An immune-modifying medicine used in selected cases of Crohn’s disease, ulcerative colitis, autoimmune hepatitis and after transplantation. Benefit takes weeks to months; it is not a rapid treatment for an acute flare.

How do I use it?

- Follow the dose calculated from your weight and tests. It is usually taken daily; doses may be divided when prescribed. Swallow tablets whole. Do not take with milk or dairy; follow the spacing instructions in your own leaflet. Never double a missed dose or adjust the dose yourself.

How do I store it?

- Keep in the original packaging away from children. Follow your pack’s temperature and light instructions; avoid a hot car. Ask the pharmacist if swallowing is difficult rather than crushing tablets yourself.

What tests do I need?

- Blood counts and liver/kidney tests are checked before treatment, frequently after starting or dose changes, and regularly afterwards. TPMT testing helps estimate the risk of certain side effects and guide dosing; NUDT15 may also be checked depending on your situation. These checks never replace regular blood counts, even when symptoms improve.

Possible side effects: what to expect

- Not everyone experiences side effects. Nausea may occur, particularly initially. Ask your pharmacist about food and dose timing for your product; your team can adjust how it is taken if needed. Do not split doses or stop it yourself.
- Blood-cell reductions, liver problems or infections can occur; regular tests help detect problems early. Pancreatitis can also occur, so persistent severe pain needs urgent assessment. Longer-term cancer risks are discussed individually, alongside sun protection and appropriate screening.

Important points

- Disclose all medicines: allopurinol requires a specialist dose-adjustment plan, and febuxostat is usually avoided. Discuss vaccines, pregnancy and breastfeeding. Do not automatically stop treatment if pregnancy occurs.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Severe persistent abdominal pain, especially with vomiting, breathing difficulty, or fever with severe illness: seek urgent assessment.

Contact your care team promptly

Fever, sore throat, mouth ulcers, unusual bruising or yellow eyes: contact the team the same day to review tests and the next dose. During pregnancy, report new intense itching without a rash to your maternity and treating teams the same day, even without jaundice; you may need liver and bile-acid tests and a treatment review.

Related guides: IBD medicine safety · Autoimmune hepatitis · Pregnancy and breastfeeding with bowel and liver disease · Anti-rejection medicines after liver transplantation: a practical guide

Sources: 1 · 2 · 3 · 4 · 5 · Source details and full guide online

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Entecavir for hepatitis B

Last updated: 11 November 2026 · Entecavir for hepatitis B

Entecavir suppresses hepatitis B virus (HBV) and protects the liver. Treatment is often long term; a low viral load does not mean you can stop.

How to use

- The usual dose for a previously untreated adult is 0.5 mg daily. Your specialist may select 1 mg in particular circumstances and adjusts dosing for kidney impairment. Follow your written food instructions: if an empty stomach is required, leave at least two hours after eating and two hours before the next meal. Instructions vary by your clinical situation and product; ask the pharmacist if uncertain. For a missed dose, follow the leaflet; never double.

Storage

- Follow the temperature on your pack: storage requirements vary between products and even between blisters and bottles. Retain the original packaging, close bottles tightly, and keep away from children, light and heat.

Tests and follow-up

- Follow-up includes HBV DNA, liver enzymes and kidney function. An HIV test is needed before treatment. Continue scheduled liver ultrasound if your clinician recommends it.

Possible side effects: what to expect

- Not everyone gets side effects. Headache, nausea, tiredness or dizziness may occur. Avoid driving if dizzy, and contact your team if symptoms persist or affect daily activities; do not adjust the dose yourself.
- Lactic acidosis, a dangerous acid build-up, is rare but important, particularly with advanced liver impairment or other serious illness. Follow-up helps detect problems. Stopping treatment can also trigger a severe hepatitis flare, so do not stop suddenly.

Important

- Do not stop or run out: stopping can trigger a severe hepatitis flare. Tell your team about previous lamivudine, medicines affecting the kidneys, all supplements, pregnancy or breastfeeding. Entecavir alone is not suitable HIV treatment.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Get urgent help for new jaundice, confusion, or breathlessness with profound weakness or abdominal pain and vomiting.

Contact your care team promptly

Contact the clinic for persistent nausea, dizziness or headache, repeated missed doses, or difficulty obtaining refills.

Related guides: Hepatitis B · Liver cirrhosis (F4) · Pregnancy and breastfeeding with bowel and liver disease

Sources: 1 · 2 · 3 · 4 · 5 · Source details and full guide online

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Tenofovir disoproxil (TDF) for hepatitis B

Last updated: 11 November 2026 · Tenofovir disoproxil (TDF) for hepatitis B

TDF suppresses hepatitis B virus. Many people need long-term treatment, with kidney and bone monitoring tailored to their health.

How to use

- The usual adult tablet contains 300 mg tenofovir disoproxil fumarate, also labelled as 245 mg tenofovir disoproxil: these describe the same strength. It is generally taken once daily; kidney impairment may change the schedule. Take with food as directed for Viread 245 mg; follow your own leaflet if its instructions differ. For a missed dose, use your leaflet and never double.

Storage

- Follow the temperature printed on your pack; storage requirements differ between tenofovir products. Keep in the original, tightly closed container and away from children and heat.

Tests and follow-up

- Before and during treatment: kidney function, urine protein/glucose, phosphorus when indicated, liver enzymes and HBV DNA. Test for HIV before starting. Bone assessment may be needed when fracture or osteoporosis risks are present.

Possible side effects: what to expect

- Not everyone gets side effects. Nausea, diarrhoea or abdominal discomfort may occur and are often mild. Follow your pack’s instructions about taking it with food; report symptoms that persist or interfere with eating or treatment.
- TDF can affect kidney function or bone density, so monitoring reflects your risk factors. Report persistent bone pain or muscle weakness. Do not stop treatment yourself: hepatitis B can flare severely after withdrawal.

Important

- Do not stop abruptly: HBV can flare severely. Check before using anti-inflammatory painkillers such as ibuprofen, especially high or repeated doses, or other kidney-affecting medicines. Do not combine tenofovir-containing products without explicit prescribing instructions. Discuss pregnancy or pregnancy plans. Treatment suppresses HBV but usually does not eliminate the virus.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Get urgent help for markedly reduced urine, breathlessness with profound weakness, new jaundice or confusion.

Contact your care team promptly

Report persistent bone pain, muscle weakness, troublesome nausea, or problems obtaining doses. Contact your care team before your supply runs out.

Related guides: Hepatitis B · Liver cirrhosis (F4) · Pregnancy and breastfeeding with bowel and liver disease

Sources: 1 · 2 · 3 · 4 · Source details and full guide online

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Tenofovir alafenamide (TAF) for hepatitis B

Last updated: 11 November 2026 · Tenofovir alafenamide (TAF) for hepatitis B

TAF is a daily medicine that controls hepatitis B virus. It differs from TDF in strength and instructions; do not switch between them yourself.

How to use

- The usual adult Vemlidy dose is one 25 mg tablet daily with food. If prescribed during haemodialysis, take it after dialysis on treatment days. Severe kidney impairment or advanced loss of liver function requires specialist assessment before prescribing. For a missed dose, follow your own leaflet or ask the pharmacist; never double the dose.

Storage

- Keep Vemlidy in its original, tightly closed container to protect from moisture. Follow your pack’s temperature requirement; some Vemlidy packs specify below 30°C. Keep away from children.

Tests and follow-up

- Check kidney function, urine protein/glucose and, with kidney disease, phosphorus before and during treatment, alongside liver enzymes and HBV DNA. Test for HIV before treatment. Continue recommended liver checks and ultrasound surveillance.

Possible side effects: what to expect

- Not everyone gets side effects. Headache, nausea or tiredness may occur, sometimes with diarrhoea or abdominal discomfort. Take the dose with food as prescribed, and discuss persistent or troublesome symptoms rather than changing treatment yourself.
- Kidney problems can occur, so kidney monitoring continues according to your circumstances even when you feel well. Report reduced urine or symptoms after adding medicines. Do not stop Vemlidy suddenly: hepatitis B can flare severely.

Important

- Do not stop or run out: a serious hepatitis flare can follow. Review all medicines, especially rifampicin, seizure medicines, St John’s wort and painkillers that affect the kidneys. Do not add TDF or another tenofovir-containing medicine. Discuss pregnancy and breastfeeding with your clinician. Treatment suppresses HBV but usually does not eliminate the virus.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Get urgent help for new jaundice, confusion, markedly reduced urine, or breathlessness with profound weakness.

Contact your care team promptly

Contact the clinic for persistent headache or nausea, symptoms after adding another medicine, or repeated missed doses.

Related guides: Hepatitis B · Liver cirrhosis (F4) · Pregnancy and breastfeeding with bowel and liver disease

Sources: 1 · 2 · 3 · 4 · 5 · Source details and full guide online

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Peginterferon alfa-2a for selected hepatitis B cases

Last updated: 11 November 2026 · Peginterferon alfa-2a for selected hepatitis B cases

A weekly injection that a liver specialist may select as a finite treatment for suitable hepatitis B cases. It needs careful monitoring during and after treatment.

How to use

- The usual adult Pegasys schedule is 180 micrograms under the skin weekly for 48 weeks; the team may adjust this for response or tolerability. Learn injection technique and safe needle disposal, and rotate injection sites. Food does not affect injection timing. If remembered within two days, take the missed dose as directed in the Pegasys leaflet; after that, contact your team. Never double.

Storage

- Pegasys: refrigerate at 2–8°C and protect from light. Do not freeze or shake. If left unrefrigerated or frozen, ask the pharmacist before use; follow your own leaflet’s permitted time outside the refrigerator.

Tests and follow-up

- Blood counts, liver/kidney function, thyroid tests, glucose and HBV DNA are monitored. Assess mood and pregnancy before starting. Blood tests are repeated early and regularly; an eye examination may be needed.

Possible side effects: what to expect

- Not everyone gets side effects. Tiredness, flu-like aches or fever after injections, and injection-site soreness may occur. Plan some rest and ask your team which pain relief suits your liver condition; report severe or persistent symptoms.
- Mood changes, depression, low blood-cell counts and thyroid problems need monitoring. Report mood changes promptly and attend blood tests. Seek immediate help for thoughts of self-harm; finding problems early allows the team to adjust treatment.

Important

- Fatigue and flu-like symptoms may follow injections. Disclose depression, autoimmune, thyroid or heart disease, and pregnancy plans. This treatment is unsuitable for decompensated liver disease. Review interactions, particularly telbivudine, theophylline and methadone; check before starting any new medicine.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Get immediate help for thoughts of self-harm, severe confusion, sudden vision loss, chest pain, breathing difficulty or major bleeding.

Contact your care team promptly

Report mood changes, persistent fever, bruising or jaundice the same day, and troublesome persistent symptoms promptly.

Related guides: Hepatitis B · Liver cirrhosis (F4) · Pregnancy and breastfeeding with bowel and liver disease

Sources: 1 · 2 · 3 · 4 · 5 · Source details and full guide online

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Sofosbuvir/velpatasvir for hepatitis C

Last updated: 11 November 2026 · Sofosbuvir/velpatasvir for hepatitis C

An oral treatment for hepatitis C across viral genotypes. It aims for cure; the regimen depends on liver health and previous treatment.

How to use

- The usual adult Epclusa dose is one 400/100 mg tablet daily, with or without food, commonly for 12 weeks. Selected patients, particularly those with liver decompensation, need a different plan or added ribavirin. Complete the prescribed course. For a missed dose or vomiting after dosing, follow your product leaflet or ask the pharmacist; never double a dose.

Storage

- Follow the temperature requirement on your dispensed pack and retain the original container. Product labels can differ. Keep away from children and heat; do not leave it in a hot car.

Tests and follow-up

- Before starting, assess liver disease, kidney function and HCV RNA, and test for HIV and hepatitis B. HBV may reactivate during or after treatment, so monitoring or preventive treatment is arranged when needed. An undetectable HCV RNA result at least 12 weeks after treatment completion confirms cure.

Possible side effects: what to expect

- Not everyone gets side effects. Headache, tiredness or nausea may occur and are usually mild. Rest and regular meals may help; contact your team if symptoms persist rather than stopping the course yourself for a minor symptom.
- Important precautions include hepatitis B reactivation in people with current or previous infection and interactions with other medicines, making screening and medication review necessary. Added ribavirin requires extra attention to anaemia and its pregnancy precautions.

Important

- Review every medicine and supplement, especially amiodarone, seizure medicines, rifampicin, statins and St John’s wort. Acid-reducing medicines can impair absorption: separate ordinary antacids by four hours; omeprazole and similar drugs need a clinician-approved plan. Discuss pregnancy/breastfeeding; added ribavirin requires its strict precautions.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Get urgent help for fainting, a markedly slow heartbeat, chest pain, breathlessness, new jaundice or confusion.

Contact your care team promptly

Contact the clinic for persistent headache, fatigue or nausea, repeated missed doses, or a new need for heartburn treatment.

Related guides: Hepatitis C · Hepatitis B · Liver cirrhosis (F4) · Ribavirin for hepatitis C · Pregnancy and breastfeeding with bowel and liver disease

Sources: 1 · 2 · 3 · 4 · 5 · 6 · Source details and full guide online

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Glecaprevir/pibrentasvir for hepatitis C

Last updated: 11 November 2026 · Glecaprevir/pibrentasvir for hepatitis C

An oral hepatitis C treatment known as Maviret or Mavyret. Each tablet contains two medicines; the usual adult dose requires three tablets together.

How to use

- Take three 100/40 mg tablets together once daily with food. Treatment is often eight weeks for suitable previously untreated adults, but prior therapy and clinical circumstances can require longer. Do not spread the tablets through the day. For a missed dose or vomiting after dosing, use your leaflet or call the pharmacist; never double.

Storage

- The Saudi-registered Maviret pack specifies below 30°C. Follow the instructions on your own pack, retain its packaging, and keep away from children and heat.

Tests and follow-up

- Before treatment, assess liver function/scarring, kidney function and HCV RNA, and test for HIV and hepatitis B. HBV can reactivate during or after treatment and needs a monitoring plan. An undetectable HCV RNA result at least 12 weeks after treatment completion confirms cure.

Possible side effects: what to expect

- Not everyone gets side effects. Headache, tiredness or nausea may occur; most reactions in trials were mild or moderate. Take your prescribed dose with food and contact the team if symptoms persist or interfere with completing treatment.
- Serious liver deterioration can occur, particularly with advanced liver disease, so liver assessment is essential before prescribing. New jaundice, abdominal swelling or confusion needs urgent assessment. Other medicines and hepatitis B reactivation risk are also reviewed.

Important

- It contains a protease inhibitor: do not use with moderate/severe liver impairment or previous decompensation such as ascites, variceal bleeding or hepatic encephalopathy. Review all medicines, especially rifampicin, atazanavir, statins, seizure medicines and St John’s wort. Ethinylestradiol-containing contraception requires review because restrictions differ by label. Discuss pregnancy and breastfeeding.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Get urgent help for new jaundice, abdominal swelling, confusion, vomiting blood, black stools or breathing difficulty.

Contact your care team promptly

Contact the clinic for persistent headache, fatigue or nausea, repeated missed doses, or difficulty completing treatment.

Related guides: Hepatitis C · Hepatitis B · Liver cirrhosis (F4) · Pregnancy and breastfeeding with bowel and liver disease

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Ledipasvir/sofosbuvir for hepatitis C

Last updated: 11 November 2026 · Ledipasvir/sofosbuvir for hepatitis C

An oral hepatitis C treatment known as Harvoni. It suits particular viral genotypes and clinical situations; your clinician selects the duration and any additional medicines.

How to use

- The usual adult dose is one 90/400 mg tablet daily, with or without food, often for 12 weeks. Selected situations require a shorter or longer course. Do not stop early because symptoms improve. For a missed dose or vomiting after dosing, follow the product leaflet or ask the pharmacist; never double.

Storage

- Follow the temperature requirement on your dispensed pack and retain the original container. Product labels can differ. Keep away from children and heat; do not leave it in a hot car.

Tests and follow-up

- Before treatment, check HCV RNA and genotype, assess liver disease and kidney function, and test for HIV and hepatitis B. HBV may reactivate during or after treatment. An undetectable HCV RNA result at least 12 weeks after treatment completion confirms cure.

Possible side effects: what to expect

- Not everyone gets side effects. Headache, tiredness or nausea may occur and are often mild. Discuss persistent symptoms or those limiting your activities; check before adding pain relief or heartburn medicines to ensure they suit your treatment.
- Important problems can result from interactions, particularly a slow heartbeat when combined with amiodarone. Hepatitis B reactivation risk also needs assessment. If ribavirin is added, its pregnancy precautions and anaemia monitoring apply.

Important

- Acid-reducing medicines need planning: separate ordinary antacids by four hours and check before omeprazole or famotidine. Review amiodarone, statins, seizure medicines, rifampicin, St John’s wort and HIV medicines, particularly those containing TDF. Check before adding medicines. Discuss pregnancy/breastfeeding and read the ribavirin card if it is added.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Get urgent help for fainting, a markedly slow heartbeat, chest pain, breathlessness, new jaundice or confusion.

Contact your care team promptly

Contact the clinic for persistent headache, fatigue or nausea, repeated missed doses, or a new need for heartburn treatment.

Related guides: Hepatitis C · Hepatitis B · Liver cirrhosis (F4) · Ribavirin for hepatitis C · Pregnancy and breastfeeding with bowel and liver disease

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Sofosbuvir/velpatasvir/voxilaprevir (Vosevi) for hepatitis C

Last updated: 11 November 2026 · Sofosbuvir/velpatasvir/voxilaprevir for hepatitis C

A three-drug combination known as Vosevi, often used by specialists to retreat hepatitis C after previous therapy failed. Selection depends on prior medicines and liver health.

How to use

- The usual adult dose is one 400/100/100 mg tablet daily with food; retreatment commonly lasts 12 weeks. Follow your prescribed duration. For missed doses or vomiting after dosing, use your leaflet or ask the pharmacist; never double, and do not combine with another sofosbuvir-containing treatment without instructions.

Storage

- Follow the temperature requirement on your dispensed pack and retain the original container. Product labels can differ. Keep away from children and heat; do not leave it in a hot car.

Tests and follow-up

- Review previous treatments and genotype where relevant, with HCV RNA, liver/kidney function, HIV and hepatitis B testing. HBV can reactivate during or after treatment and needs monitoring. An undetectable HCV RNA result at least 12 weeks after treatment completion confirms cure.

Possible side effects: what to expect

- Not everyone gets side effects. Headache, tiredness, nausea or diarrhoea may occur. Take your dose with food and report ongoing diarrhoea or vomiting, especially if you cannot retain fluids or medicine; do not repeat a dose yourself.
- Serious liver deterioration can occur, particularly with advanced liver disease, so treatment selection requires liver assessment. Medication interactions and hepatitis B reactivation also need review. New jaundice, confusion or abdominal swelling warrants urgent assessment.

Important

- It contains a protease inhibitor and is unsuitable with moderate/severe liver impairment or previous decompensation such as ascites, variceal bleeding or hepatic encephalopathy. Rifampicin is contraindicated. Also review amiodarone, ciclosporin, statins, seizure medicines and St John’s wort. Separate ordinary antacids by four hours; other acid-reducing medicines require review. Discuss pregnancy and breastfeeding.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Get urgent help for new jaundice, abdominal swelling, confusion or bleeding, or fainting, a slow heartbeat or chest pain.

Contact your care team promptly

Contact the clinic for persistent headache, nausea, diarrhoea or fatigue, repeated missed doses, or newly started medicines.

Related guides: Hepatitis C · Hepatitis B · Liver cirrhosis (F4) · Pregnancy and breastfeeding with bowel and liver disease

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Ribavirin for hepatitis C

Last updated: 11 November 2026 · Ribavirin: an add-on for selected hepatitis C regimens

Ribavirin is added to selected hepatitis C regimens; it does not treat HCV effectively alone. Pregnancy prevention and monitoring for anaemia are essential.

How to use

- Tablets or capsules commonly contain 200 mg. Your specialist selects the dose using weight, kidney function, haemoglobin and the accompanying regimen; do not calculate it yourself. It is usually divided into two doses with food. Do not break/crush tablets or open capsules. For a missed dose, follow your product leaflet and never double.

Storage

- Follow the temperature on your pack; storage requirements differ between ribavirin products. Keep away from children and heat, and ask the pharmacist about damaged packs.

Tests and follow-up

- Check blood count/haemoglobin and kidney function before treatment and early during it, often at weeks two and four, then as needed. Pregnancy testing is required before starting and regularly during and after treatment according to the product-specific plan.

Possible side effects: what to expect

- Not everyone gets side effects. Nausea, itching, rash or tiredness may occur. Take it with food as prescribed and report troublesome symptoms; increasing fatigue or palpitations may indicate anaemia and need assessment.
- Anaemia from red-cell breakdown is an important effect that may require clinician-directed dose adjustment, so blood counts are checked early. It can worsen heart disease. Serious harm to an unborn baby makes the contraception plan essential; your team balances these risks against the expected benefit.

Important

- Do not start if you or your partner are pregnant; contact your team first. It can seriously harm an unborn baby. Agree a written contraception/testing plan before starting: some current labels require prevention for nine months after the last dose for treated women and six months for female partners of treated men; other products differ, so do not assume one universal interval. Disclose heart/blood disorders and review didanosine, azathioprine, HIV medicines and breastfeeding.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Get urgent help for chest pain, severe breathlessness or fainting. Tell the team immediately about pregnancy in you or your partner during the risk period.

Contact your care team promptly

Report palpitations, pallor, increasing fatigue, rash or difficulty following the contraception plan promptly.

Related guides: Hepatitis C · Liver cirrhosis (F4) · Sofosbuvir/velpatasvir for hepatitis C · Ledipasvir/sofosbuvir for hepatitis C · Pregnancy and breastfeeding with bowel and liver disease

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Acid medicines: proton pump inhibitors (PPIs)

Last updated: 11 November 2026 · Proton pump inhibitors (PPIs)

Omeprazole, esomeprazole, pantoprazole, lansoprazole and rabeprazole reduce stomach acid. They treat reflux and ulcers and form part of some H. pylori treatments.

How do I use it?

- For reflux, most PPIs work best 30–60 minutes before a meal: before breakfast if once daily, and before breakfast and the evening meal if twice daily. Some formulations have different food instructions; follow your own pack and prescription. Swallow gastro-resistant tablets or granules without crushing or chewing. Ask a pharmacist about options if swallowing is difficult.

How do I store it?

- Keep in the original container, away from children. Follow the temperature and moisture instructions on your particular product; liquids may have different storage requirements.

What tests do I need?

- Review the reason, dose and duration with your clinician. Kidney, vitamin B12 and bone-density tests are not routinely required solely because you take a PPI without other risk factors. Symptoms, other medicines and existing illnesses may justify targeted tests.

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Possible side effects: what to expect

- Not everyone gets side effects. Headache, nausea or bowel changes are usually mild; discuss persistent or troublesome symptoms with your doctor or pharmacist.
- Kidney inflammation and severe magnesium deficiency are recognised risks; testing depends on individual risk. Many reported long-term associations do not prove causation. Keep reviewing the need and dose with your clinician rather than stopping necessary treatment yourself.

Important points

- When treatment is indicated, benefits usually outweigh potential risks. Severe oesophagitis or protection from gastrointestinal bleeding may require long-term treatment. Use the lowest effective prescribed dose. Do not stop a PPI you need because of general concerns about long-term use; temporary rebound acidity can occur after stopping. Check interactions, especially with clopidogrel, with your pharmacist.

Before testing for H. pylori

- PPIs can cause a false-negative H. pylori test, including stomach biopsy tests. For planned testing, they are usually paused for 14 days with medical approval, with 4 weeks without antibiotics or bismuth. Do not interrupt essential treatment yourself; not every gastroscopy requires stopping PPIs. A negative result during treatment may need confirmation by a breath or stool test after an appropriate interval. See My medicines before endoscopy.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Seek emergency care for vomiting blood, black tarry stools, or new or severe chest pain, particularly with breathlessness.

Contact your care team promptly

Arrange assessment for progressive swallowing difficulty, unexplained weight loss, persistent vomiting or continuing symptoms despite correct use.

Related guides: Gastroesophageal reflux disease · Helicobacter pylori infection · Pregnancy and breastfeeding with bowel and liver disease · Gastrointestinal bleeding · My medicines before endoscopy

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Vonoprazan

Last updated: 11 November 2026 · Vonoprazan

Vonoprazan is a potassium-competitive acid blocker (P-CAB), a different class from PPIs. It reduces stomach acid and may be prescribed for reflux or an H. pylori regimen.

How do I use it?

- Take only the prescribed strength and schedule, with or without food. Swallow tablets whole unless your own leaflet gives different instructions. The dose and treatment length depend on the reason for use; a 10-mg tablet is not equivalent to a 20-mg tablet. H. pylori treatment requires prescribed antibiotics as well: vonoprazan alone does not eradicate the infection.

How do I store it?

- Follow the storage instructions on your pack. Keep it away from children, direct sunlight and excess heat; ask your pharmacist if it has been stored incorrectly.

What tests do I need?

- Tell your clinician about kidney or liver disease so they can check suitability and dose. Selected patients need magnesium or other blood tests during prolonged treatment. After H. pylori treatment, arrange a breath or stool antigen test at least four weeks after the last antibiotic or bismuth dose. The team plans a two-week pause in PPIs or vonoprazan before testing to reduce false-negative results. They may use an H2 blocker or antacid temporarily; follow the team's and laboratory's instructions rather than stopping prescribed treatment yourself.

Possible side effects: what to expect

- Not everyone gets side effects. Nausea, abdominal discomfort or diarrhoea may occur; seek advice if persistent. Accompanying antibiotics can also contribute.
- Kidney inflammation, severe allergy and serious skin reactions have been reported; some reported risks have no reliable frequency estimate. Persistent watery diarrhoea or reduced urine needs prompt assessment. During prolonged treatment, selected patients may need magnesium or vitamin B12 testing.

Important points

- Complete the prescribed H. pylori course. Do not add leftover antibiotics or substitute another acid medicine yourself. Ask a pharmacist to check all medicines, particularly HIV treatment and clopidogrel. Discuss pregnancy, plans for pregnancy or breastfeeding before use. If other symptoms persist despite improved heartburn, ask your doctor to assess their cause.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Seek emergency care for facial or throat swelling, difficulty breathing, vomiting blood or severe chest pain.

Contact your care team promptly

Contact your clinician promptly for persistent watery diarrhoea, reduced urination, new jaundice, swallowing difficulty or unexplained weight loss.

Related guides: Gastroesophageal reflux disease · Helicobacter pylori infection · Pregnancy and breastfeeding with bowel and liver disease

Sources: 1 · 2 · 3 · 4 · 5 · Source details and full guide online

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PEG / macrogol for constipation

Last updated: 11 November 2026 · PEG / macrogol for constipation

Polyethylene glycol (PEG), also called macrogol, draws water into the bowel to soften stool. Constipation products may contain PEG alone or PEG with electrolytes.

How do I use it?

- Use the dose and mixing volume for your exact product. A common adult PEG 3350 product uses 17 g once daily, while macrogol sachets have different strengths and instructions. Dissolve powder fully as directed; do not swallow it dry. It may take one to three days to work. Aim for comfortable, soft stools and reduce or pause treatment if diarrhoea develops, following your care plan.

How do I store it?

- Keep the product away from children and follow its storage label. Drink the solution after mixing. If preparing it in advance, check the leaflet for storage and the time limit before discarding it. Ready-to-drink products have their own instructions.

What tests do I need?

- Tell your team about kidney or heart disease, a fluid restriction, or medicines affecting fluid balance. They can decide whether electrolyte or kidney tests are needed, especially with diarrhoea, dehydration or prolonged treatment.

Possible side effects: what to expect

- Not everyone gets side effects. Bloating, wind, cramps or loose stools often improve with dose adjustment under your plan. Aim for comfortable soft stools, not watery diarrhoea.
- Severe diarrhoea can cause dehydration and disturbed blood salts, especially with excessive dosing. Seek advice if diarrhoea persists; follow your permitted fluid intake. Serious allergy is possible, with frequency unspecified; breathing difficulty or facial swelling needs emergency care.

Important points

- Drink your usual permitted fluids; mixing water does not replace normal intake. Some macrogol products require other oral medicines to be separated by one hour. Check with your pharmacist. Constipation sachets and colonoscopy preparation are not interchangeable. Large doses for faecal impaction need a confirmed diagnosis and a separate clinical plan.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Seek urgent care for severe or persistent abdominal pain, marked swelling with vomiting or inability to pass gas, or difficulty breathing.

Contact your care team promptly

Contact your clinician for rectal bleeding, persistent diarrhoea, dehydration, or constipation that continues beyond the self-treatment period on your pack.

Related guides: Constipation, difficult evacuation and bowel leakage · Pregnancy and breastfeeding with bowel and liver disease

Sources: 1 · 2 · 3 · 4 · Source details and full guide online

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Lactulose

Last updated: 11 November 2026 · Lactulose

Lactulose softens stool for constipation. In advanced liver disease, it also helps treat and prevent hepatic encephalopathy, which can cause confusion and drowsiness. These uses require different plans.

How do I use it?

- Measure the prescribed millilitres with a medicine cup or oral syringe, not a kitchen spoon. Take with or without food; mixing with water or juice may help the taste. Constipation relief can take two to three days. For hepatic encephalopathy, follow your team's adjustment plan to achieve two to three soft stools daily—not watery diarrhoea. Do not copy another patient's dose.

How do I store it?

- Keep the bottle closed and away from children. Follow your product's temperature and light instructions; do not freeze. Ask a pharmacist about an unusually dark or cloudy solution or storage after opening.

What tests do I need?

- During encephalopathy treatment, your team checks bowel pattern, hydration, thinking and blood salts as needed. A stool diary helps dose review. Excess diarrhoea can cause dehydration and low potassium; older or frail people may need closer monitoring.

Possible side effects: what to expect

- Not everyone gets side effects. Wind, bloating, cramps or nausea may occur. Discuss troublesome symptoms; for hepatic encephalopathy, follow your dose plan to reach the soft-stool target.
- Excess dosing or persistent diarrhoea can cause dehydration and sodium or potassium disturbances. Repeated watery stools, dizziness or reduced urine need prompt advice. New confusion requires urgent assessment, not an assumption that it is a mild side effect.

Important points

- Bloating, wind and cramps are common, particularly initially. Drink the amount of fluid permitted in your care plan and tell your clinician about diabetes. Lactulose contains residual sugars: if you have galactosaemia or must follow a medically prescribed low-galactose diet, do not start it before the prescriber or pharmacist checks it, because the product may be contraindicated. This differs from ordinary lactose intolerance. Do not stop encephalopathy prevention just because thinking has improved; contact the team for dose advice if side effects interfere.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Seek urgent assessment for new confusion, unusual sleepiness, inability to wake normally, or severe or persistent abdominal pain, especially with vomiting.

Contact your care team promptly

Contact your team promptly for repeated watery stools, dizziness, reduced urine, or failure to meet your agreed stool target.

Related guides: Constipation, difficult evacuation and bowel leakage · Liver cirrhosis (F4) · A family guide to cirrhosis · Hepatic encephalopathy: confusion and altered awareness

Sources: 1 · 2 · 3 · 4 · Source details and full guide online

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Rifaximin

Last updated: 11 November 2026 · Rifaximin

Rifaximin is an antibiotic that works mainly inside the bowel. It helps prevent recurrent hepatic encephalopathy, which can cause confusion and drowsiness, and treats selected adults with diarrhea-predominant IBS (IBS-D). A specialist may also prescribe it for selected cases of small intestinal bacterial overgrowth (SIBO). Dose and duration depend on the reason for treatment.

How do I use it?

- For hepatic encephalopathy prevention, a common adult prescription is 550 mg twice daily, with or without food. It is usually added to lactulose; do not replace lactulose yourself. IBS-D commonly uses 550 mg three times daily for 14 days. Your clinician may prescribe another course after an initial response and later recurrence. SIBO treatment needs an individual plan.

How do I store it?

- Keep the tablets in their original pack, away from children. Follow the temperature limit printed on your medicine. Ask the pharmacist if the pack was exposed to excessive heat.

What tests do I need?

- For encephalopathy, follow-up assesses alertness, bowel pattern and the underlying liver disease. Tell your team if you take warfarin: INR monitoring may need adjustment when rifaximin starts or stops. Other testing depends on the reason for treatment and your health.

Possible side effects: what to expect

- Not everyone gets side effects. Nausea, headache or dizziness may occur. Seek advice if persistent; liver disease or other medicines can contribute.
- Low absorption does not eliminate interactions or effects elsewhere in the body. Severe allergy and serious skin reactions have been reported with frequency unknown. Persistent or severe diarrhoea needs assessment for antibiotic-associated infection. Advanced liver disease and some interactions increase exposure.

Important points

- Improvement of IBS-D does not prove bacterial overgrowth. Do not repeatedly restart leftover antibiotics for bloating. When SIBO is diagnosed, its underlying cause also needs attention. Tell your clinician about rifamycin allergy, pregnancy or breastfeeding. Check the tablet strength and schedule when collecting a new supply. Tell your team if you take ciclosporin: it can increase rifaximin exposure, particularly with severe liver impairment. A specialist should review the combination; do not stop transplant medicine yourself.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Seek urgent care for new confusion or marked drowsiness, facial swelling, breathing difficulty, or a blistering or peeling rash.

Contact your care team promptly

Contact your clinician promptly for severe or persistent diarrhoea, especially with fever or blood, during treatment or in the weeks afterwards.

Related guides: Medicines for irritable bowel syndrome (IBS) · Liver cirrhosis (F4) · A family guide to cirrhosis · Irritable bowel syndrome · Chronic diarrhea · Hepatic encephalopathy: confusion and altered awareness

Sources: 1 · 2 · 3 · 4 · 5 · 6 · Source details and full guide online

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Ursodeoxycholic acid (UDCA)

Last updated: 11 November 2026 · Ursodeoxycholic acid (UDCA)

Ursodeoxycholic acid, also called ursodiol or UDCA, is a bile acid medicine and first-line treatment for primary biliary cholangitis (PBC). It is not a general “liver protector”.

How do I use it?

- Your liver team calculates the dose from your weight and diagnosis. For PBC, the usual total is 13–15 mg/kg/day, divided according to the prescribed product, often with food. Do not calculate or increase your own dose. Treatment for PBC is usually long term, even when you feel well. Ask the pharmacist before splitting a tablet.

How do I store it?

- Follow the temperature instructions for your brand and keep it away from children. Keep tablets in their supplied packaging; ask about storage and expiry if tablets are split or a liquid is supplied.

What tests do I need?

- Liver blood tests, including alkaline phosphatase and bilirubin, track safety and response. Testing is more frequent initially, then follows your liver team’s schedule. Response is formally reviewed around 12 months; an incomplete response may require additional treatment. Report important weight changes for dose review.

Possible side effects: what to expect

- Not everyone gets side effects. Loose stools or diarrhoea are common; if persistent, contact your liver team for dose review without stopping PBC treatment yourself.
- Very rarely, worsening liver function has been reported during treatment of advanced PBC. Scheduled tests help detect changes. Increasing jaundice or abdominal swelling needs prompt review; severe upper abdominal pain needs urgent assessment. Symptoms can also reflect the underlying disease.

Important points

- UDCA is not routine treatment for every liver condition. Use in primary sclerosing cholangitis (PSC) is a separate specialist decision; high-dose treatment can be harmful. Cholestyramine and some antacids can reduce its absorption, so ask for a medicine-spacing plan. Loose stools may occur. Do not stop a prescribed PBC treatment without discussing it.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Seek urgent care for sudden severe upper abdominal pain or fever with jaundice. Call emergency services for sudden swelling of the lips, tongue or throat, or difficulty breathing or swallowing; do not wait for swelling and breathlessness together.

Contact your care team promptly

Contact your liver team for persistent diarrhoea, worsening jaundice or itching, or difficulty taking the prescribed dose.

Related guides: Primary biliary cholangitis · Primary sclerosing cholangitis (PSC) · Pregnancy and breastfeeding with bowel and liver disease

Sources: 1 · 2 · 3 · 4 · 5 · Source details and full guide online

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Cholestyramine

Last updated: 11 November 2026 · Cholestyramine

Cholestyramine, also spelled colestyramine, binds bile acids in the bowel. It may help bile-acid diarrhoea or itching caused by impaired bile flow. The reason for treatment determines the plan.

How do I use it?

- Mix the prescribed powder with the liquid volume on your product label and stir well. Never swallow the powder dry. Your clinician may start with a small dose and adjust it according to how well it works and whether it causes constipation. Sachets and scoops differ between products; use the measuring device supplied with your own medicine.

How do I store it?

- Keep the container closed and away from children. Follow the temperature limit on your pack. If mixing a dose ahead of time, ask the pharmacist how to store it and when to discard it.

What tests do I need?

- During prolonged treatment, your clinician may review triglycerides, nutrition and fat-soluble vitamins, particularly if doses are high or absorption is already poor. Additional monitoring is needed with medicines such as warfarin. Do not start high-dose vitamin supplements without advice.

Possible side effects: what to expect

- Not everyone gets side effects. Constipation is most frequent; bloating or nausea may occur. Constipation is often mild and manageable. Discuss troublesome symptoms early and follow your appropriate fluid intake.
- Bowel obstruction is a rare reported risk. Prolonged use can impair vitamin absorption, including vitamin K needed for clotting. Follow-up and medicine spacing help prevent problems. Report unusual bruising; severe pain with vomiting needs urgent assessment.

Important points

- Take other oral medicines at least one hour before, or four to six hours after, cholestyramine unless your pharmacist gives a specific plan. This includes ursodiol and thyroid medicine. Ask for a practical schedule when you take several medicines. Constipation and bloating are common. Bile-acid diarrhoea needs assessment; this medicine does not treat every cause of diarrhoea.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Seek urgent care for sudden severe abdominal pain, or abdominal pain and swelling with inability to pass stool or gas, especially with vomiting. Do not wait for every symptom. Breathing difficulty also needs urgent help.

Contact your care team promptly

Contact your clinician for troublesome constipation, persistent diarrhoea, unusual bruising or bleeding, or difficulty separating your medicines safely.

Related guides: Chronic diarrhea · Primary biliary cholangitis · Primary sclerosing cholangitis (PSC)

Sources: 1 · 2 · 3 · 4 · Source details and full guide online

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Pregnancy and breastfeeding with bowel and liver disease

Last updated: 10 November 2026 · Pregnancy and breastfeeding

Many people with bowel or liver disease can have a safe pregnancy and breastfeed with planning and follow-up. Controlling the disease helps protect mother and baby; do not change treatment yourself.

Your next step

Book a pre-pregnancy review and take a list of your medicines and doses to your gastroenterologist or liver specialist and obstetrician.

Before pregnancy

- Ideally, plan pregnancy during stable remission, with a review of tests, nutrition, iron, folic acid and vaccinations. You may need to delay trying until your condition is stable or a medicine unsuitable for pregnancy has been changed.
- Tell the team about all medicines, supplements and herbs, and any history of blood clots or bowel surgery. The specialist will determine suitable contraception, the plan for changing medicines and when you can start trying; there is no single waiting period for every medicine.

Crohn’s disease and ulcerative colitis (IBD)

- Active inflammation during pregnancy may increase the risk of premature birth and poor fetal growth. Stopping effective treatment out of concern about pregnancy can trigger a flare; your doctor weighs the risks of both the disease and the medicine.
- Mesalazine, azathioprine and suitable biologics can often be continued during pregnancy and breastfeeding, depending on the medicine and your circumstances. Steroids may be used when needed with monitoring. Methotrexate and some newer oral medicines are unsuitable for pregnancy or breastfeeding and need an advance specialist plan.
- The delivery plan is agreed with your obstetrician; IBD does not automatically mean a cesarean section. Active fistulas or inflammation around the anus, or previous pouch surgery, may affect the decision.

Autoimmune hepatitis (AIH)

- Stable inflammation before pregnancy is important. Azathioprine and certain steroids can be used during pregnancy and breastfeeding with monitoring. Mycophenolate needs a planned switch before pregnancy and is not used during pregnancy or breastfeeding.
- The disease may flare after delivery even if it was stable during pregnancy. Keep your post-delivery liver tests and appointments, and do not reduce treatment because you feel better.

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After liver transplantation

- Pregnancy needs early coordination with the transplant team. Usually, waiting at least one year after transplantation with stable graft function is preferred; the decision is individualized.
- Do not stop anti-rejection medicines yourself. Tacrolimus, ciclosporin or azathioprine may continue according to the plan, with monitoring of drug levels, kidney function and blood pressure. Mycophenolate and certain other medicines need changing before pregnancy; the transplant team determines the alternative and its timing.

Hepatitis B (HBV)

- Your doctor needs viral load testing (HBV DNA by PCR) and liver tests. If the viral load is high, tenofovir may be prescribed during pregnancy to reduce transmission to the baby. The specialist decides the formulation, when to start it and whether to continue after delivery.
- Arrange hepatitis B vaccine and hepatitis B immune globulin (HBIG) for the baby within the first 12 hours after birth, followed by completion of vaccinations and follow-up tests. Inform the maternity hospital early and bring your results.
- Hepatitis B does not usually prevent breastfeeding, and breastfeeding with tenofovir is possible under the agreed plan. Do not stop treatment after delivery without review; liver inflammation may increase after stopping.

Breastfeeding and your baby’s vaccinations

- Many IBD, AIH and transplant medicines can be used while breastfeeding, but this does not apply to every medicine. Review the exact drug with the team before delivery; do not rely only on the drug class name.
- If you used a biologic during pregnancy, tell the pediatrician the drug name and date of the last dose before any live vaccine, especially the BCG tuberculosis vaccine. Do not automatically delay all vaccines; rotavirus recommendations differ from BCG, and the pediatrician will make the appropriate plan.

Plan to share with the maternity and pediatric teams
Maternal medicine and last dose: .....
Infant vaccine plan, including any live-vaccine decisions: .....
If hepatitis B is present: newborn vaccine / immunoglobulin plan: .....
Specialist contact and review date: .....

When to get help

Get urgent medical care / go to the emergency department

Heavy bleeding, persistent severe pain, vomiting that prevents drinking, fainting, breathlessness, or marked jaundice with feeling very unwell; also any emergency warning sign identified by your maternity team.

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Contact your care team promptly

Contact the team the same day if your pregnancy test is positive while taking mycophenolate, methotrexate or a medicine you have been told is unsuitable for pregnancy. Do not wait for a routine visit to arrange an urgent plan. Report returning diarrhea or bleeding, fever or repeated vomiting early. During pregnancy, report new intense itching without a rash to your maternity and treating teams the same day, even without jaundice; you may need liver and bile-acid tests and a treatment review.

Related guides: Crohn’s disease · Ulcerative colitis · Autoimmune hepatitis · Care after liver transplantation · Hepatitis B · Herbs, mixtures and supplements: benefits and risks · Benign liver lesions and cysts · Mycophenolate: CellCept and Myfortic · Anti-rejection medicines after liver transplantation: a practical guide · Safe use of blood thinners (anticoagulants)

Sources and further information Global consensus on pregnancy in IBD, 2025/2026 EASL: Autoimmune hepatitis, 2025 AASLD: Reproductive health and liver disease — patient summary AASLD–IDSA: Hepatitis B treatment, 2025 CDC: Preventing hepatitis B transmission at birth

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Chronic diarrhea

Last updated: 10 November 2026 · Chronic diarrhea

Diarrhea lasting four weeks or longer needs assessment to find the cause. It does not automatically mean IBS or an infection.

Your next step

For several days, record bowel movement frequency, stool appearance and associated symptoms. Bring your medicine list.

Understanding the condition

Diarrhea means passing loose or watery stools more often than usual. It may be watery, contain blood, or be greasy and difficult to flush away. Its duration and pattern matter more than the number of toilet visits alone.

Causes include side effects of some medicines, intolerance of certain foods, celiac disease, inflammatory bowel disease and microscopic colitis. It may also relate to altered gut–brain interaction, bile acids or poor fat digestion. Tests and treatments depend on the likely cause, and more than one cause may be present.

What will the doctor ask?

- When did it start? Does it wake you at night? Is there blood or weight loss? Mention travel, antibiotics and previous operations, particularly removal of the gallbladder or parts of the bowel.
- Bring a list of medicines and supplements, including magnesium, laxatives and diabetes medicines. Do not stop a prescribed medicine yourself.

Which tests might I need?

- Blood tests may check for anemia, electrolyte changes and celiac disease. Selected stool tests may check for infection, inflammation or poor digestion. Not everyone needs every test.
- Colonoscopy with biopsies may be needed: in microscopic colitis the lining can look normal, while inflammation is seen in samples under a microscope. Do not begin a gluten-free diet before arranging celiac testing.

What can I do before my appointment?

- Replace lost fluids. Oral rehydration solution may be needed with repeated losses. If heart or kidney disease means you must restrict fluids, follow your team’s plan.
- Eat a balanced diet as tolerated and record food and symptoms. Avoid broad restrictive diets, antibiotics or antidiarrheal medicines without assessment, particularly with blood or fever.

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Why follow up?

- We treat the cause and assess weight, nutrition and response. Temporary improvement with symptom-relieving medicine does not prove the cause has gone.

When to get help

Get urgent medical care / go to the emergency department

Severe dehydration or markedly reduced urination, fainting, heavy bleeding, or severe pain with bloating or fever and feeling very unwell.

Contact your care team promptly

Persistent diarrhea, repeated blood in stools, weight loss or nighttime diarrhea: arrange an assessment rather than assuming it is IBS.

Related guides: Irritable bowel syndrome · Microscopic colitis · Celiac disease · Colonoscopy · Cholestyramine · C. difficile infection · Pancreatitis and pancreatic enzyme insufficiency · Gastroenteritis and food poisoning

Sources and further information NIDDK: Diagnosing diarrhea

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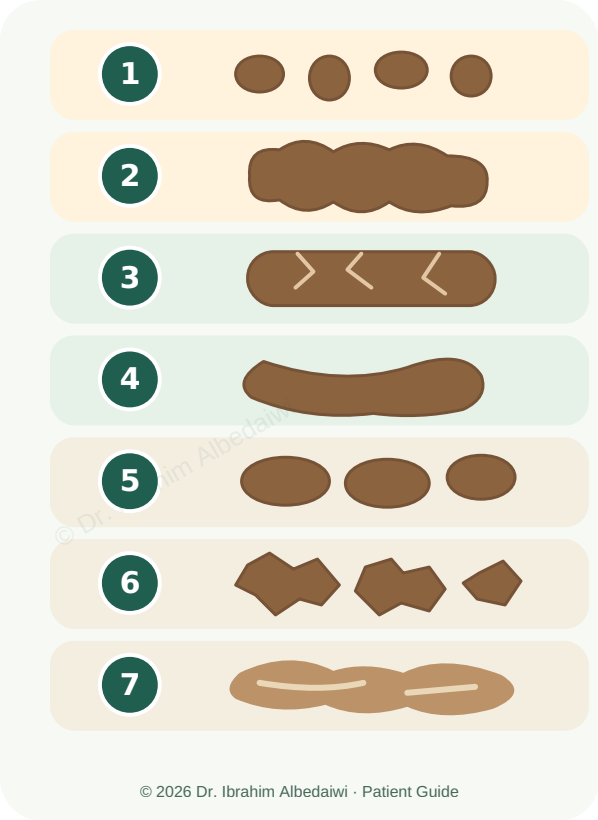
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ILLUSTRATED PATIENT GUIDE

How to describe your stool

Original schematic drawings based on the Bristol stool classification.



1 · Separate hard pellets

Small, firm pieces.

2 · Firm and lumpy

A long piece made up of lumps.

3 · Formed with cracks

A long piece with cracks on the surface.

4 · Smooth and soft

A soft, formed piece.

5 · Separate soft pieces

Soft pieces with clear edges.

6 · Mushy pieces

Loose pieces with uneven edges.

7 · Watery

Liquid without formed pieces.

> Types 1–2 can accompany constipation, 3–4 are usually formed stool, and 6–7 are loose or watery. Shape alone does not diagnose illness; also describe frequency, pain and any blood.

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NHS England: Bristol stool classification

These illustrations support education and do not replace your doctor’s advice or follow-up. Plans vary by patient.

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Difficulty swallowing and food getting stuck

Last updated: 10 November 2026 · Dysphagia and food impaction

Repeated difficulty swallowing needs assessment. If food remains stuck or liquids will not pass, go to the emergency department without waiting, even if you can swallow saliva. Inability to swallow saliva or difficulty breathing needs immediate help.

Your next step

Record whether the problem affects solids or liquids, and bring previous test reports.

Understanding the condition

The problem may occur when starting a swallow, with coughing or choking, or after swallowing, when food feels stuck in the chest. Tell your doctor whether it happens only with solids or also with liquids, and whether it started suddenly or is progressively worsening.

Causes include narrowing or rings in the esophagus, eosinophilic esophagitis and movement disorders such as achalasia. Other causes may need to be ruled out. New swallowing difficulty should not be attributed to reflux without assessment.

If food is stuck now

- If food remains stuck or liquids will not pass, go to emergency care even if you can swallow saliva. Inability to swallow saliva or difficulty breathing needs immediate help.
- Do not try to push the food down with water, fizzy drinks or more food, and do not try to make yourself vomit. The food may need to be removed by endoscopy.

How do we find the cause?

- Tests may include upper endoscopy with biopsies, a swallowing X-ray study or esophageal manometry to measure muscle movement. The choice depends on the location and pattern of the problem.
- If the difficulty is starting a swallow or involves choking, a swallowing specialist may need to assess you; endoscopy alone does not assess every stage of swallowing.

What happens after treatment?

- Treatment may involve controlling inflammation, widening a narrowing or treating a movement disorder, depending on the diagnosis. Not everyone needs the same treatment.
- Even if the food passes on its own or is removed, we need to find the cause to prevent recurrence. Bring previous endoscopy and biopsy reports.

Eating safely until assessment

- If you can swallow safely, sit upright, eat slowly and chew well. Follow the texture recommended by the specialist; do not automatically thicken liquids. Stop eating and seek assessment if choking or food sticking recurs.

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When to get help

Get urgent medical care / go to the emergency department

Food stuck in the esophagus, inability to swallow saliva, choking or difficulty breathing. Sudden swallowing difficulty with weakness or altered speech also requires emergency care.

Contact your care team promptly

Repeated or worsening swallowing difficulty, painful swallowing, weight loss or repeated choking.

Related guides: Eosinophilic esophagitis · Gastroesophageal reflux disease · Gastroscopy · Achalasia: a swallowing movement disorder

Sources and further information ASGE: Esophageal food impaction NHS: Swallowing problems

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Stomach and duodenal ulcers

Last updated: 10 November 2026 · Peptic ulcer disease

An ulcer is a sore in the lining of the stomach or the first part of the small intestine. Treating its cause helps it heal and reduces recurrence.

Your next step

Review the names of your painkillers and confirm the plan to treat the cause and check healing.

Understanding the condition

An ulcer differs from indigestion or superficial inflammation. It may cause upper abdominal pain, nausea or fullness, but may cause little obvious pain until bleeding occurs. The pattern of pain alone cannot confirm an ulcer.

Common causes are Helicobacter pylori infection and anti-inflammatory painkillers such as ibuprofen and diclofenac. Spicy food may bother some people, but is not the main explanation for ulcers.

How is it diagnosed?

- Upper endoscopy may be needed to locate the ulcer and take biopsies, especially from a stomach ulcer, along with testing for H. pylori. Taking a sample does not by itself mean cancer is present.

How is it treated?

- Your doctor prescribes acid-reducing medicine and treats H. pylori if confirmed. Complete the prescribed course even if the pain disappears.
- Review all painkillers with your doctor. Do not stop aspirin or blood thinners prescribed for heart disease or clots yourself; the risks of bleeding and clotting must be balanced with a clear plan.

Do I need repeat testing?

- After treatment for H. pylori, a test at the correct time is needed to confirm it has cleared; pain relief is not enough. See the H. pylori page for testing instructions.
- A stomach ulcer may need repeat endoscopy to confirm healing, depending on its appearance, biopsy results and cause. This differs from a duodenal ulcer, and there is no single timing suitable for everyone.

What can help?

- Stop smoking, and avoid foods that personally trigger symptoms without following a broadly restrictive diet. Do not replace treatment with herbs.
- Tell your doctor about repeated vomiting, loss of appetite or weight loss. Bring your biopsy result and repeat-endoscopy plan if you have one.

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When to get help

Get urgent medical care / go to the emergency department

Vomiting blood or material resembling coffee grounds, black, tarry stools even without dizziness, fainting, or sudden severe abdominal pain.

Contact your care team promptly

Pain continuing despite treatment, repeated vomiting, weight loss or a biopsy result that has not arrived.

Related guides: Helicobacter pylori infection · Gastroscopy · Iron deficiency, anemia and the digestive system · Stomach cancer · Acid medicines: proton pump inhibitors (PPIs) · Gastrointestinal bleeding

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Sources and further information NIDDK: Stomach and duodenal ulcers

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Iron deficiency, anemia and the digestive system

Last updated: 10 November 2026 · Iron deficiency and anemia

Replacing iron is important, but finding the reason for the deficiency matters too. Digestive investigations may be needed even without pain or visible bleeding.

Your next step

Bring previous results and the names of blood thinners and painkillers. Ask about the cause of the deficiency and when to repeat tests.

Understanding the condition

Iron deficiency means low iron stores and can develop before hemoglobin falls, which is called anemia. It may cause tiredness, palpitations or reduced exercise tolerance. Not all anemia is caused by iron deficiency.

Iron may be low because of blood loss, low intake or poor absorption, for example in celiac disease. Bleeding from the digestive tract may be hidden and not visible. In women, we also review menstrual bleeding without assuming it is the only cause.

How is iron deficiency confirmed?

- We review the blood count, ferritin and transferrin saturation as appropriate. Ferritin can rise with inflammation, so a single result should not be interpreted separately from other tests.

Why might I need both gastroscopy and colonoscopy?

- Men and postmenopausal women with iron-deficiency anemia often need evaluation of both the stomach and colon. Before menopause, the doctor discusses the need according to age, menstrual history, symptoms, risk factors and preferences.
- Celiac and H. pylori testing may be requested depending on the situation. Having no pain or a negative stool blood test does not remove the need for appropriate evaluation.

How is it treated?

- Iron may be given orally or intravenously depending on tolerance, absorption and the degree of deficiency. Do not double doses if you do not improve quickly; follow the testing and treatment plan.
- Iron tablets may cause constipation and darken the stool. Black, tarry or unusually sticky stools need urgent assessment even without dizziness or weakness; do not automatically attribute them to iron. Keep iron out of children’s reach.

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If the endoscopies are normal

- We may start or continue iron replacement and monitor response. Persistent or returning deficiency may require further investigations, including the small intestine; capsule endoscopy is not immediately required for every patient.

When to get help

Get urgent medical care / go to the emergency department

Chest pain, severe breathlessness or breathlessness at rest, fainting, vomiting blood or obvious bleeding.

Contact your care team promptly

Recurrent iron deficiency, inability to tolerate treatment, or blood tests not improving by the planned review.

Related guides: Celiac disease · Stomach and duodenal ulcers · Gastroscopy · Colonoscopy · Gastrointestinal bleeding

Sources and further information AGA: Gastrointestinal evaluation of iron-deficiency anemia

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Raised liver enzymes: what do they mean?

Last updated: 10 November 2026 · Elevated liver enzymes

Raised enzymes are a finding that needs interpretation, not a diagnosis by itself. The degree of elevation alone does not measure liver function or the amount of scarring.

Your next step

Collect previous results and a list of everything you take, and agree with the team on when results will be reviewed.

Understanding the condition

ALT and AST may rise when cells are injured, while ALP and GGT help assess a pattern related to the bile ducts. Some markers may also come from other organs, such as muscles or bones.

Albumin, INR and bilirubin provide different information from enzymes and are interpreted as part of the whole picture. Liver disease can be present with normal enzymes, and an enzyme can rise temporarily without chronic disease.

What are the possible causes?

- Causes include fatty liver, viruses, effects of certain medicines and supplements, autoimmune conditions and bile duct disease. Depending on age and results, we may also investigate iron disorders and other causes.

How does evaluation begin?

- We review previous results and their trend, symptoms, medicines and supplements, and when they were started. Depending on the pattern, we may repeat tests and request viral, iron and autoimmune tests and an ultrasound.
- If the cause remains unclear or scarring needs assessment, FibroScan, further imaging or a biopsy may be requested. Not every elevation needs a biopsy.

What should I do now?

- Bring the full report with units and reference ranges, plus photos of medicine, herbal and sports-supplement packaging. Mention every new medicine, including nonprescription products.
- Do not start “liver cleanse” mixtures or automatically stop prescribed treatment. Your doctor decides what needs stopping or changing and how urgently tests are needed.

Why follow up if I feel well?

- Some liver conditions cause few symptoms. Our aim is to find and treat the cause and assess scarring, not merely lower a test number. Agree on a date for repeat tests and review of the results.

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When to get help

Get urgent medical care / go to the emergency department

Jaundice with confusion or unusual drowsiness, bleeding, severe pain with fever, or rapid deterioration. If a paracetamol (acetaminophen) overdose is possible, go to emergency care even without symptoms.

Contact your care team promptly

New jaundice, dark urine, significant itching or a result the laboratory describes as critical: contact the team promptly rather than waiting for a routine appointment.

Related guides: Fatty liver and steatohepatitis · Herbs, mixtures and supplements: benefits and risks · Liver biopsy and FibroScan · Hereditary iron overload (hemochromatosis) · Drug-induced liver injury · Alcohol-related liver disease

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Sources and further information AASLD: Assessing elevated liver enzymes

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Benign liver lesions and cysts

Last updated: 10 November 2026 · Benign focal liver lesions

A liver lesion does not automatically mean cancer. A confirmed simple cyst, hemangioma or FNH is usually reassuring, while a hepatic adenoma needs a different plan.

Your next step

Bring your images and medicine list. Ask: Is this a simple cyst, hemangioma, FNH or adenoma, and what follow-up is needed?

What does a liver lesion or mass mean?

A lesion is an area that looks different on a scan, often found incidentally. It may contain fluid, blood vessels or liver cells. “Lesion” is a description, not a diagnosis; “tumor” does not necessarily mean cancer.

Assessment considers images, symptoms, previous liver disease or cancer, and medicines. Not every pain comes from the lesion, and size alone does not determine treatment.

How is the type identified?

- Ultrasound may suffice; otherwise, liver-specific multiphase contrast MRI or CT may be needed. Specialized MRI contrast helps distinguish FNH from adenoma. Report possible pregnancy, kidney disease or previous contrast reactions.
- Biopsy, or tissue sampling, is reserved for selected uncertain findings after specialist review. Biopsy of a suspected hemangioma is avoided when possible because it can bleed.

Simple cyst: a fluid-filled pocket

- A confirmed simple cyst has a thin wall and characteristic scan appearance. It is not cancer and does not become cancer. Without symptoms, treatment or regular scans are usually unnecessary.
- If it causes confirmed pressure-related symptoms, drainage with treatment of the cyst wall or surgery may help. Drainage alone can allow refilling. Internal partitions, nodules or an irregular wall need further assessment; not every cyst is simple.

Hemangioma: a cluster of blood vessels

- This benign blood-vessel cluster is not cancer or a precancerous lesion. It is sometimes informally called a “blood cyst” in Arabic, but it is not a simple fluid-filled cyst. Its contrast-filling pattern often establishes the diagnosis; ultrasound may suffice in typical cases.
- A secure diagnosis without symptoms or special risks usually needs neither treatment nor repeated scans. Size alone does not require surgery. Bleeding or significant pressure on nearby organs may prompt intervention; complications are rare.

Focal nodular hyperplasia (FNH)

- FNH is localized benign liver-cell growth, thought to respond to altered blood flow. It is neither cancer nor a precancerous lesion.
- Imaging-confirmed FNH usually needs neither treatment nor regular surveillance. Atypical imaging or symptoms prompt specialist review of the diagnosis and other possible causes before surgery is considered.

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Hepatic adenoma: a different type of benign tumor

- An adenoma arises from liver cells and differs from FNH. Estrogen, anabolic steroids and excess weight may be associated with it. Some adenomas bleed or rarely become cancer, so assessment and follow-up matter even without symptoms.
- Subtype, size, growth and sex guide the plan. Some cases can be monitored; intervention is more likely in men, growing or large lesions, or high-risk subtypes. Not every adenoma needs immediate surgery.
- The team reviews hormones, contraception and anabolic steroids, and recommends weight loss when appropriate. Arrange suitable alternative contraception before changes. Selected treatments include removal, blocking feeding blood vessels by embolization, or ablation.

Pregnancy and contraception: the lesion type matters

- Confirmed FNH or hemangioma usually does not prevent pregnancy or automatically require stopping contraception. Large, symptomatic or uncertain lesions need individual review.
- With adenoma, discuss pregnancy beforehand with liver and maternity teams: growth may require closer monitoring or treatment before conception. Size and features guide the plan; FNH advice does not apply.

Are all cysts and lesions alike?

- Complex or parasitic (hydatid) cysts and polycystic liver disease differ from simple cysts. Travel, animal exposure and family history may matter. Uncertain findings need assessment; a suspected parasitic cyst must not be sampled outside a specialist plan.

Make follow-up clear

- Bring old and new images, reports and a medicine list. Ask for the diagnosis, how certain it is, and whether the next scan monitors the lesion or the liver overall.
- A confirmed benign lesion does not cancel liver cancer surveillance needed for F4 cirrhosis or hepatitis B. Your team determines the plan for the underlying liver disease separately from the lesion.

Quick comparison after diagnosis is confirmed

Type	What is it?	Usual plan without symptoms or special circumstances
Simple cyst	Fluid-filled pocket	Usually no treatment or routine scans.
Hemangioma	Cluster of blood vessels	Usually no intervention once confirmed; consider background liver risks.
FNH	Localized benign growth of liver cells	Usually no treatment or routine surveillance.
Adenoma	Liver-cell tumor that can bleed or change	Specialist follow-up; hormone changes or intervention may be needed.

This comparison excludes uncertain lesions and complex cysts. It does not replace monitoring of underlying liver disease.

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When to get help

Get urgent medical care / go to the emergency department

Sudden severe upper abdominal pain needs urgent assessment even without dizziness. Fainting, pallor or sweating with pain, or fever with marked illness, requires emergency care.

Contact your care team promptly

Persistent pain or fullness, unexplained weight loss, jaundice, or a report requesting further testing: arrange review. Contact the team early when planning pregnancy with an adenoma.

Related guides: Liver cancer surveillance · Liver cirrhosis (F4) · Liver biopsy and FibroScan · Liver cancer: diagnosis and treatment · Pregnancy and breastfeeding with bowel and liver disease · Herbs, mixtures and supplements: benefits and risks

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Sources and further information ACG: focal liver lesions guideline (2024) ACG: focal liver lesions guideline highlights EASL: benign liver tumors guideline EASL: cystic liver diseases guideline (2022) EASL: liver diseases in pregnancy guideline (2023) AASLD: hepatocellular adenoma Cambridge University Hospitals: cyst sclerotherapy

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Hereditary iron overload (hemochromatosis)

Last updated: 10 November 2026 · Hereditary hemochromatosis

A high ferritin result alone does not prove hereditary iron overload. The iron tests and underlying cause need to be understood before treatment starts.

Your next step

Bring ferritin, transferrin saturation and previous results; do not start treatment based on the ferritin number alone.

Understanding the condition

In hereditary hemochromatosis, the body absorbs more iron than it needs. Iron may gradually build up in the liver and other organs. There may be no early symptoms, or there may be fatigue and joint pain; symptoms alone are not enough for diagnosis.

Ferritin reflects iron stores but may also rise because of inflammation, fatty liver and other causes. Iron overload from repeated blood transfusions differs from the hereditary type and may need different treatment.

How is the diagnosis confirmed?

- We review ferritin, transferrin saturation and liver tests. Genetic testing or an MRI designed to measure liver iron may be requested, and the degree of liver scarring is assessed. Not everyone needs a biopsy.
- A genetic change alone does not mean organs have been damaged; the specialist interprets it alongside blood tests and family history.

How is it treated?

- The usual treatment for confirmed hereditary disease is planned therapeutic blood removal (phlebotomy), with hemoglobin and ferritin monitoring, followed by a maintenance plan. The team determines the volume and frequency.
- Do not start repeated blood donation or cupping as a substitute for treatment. Blood removal is not done merely because ferritin is high without establishing the cause. Iron-chelating medicines are not the usual choice for this type.

Do I need a special diet?

- Eat a balanced diet; severe dietary restriction does not replace treatment. Avoid supplements containing iron and vitamin C supplements unless your doctor prescribes them for a specific need. You do not need to avoid ordinary iron-containing foods or normal portions of fruit and vegetables.
- Avoid raw or undercooked shellfish, and discuss avoiding alcohol and protecting liver health with the team.

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Family and follow-up

- Once hereditary disease is confirmed, the team discusses testing first-degree relatives, especially adults, and interpreting their results. Do not assume every relative is affected.
- People with advanced liver scarring may still need liver cancer surveillance even after iron levels fall. Follow the testing schedule and do not stop follow-up simply because ferritin improves.

When to get help

Get urgent medical care / go to the emergency department

Chest pain, severe breathlessness or fainting, or jaundice with confusion or feeling very unwell.

Contact your care team promptly

Unusual dizziness or fatigue after blood removal, difficulty completing sessions, or a relative diagnosed with hereditary iron overload.

Related guides: Raised liver enzymes: what do they mean? · Liver cirrhosis (F4) · Liver cancer surveillance

Sources and further information NIDDK: Hemochromatosis EASL: Hemochromatosis guideline, 2022

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Bile and pancreatic duct endoscopy (ERCP)

Last updated: 10 November 2026 · ERCP

ERCP mainly treats blocked or leaking ducts. If a stent is placed, its follow-up plan is an essential part of treatment.

Your next step

Confirm fasting, medicines and your escort; record the follow-up plan for any stent before leaving.

What does ERCP do?

Bile ducts carry fluid from the liver to the intestine; pancreatic ducts carry digestive juice. During ERCP, a scope passes through the mouth into the first part of the small intestine. Small instruments enter the duct opening, guided by contrast dye and X-rays. Sedation or anesthesia is used.

Treatment may remove a stone, widen a narrowing, insert a drainage tube called a stent, or collect a sample. ERCP does not remove the gallbladder. When only diagnosis is needed, magnetic resonance imaging of the ducts (MRCP) or endoscopic ultrasound (EUS) may answer the question with less risk.

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Before your appointment

- Send your medicine list, especially blood thinners and diabetes or weight-management medicines. Report allergies, possible pregnancy, heart, kidney or lung disease, and previous anesthesia or ERCP problems. Do not stop medicines yourself.
- Obtain written fasting and medicine instructions and arrange an adult escort. Bring imaging and surgery reports. Tell the unit if you have not followed the fasting instructions.

Risks and their prevention

- Risks include pancreatitis, bleeding, duct infection, perforation and sedation or anesthesia complications. Some require hospital treatment or another intervention. Ask about your individual benefits, risks and alternatives.
- To reduce pancreatitis risk, the team may give a rectal anti-inflammatory medicine if suitable, tailored intravenous fluids, and sometimes a temporary pancreatic duct stent. Heart or kidney problems affect these choices. These are clinician-directed measures; do not take extra painkillers yourself.

If treatment needs another session

- A large stone or difficult narrowing may require further specialist treatment. A temporary stent may allow drainage meanwhile. Occasionally another drainage method or surgery is needed. Less jaundice does not prove that the underlying problem is fully treated.

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Leave with a written stent plan

- Ask where the stent is, its type and purpose, and when it must be removed or replaced. Many stents are temporary, but timing varies. Stents can block or move; feeling better is not a reason to miss follow-up.
- For a preventive pancreatic stent, ask how the team will check that it has passed or arrange removal if it remains. Contact the unit if no appointment arrives, and keep your procedure report.

After ERCP

- Brief bloating or a mild sore throat can occur. Observation or an overnight stay may be needed. Follow your specific instructions for food, fluids and restarting medicines.
- After sedation, avoid driving, machinery and important decisions for 24 hours, or longer if advised. Leave with an escort. Ask when sample results will arrive and whom to contact.

When to get help

Get urgent medical care / go to the emergency department

Severe or increasing abdominal pain, especially with vomiting; fever or shaking chills; vomiting blood or black tarry stools; breathing difficulty or fainting. Seek emergency care and mention your recent ERCP or stent. Do not wait for follow-up.

Contact your care team promptly

No stent plan or sample result, or jaundice and itching that are not improving. Increasing jaundice needs urgent contact, especially with pain or fever.

Related guides: Bile duct stones and obstructive jaundice · Endoscopic ultrasound · Gallbladder and bile duct stones · Pancreatitis and pancreatic enzyme insufficiency

Sources and further information ASGE: ERCP patient information NIDDK: ERCP preparation and risks ASGE: Preventing pancreatitis after ERCP ESGE: Biliary stent follow-up ESGE: Biliary stricture management 2026

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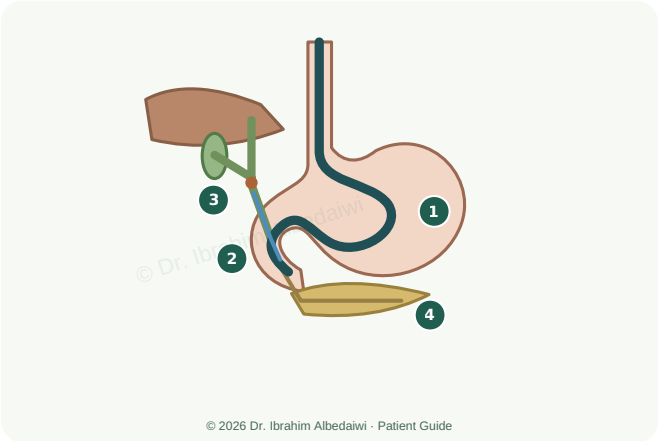
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ILLUSTRATED PATIENT GUIDE

How does ERCP work?

ERCP is mainly used for treatment, such as removing a duct stone or placing a stent.



1 · Endoscope

Passes through the mouth and stomach into the duodenum.

2 · Duct opening

The scope tip stays in the duodenum beside the duct opening.

3 · Thin catheter

Enters the duct through its opening; the scope itself does not enter the duct. Contrast and X-rays show the duct.

4 · Pancreas

Its duct drains near the bile duct; treatment depends on the problem.

> Simplified illustration. The team decides whether stone removal, narrowing treatment or a stent is needed.

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ASGE: ERCP

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Endoscopic ultrasound

Last updated: 10 November 2026 · Endoscopic ultrasound · EUS

EUS combines endoscopy and ultrasound to examine the gut wall and nearby organs. It may involve imaging alone or a tissue sample; not every EUS includes a biopsy.

Your next step

Ask whether your EUS is for imaging, sampling or treatment, and confirm your medicine and results plan.

How is it different from gastroscopy?

Gastroscopy shows the digestive tract lining. An EUS scope also carries an ultrasound probe, showing wall layers and nearby structures from close range. Upper EUS passes through the mouth and can examine the pancreas, bile ducts and surrounding tissues. Lower EUS examines the rectal area and has different preparation.

EUS may clarify a small stone, cyst or mass seen on another scan, identify the origin of a lump within the gut wall, or assess the extent of a known cancer. Being referred for EUS or a biopsy does not mean you have cancer. Other scans may still be needed.

Imaging or a biopsy?

- Diagnostic EUS uses sound waves rather than X-rays. If sampling would help guide treatment, the doctor may pass a fine needle through the scope to obtain cells or a small piece of tissue for laboratory examination.
- FNA means fine-needle aspiration of cells; FNB means fine-needle biopsy of tissue. The team selects the appropriate method. Not every cyst or mass needs sampling. Results are considered alongside imaging and other tests; an inadequate sample may need repeating.

Preparing safely

- Confirm whether your EUS is upper or lower, and whether sampling or treatment is planned. Follow the unit’s fasting instructions. Use bowel preparation only if specifically requested; upper EUS does not automatically require colon cleansing.
- Provide your medicine list, particularly blood thinners and diabetes or weight-management medicines. Report allergies, possible pregnancy, heart, lung or kidney disease, swallowing difficulty and previous surgery. Obtain a written medicine plan; do not stop treatment yourself. Bring previous scan and biopsy reports and arrange an escort if sedation is planned.

Can EUS also provide treatment?

- Specialist teams may use EUS to guide drainage of a fluid collection or blocked duct. This differs from imaging or simple sampling and requires its own discussion of benefits, risks and follow-up. An EUS booking does not mean you will need these treatments.

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Possible complications

- Diagnostic EUS is generally low risk. Complications include sedation reactions, aspiration of stomach contents, bleeding or perforation. Sampling can add infection or bleeding risk, and rarely pancreatitis when the pancreas is sampled. Therapeutic procedures have different risks; ask about your planned procedure.

Recovery and results

- A mild sore throat or brief bloating can occur. Follow instructions for eating, drinking and restarting medicines. After sedation, avoid driving, machinery and important decisions for 24 hours, or longer if advised, and leave with an escort.
- Ask what the images showed, whether a sample was taken, when results are expected and who will contact you. An initial impression is not the final laboratory result. After treatment or stent insertion, obtain written follow-up and removal or replacement instructions.

When to get help

Get urgent medical care / go to the emergency department

Severe or increasing chest or abdominal pain, fever or chills, persistent vomiting, vomiting blood or black tarry stools, severe new swallowing difficulty, breathlessness or fainting after EUS need urgent assessment.

Contact your care team promptly

Discomfort that persists instead of improving, a missing sample result or an unclear follow-up plan. No telephone call does not necessarily mean a normal result.

Related guides: Bile and pancreatic duct endoscopy (ERCP) · Bile duct stones and obstructive jaundice · Gastroscopy · Pancreatitis and pancreatic enzyme insufficiency · Pancreatic cysts

Sources and further information AGA: Endoscopic ultrasound patient information ASGE: Adverse events of EUS and EUS-guided procedures ASGE: Pancreatic mass sampling 2024 ASGE: Sampling unexplained biliary strictures ESGE: Biliary drainage and therapeutic EUS 2026

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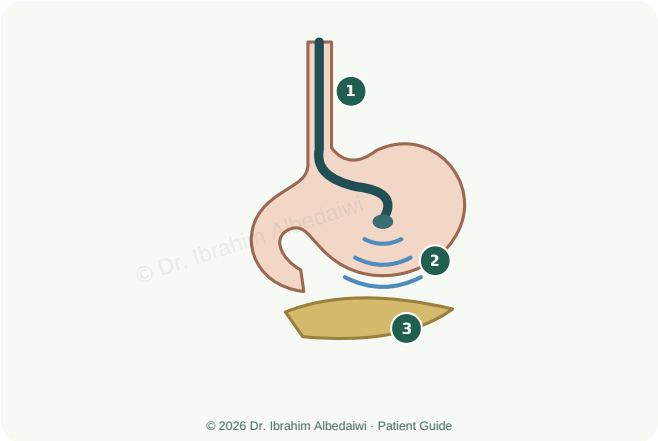
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How does endoscopic ultrasound (EUS) work?

This drawing shows upper EUS.



1 · Scope and ultrasound probe

Enter through the mouth into the stomach or duodenum.

2 · Sound waves

Show the gut-wall layers and nearby organs; these are not X-rays.

3 · Pancreas and nearby structures

The pancreas, bile ducts and other structures can be assessed. A needle sample may be taken through the scope when needed.

> Lower EUS is also used for selected problems. Not every examination needs a needle sample.

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AGA: Endoscopic ultrasound

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Bile duct stones and obstructive jaundice

Last updated: 10 November 2026 · Bile duct stones / obstructive jaundice

A stone inside the drainage duct differs from one remaining in the gallbladder. New jaundice needs prompt assessment; fever or pain can signal an emergency.

Your next step

Ask whether the stone is in the gallbladder or duct, whether treatment is complete, and when stent and gallbladder follow-up are due.

What happens when a duct is blocked?

The liver makes bile to help digest fats, and the gallbladder stores some of it. Ducts carry bile into the intestine. A stone can leave the gallbladder and lodge in the common bile duct. Bilirubin then accumulates, causing yellow eyes or skin, called jaundice.

Symptoms may include dark urine, pale stools, itching, upper abdominal pain or nausea. Obstruction can also be painless. Not all jaundice comes from a stone or blockage; liver disease and other causes are possible. A benign narrowing or a tumor can also obstruct the duct, so tests must establish the cause.

Finding the cause

- Assessment usually starts with examination, liver and bilirubin blood tests and abdominal ultrasound. Further tests may check for infection or pancreatitis. Ultrasound does not detect every small duct stone.
- If suspicion remains, magnetic resonance imaging of the ducts (MRCP) or endoscopic ultrasound (EUS) may help. A narrowing or mass may need CT imaging or tissue sampling. One result or a tumor marker alone cannot diagnose cancer.

When does blockage become an emergency?

- Trapped bile can become infected, causing cholangitis. Fever or shaking chills with jaundice or upper abdominal pain needs emergency assessment; not all features have to be present. Confusion, fainting or marked deterioration adds urgency.
- Hospital treatment may include fluids, antibiotics and prompt drainage. Antibiotics alone do not remove a persistent blockage. A stone may also trigger pancreatitis: severe persistent pain, especially with vomiting or pain spreading to the back, needs urgent assessment.

Treating the underlying problem

- Duct stones are commonly removed by ERCP, sometimes after enlarging the drainage opening. If complete removal is not possible, a temporary stent may allow drainage until another session. Narrowings and tumors need a plan suited to their cause.
- Complex stones may require specialist fragmentation or another intervention. Occasionally surgery or another drainage route is needed. Your team weighs benefits and risks; jaundice does not automatically mean everyone needs ERCP.

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Will I still need gallbladder surgery?

- Clearing the duct does not remove the gallbladder or stones inside it. If it is the source and you are fit for surgery, early gallbladder removal is usually advised after treating the duct to reduce recurrence. Timing depends on inflammation, recovery and your health.
- A confirmed duct stone differs from a silent gallbladder stone that may not need treatment. Do not cancel the treatment plan just because pain has stopped.

Stents and recovery

- Keep the stent type, location, removal or replacement date and unit contact details. Stents can block or move. Do not wait for symptoms before arranging follow-up; give any new team your procedure report.
- Follow the liver-test, scan and sample-result plan. Jaundice may take time to improve, but worsening or recurrent yellowing needs urgent contact. Diets, herbs and gallbladder cleanses cannot reliably clear a blocked duct.

When to get help

Get urgent medical care / go to the emergency department

Fever or chills with jaundice or upper abdominal pain; severe persistent pain with vomiting; confusion, fainting or major deterioration. Go to emergency care immediately and mention any duct stent. Do not wait for all symptoms to appear.

Contact your care team promptly

New jaundice even without pain, or dark urine with pale stools and persistent itching: seek medical assessment the same day. Clarify any missing stent or gallbladder surgery plan.

Related guides: Gallbladder and bile duct stones · Bile and pancreatic duct endoscopy (ERCP) · Endoscopic ultrasound · Pancreatitis and pancreatic enzyme insufficiency

Sources and further information NIDDK: Gallstone symptoms and urgent signs NIDDK: Gallstone and gallbladder treatment ESGE: Common bile duct stones ASGE: Cholangitis management ESGE: Diagnosing bile duct strictures 2025 ESGE: Biliary stricture management 2026

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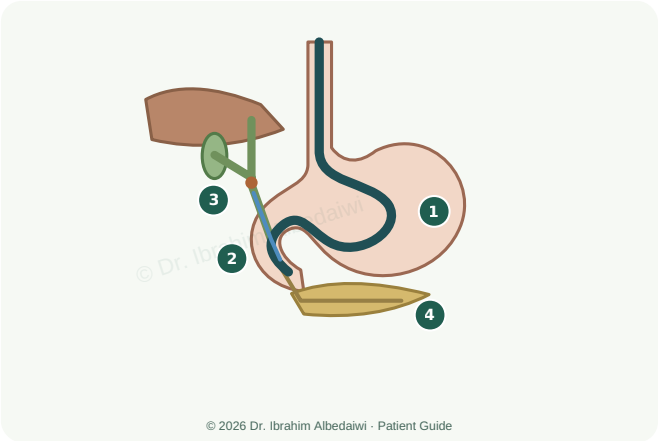
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Its duct drains near the bile duct; treatment depends on the problem.

> Simplified illustration. The team decides whether stone removal, narrowing treatment or a stent is needed.

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ASGE: ERCP

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Pancreatic cancer

Last updated: 10 November 2026 · Pancreatic cancer

The plan depends on the tumor type, extent, whether it can be removed and your overall health. Diagnosis does not automatically mean treatment is impossible; ask what each step aims to achieve.

Your next step

Ask about the tumor type, stage, treatment goal, digestive enzymes and nutrition support.

Understanding the disease

The pancreas lies behind the stomach. It makes digestive enzymes and hormones that regulate blood glucose. Pancreatic cancer is uncontrolled cell growth; this guide mainly concerns adenocarcinoma, which usually starts in pancreatic ducts.

Other tumors, including neuroendocrine tumors, behave differently and need different treatment. A pancreatic cyst or pancreatitis alone does not mean cancer. Imaging and tissue findings help identify the problem; symptoms alone cannot establish the diagnosis.

Symptoms worth checking

- Possible symptoms include persistent upper abdominal or back pain, unintentional weight loss, reduced appetite, or jaundice with dark urine and pale stools. Blood glucose may change. These symptoms have many causes; most diabetes is not caused by pancreatic cancer.
- Explain when symptoms began and how they changed. New jaundice needs prompt assessment even without pain.

Diagnosis and staging

- Tests may include a pancreas-specific CT scan, MRI or endoscopic ultrasound, sometimes with a biopsy. A biopsy is a small tissue sample examined to identify the cells. The team decides when it is needed; not everyone requires the same tests.
- Staging assesses nearby blood vessels, lymph nodes and other organs. CA 19-9 may help monitor treatment, but cannot confirm or exclude cancer alone and is not a standalone screening test for healthy people.
- Ask about inherited genetic testing and tumor testing. These can influence treatment and advice for relatives, even without a family history.

Choosing treatment together

- Specialists in oncology, surgery, gastroenterology and imaging review the case. Options may include surgery with medicines before or afterwards, or medicines and sometimes radiotherapy when removal is unsuitable. Targeted treatments or immunotherapy help selected tumors based on testing.
- Treatment may aim for cure in selected cases, or for disease control and symptom relief. Discuss expected benefits, side effects, a second opinion and suitable clinical trials.

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Nutrition and symptom support

- Report eating difficulties, greasy stools or weight loss early. You may need a dietitian, pancreatic enzymes with food and glucose monitoring. Small frequent meals with enough protein and calories may help; avoid restrictive diets.
- Pain and nausea can be treated. Bile duct blockage may need drainage or a stent; keep its follow-up plan. Psychological support and symptom relief can start alongside cancer treatment.

Keep a written plan

- Bring the pathology report, scan images and medicine and supplement list. Record result appointments and an out-of-hours contact number. Check before using herbs or changing prescribed treatment.

When to get help

Get urgent medical care / go to the emergency department

Jaundice with fever or chills, vomiting that prevents drinking, sudden severe pain, bleeding or sudden breathlessness need urgent assessment. During cancer treatment, follow the team's emergency fever instructions without waiting for an appointment. During chemotherapy, a temperature of 38°C or higher requires immediate contact with the oncology team or emergency care; do not wait for WhatsApp.

Contact your care team promptly

New jaundice, continued weight loss, uncontrolled pain or difficulty eating: contact the team promptly.

Related guides: Pancreatitis and pancreatic enzyme insufficiency · Gallbladder and bile duct stones · Herbs, mixtures and supplements: benefits and risks · My treatment and follow-up plan · Pancreatic enzymes: pancreatin / Creon

Sources and further information NCI: Understanding pancreatic cancer NCI: Symptoms NCI: Diagnosis, staging and genetic testing NCI: Treatment and symptom support NCI: Pancreatic cancer treatment guidance NCI: Inherited cancer testing CDC: fever during chemotherapy

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Stomach cancer

Last updated: 10 November 2026 · Gastric cancer

Common stomach symptoms do not mean cancer. If cancer is confirmed, tissue findings, stage and overall health guide treatment, which may aim for cure in suitable cases.

Your next step

Ask about the tumor type, stage, further tissue tests and your nutrition plan.

Understanding the disease

The stomach receives food and mixes it with digestive juices. Stomach cancer develops when some cells grow uncontrollably. The commonest type is adenocarcinoma, starting in the lining; other tumors need different treatment.

Gastritis or an ulcer does not establish cancer. H. pylori infection, certain chronic stomach changes, smoking or inherited factors may increase risk, but a risk factor does not mean cancer will develop. Pain or one blood test cannot confirm it.

Symptoms that need assessment

- Possible symptoms include increasing difficulty eating, early fullness, persistent nausea, unintentional weight loss or iron-deficiency anemia. Vomiting or bleeding may occur. Many other conditions cause these symptoms, so assessment matters more than assuming cancer or ignoring them.
- Explain their duration, weight changes, swallowing difficulties and family history. Temporary improvement with acid medicine does not replace investigation when concerning symptoms persist.

Confirming diagnosis and stage

- The main test is usually gastroscopy with biopsies: small tissue samples examined by a pathologist. The sample identifies the tumor type. CT scans, and sometimes endoscopic ultrasound or keyhole inspection of the abdomen, assess its extent.
- Stage describes depth, lymph nodes and any spread elsewhere. Tissue may be tested for HER2, PD-L1, DNA repair features and other markers to guide treatment.
- Blood tumor markers alone cannot confirm or exclude stomach cancer, or replace endoscopy and biopsy when indicated. Screening before symptoms differs from investigating an existing symptom.

Choosing treatment

- Specialists in oncology, surgery, endoscopy, imaging and nutrition review the findings with you. Selected very early cancers can be removed endoscopically. Other cases may need removal of part or all of the stomach and nearby lymph nodes, with medicines before or after surgery.

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- Targeted medicines or immunotherapy may suit particular tumor features; radiotherapy is used in selected situations. Treatment may aim for cure, disease control or symptom relief. The diagnosis alone cannot predict an individual outcome.

Nutrition and recovery

- Request early nutrition support if eating is difficult or weight is falling. Small frequent protein-rich meals and treatment for pain or nausea may help. Avoid excluding entire food groups or replacing treatment with herbal mixtures.
- Food tolerance changes after stomach surgery. Iron, vitamin B12 and other nutrients may need monitoring and replacement. Report dizziness, sweating or diarrhea after meals so the plan can be adjusted. Psychological support and symptom relief can accompany cancer treatment.

Before the next appointment

- Keep the biopsy report, scan images and medicine list. Ask about H. pylori treatment if present, and family assessment when age or history suggests an inherited cause. Record result appointments and contact details.

When to get help

Get urgent medical care / go to the emergency department

Vomiting blood, black tarry stools, fainting, sudden severe abdominal pain or vomiting that prevents drinking need urgent care; do not wait for dizziness with bleeding. Follow the cancer team’s urgent instructions for fever during treatment. During chemotherapy, a temperature of 38°C or higher requires immediate contact with the oncology team or emergency care; do not wait for WhatsApp.

Contact your care team promptly

Worsening swallowing, continued weight loss, poor food intake or uncontrolled pain need early review.

Related guides: Gastroscopy · Helicobacter pylori infection · Difficulty swallowing and food getting stuck · Iron deficiency, anemia and the digestive system

Sources and further information NCI: Understanding stomach cancer NCI: Symptoms NCI: Diagnosis and biomarkers NCI: Treatment guidance NCI: Causes and risk factors NCI: Nutrition after gastrectomy CDC: fever during chemotherapy

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Liver cancer: diagnosis and treatment

Last updated: 10 November 2026 · Liver cancer

A liver spot does not automatically mean cancer. If cancer is confirmed, treatment depends on its type, extent, liver function and overall health. Treatment with the aim of cure may be possible.

Your next step

Ask whether the cancer started in the liver or spread there, and how liver function affects treatment.

Which cancer does this mean?

Hepatocellular carcinoma (HCC) starts in liver cells. Risk increases with cirrhosis, meaning stage F4 scarring, and it can occur with hepatitis B without cirrhosis. Other primary cancers, including bile duct cancer, need different treatment.

Cancer that started in the colon or pancreas and reached the liver is metastatic cancer from that organ; it does not become HCC. Establishing the origin is essential. Many spots discovered on scans are benign.

Symptoms and surveillance

- Early cancer may cause no symptoms. Weight or appetite loss, persistent upper abdominal pain, swelling or jaundice can occur, but may also result from liver disease or other conditions.
- Surveillance means scheduled checks before symptoms for people at sufficient risk, usually ultrasound with AFP every six months. Investigating an existing liver spot is different; do not delay that assessment until the next routine scan.

Confirming the diagnosis

- Diagnosis may require contrast-enhanced MRI or CT with dedicated liver imaging phases. In selected people at risk, a characteristic scan pattern can diagnose HCC without biopsy. Others need a tissue sample.
- AFP is a blood protein. A raised result does not establish cancer, and a normal result does not exclude it. AFP does not replace imaging.
- Assessment includes tumor number, size, blood vessel involvement and spread, together with liver function, abdominal fluid, varices and activity level. Size alone cannot establish the stage or best treatment.

Treatment choices

- Liver, oncology, surgical and interventional radiology specialists discuss the case, with transplant specialists when appropriate. Options include removing the tumor, liver transplantation or ablation to destroy it. These may aim for cure in selected situations.

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- Other options include treatment delivered through a catheter, radiotherapy, immunotherapy or targeted medicines. Treatments may be combined or used in sequence. Liver function, bleeding risk, other conditions and availability affect selection.
- Ask whether the goal is cure, shrinking the cancer to enable another treatment, or disease control and symptom relief. A cancer diagnosis does not automatically mean treatment is impossible; two patients may need different plans.

Protecting the liver and nutrition

- Continue treatment for the underlying liver disease as prescribed; do not stop antiviral medicine yourself. Avoid alcohol and unknown herbal products, and review all medicines and supplements with the team.
- Eat regularly with suitable protein, and request dietitian support for weight or muscle loss. With ascites, follow your individual salt, fluid and diuretic plan. Treat pain, nausea and anxiety early; supportive care is part of cancer treatment.

Follow-up

- Scans and blood tests assess response and possible recurrence on a schedule set by your team. Improved AFP alone is insufficient. Keep scan images, any biopsy report, result appointments and contact details.

When to get help

Get urgent medical care / go to the emergency department

Vomiting blood, black tarry stools, new confusion, sudden severe abdominal pain even without dizziness or fainting, or fever with marked deterioration need urgent care. During chemotherapy, a temperature of 38°C or higher requires immediate contact with the oncology team or emergency care; do not wait for WhatsApp.

Contact your care team promptly

New jaundice or swelling, continued weight loss, uncontrolled pain or a scan result without a clear plan: contact the team early.

Related guides: Liver cancer surveillance · Benign liver lesions and cysts · Liver cirrhosis (F4) · Care after liver transplantation · Liver transplantation: when is evaluation needed?

Sources and further information NCI: Primary liver cancer NCI: Liver cancer diagnosis NCI: Primary liver cancer treatment AASLD: HCC surveillance, diagnosis and management guidance AASLD: Nutrition and complications of cirrhosis CDC: fever during chemotherapy

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Colon and rectal cancer

Last updated: 10 November 2026 · Colorectal cancer

Treatment can aim for cure in many cases. The plan depends on the tumor’s location, stage and features. Symptoms or a single blood test cannot establish the diagnosis.

Your next step

Ask about tumor location, stage, tissue tests and how treatment may affect eating, bowel function and daily life.

Understanding the disease

The colon is part of the large bowel and ends in the rectum, which stores stool. Cancer develops when cells in the lining grow uncontrollably. Some cancers develop from polyps that change over time, but most polyps are not cancer.

Cancer may extend into the bowel wall, lymph nodes or other organs. Location matters: rectal treatment can differ from colon treatment because of nearby pelvic organs and muscles controlling bowel movements.

When to seek assessment

- Possible symptoms include blood in stool, a persistent bowel habit change, abdominal pain, iron-deficiency anemia or unintentional weight loss. Other conditions cause these symptoms, but do not automatically attribute bleeding to hemorrhoids without appropriate assessment.
- Screening may detect disease before symptoms. A positive stool screening test does not establish cancer, but needs further assessment, usually colonoscopy. Symptoms need diagnostic assessment even when routine screening is not due.

Diagnosis and staging

- Colonoscopy allows biopsy, identifies the tumor location and examines the remaining colon when possible. The biopsy establishes the cell type. CT scans of the chest, abdomen and pelvis may be needed; pelvic MRI commonly helps plan rectal cancer treatment.
- CEA blood testing may help follow-up, but cannot confirm or exclude cancer alone or replace screening. Results are interpreted alongside scans and clinical assessment.
- Ask about tests on the tumor, including MMR/MSI. These can help guide treatment and determine whether genetic counseling is needed. Results can guide treatment and genetic counseling. A tumor alteration is not necessarily inherited.

Choosing treatment

- Specialists review stage, overall health and your priorities. Selected early cancers may need endoscopic removal or surgery; additional medicines may be required. Rectal cancer may need medicines or radiotherapy before surgery. Immunotherapy suits some tumor types.

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- When cancer has spread, treatment options remain. Selected limited spread may be suitable for surgery or other local treatment. Ask the team to explain the treatment goal rather than assuming that spread rules out every option.
- A stoma, an opening on the abdomen for stool, may be temporary or permanent depending on surgery. Not everyone needs one. Ask about its likelihood and specialist stoma-nurse support.

Food and everyday life

- Monitor weight and hydration, and request nutrition support for poor intake. Suitable fiber intake varies after surgery or with bowel narrowing; do not automatically increase fiber with pain, swelling or suspected obstruction.
- Report diarrhea, constipation, pain or bowel-control difficulties. Discuss possible sexual and fertility effects of pelvic treatment beforehand. Psychological and symptom support are part of care.

After treatment and family care

- Keep a personalized schedule for colonoscopy, scans and blood tests. Ask about relatives' assessment with a young diagnosis or concerning family history. Bring biopsy reports and scan images, and keep contact numbers.

When to get help

Get urgent medical care / go to the emergency department

Severe abdominal pain and swelling with vomiting and inability to pass gas or stool, heavy bleeding, fainting or sudden severe pain need urgent care. Follow emergency instructions for fever during cancer treatment. During chemotherapy, a temperature of 38°C or higher requires immediate contact with the oncology team or emergency care; do not wait for WhatsApp.

Contact your care team promptly

Repeated bleeding, persistent bowel changes, unexplained weight or iron loss, or symptoms limiting eating or activity need prompt review.

Related guides: Colon polyps · Colonoscopy · Colorectal cancer screening · Iron deficiency, anemia and the digestive system

Sources and further information NCI: Colon cancer treatment and staging NCI: Rectal cancer treatment NCI: Rectal cancer workup and biomarker guidance NCI: Colorectal screening NCI: CEA blood testing NCI: Inherited cancer testing CDC: fever during chemotherapy

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Hepatitis D (delta)

Last updated: 10 November 2026 · Hepatitis D

Hepatitis D requires hepatitis B infection. Testing matters even without symptoms because finding D can change treatment and follow-up.

Your next step

If you have hepatitis B, ask whether D testing was completed and whether RNA testing is needed.

How does it differ from hepatitis B?

B and D may be acquired together, or D may infect someone who already has B. D can accelerate liver injury and scarring, but its presence does not mean liver failure has occurred. Tests and liver function guide assessment, not tiredness alone.

Testing

- People who are HBsAg positive should have hepatitis D antibody testing at least once. A positive antibody result needs HDV RNA testing to establish active infection.
- Repeat testing may be appropriate according to exposure or liver results. Low HBV DNA does not exclude D, and a pending result is not negative.

Treatment and follow-up

- A liver specialist assesses scarring, liver function and both viruses. HDV treatment such as bulevirtide, with or without interferon in selected cases, may be suitable depending on safety, approval and local availability.
- Hepatitis B medicines may remain necessary but do not directly treat D. Do not stop treatment yourself. Adults with chronic D need regular follow-up, usually including liver imaging every six months for cancer surveillance; your team chooses the method.

Protecting family

- Transmission occurs through blood and certain body fluids, not hugging or ordinary food sharing. Do not share needles, razors or toothbrushes. Discuss sexual precautions and family testing.
- Hepatitis B vaccination protects uninfected people against B and associated D. It does not prevent D infection in someone who already has B, so blood precautions remain important. There is no separate D vaccine.

A practical next step

- Bring complete B and D results and a medicine list. Discuss hepatitis A vaccination if not immune. Avoid alcohol and unknown supplements, and arrange result review and follow-up.

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When to get help

Get urgent medical care / go to the emergency department

Vomiting blood, black stools, new confusion or drowsiness, or severe jaundice with significant illness need urgent care.

Contact your care team promptly

New jaundice, abdominal or leg swelling, or difficulty obtaining medicine need early contact.

Related guides: Hepatitis B · Understanding hepatitis B blood tests · Liver cirrhosis (F4) · Liver cancer surveillance

Sources and further information AASLD: HDV expert-based practice opinion, 6 November 2026 AASLD: HDV screening and treatment recommendations WHO: Hepatitis D, 28 July 2026 CDC: Hepatitis D basics

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Fasting, travel and medicine planning

Last updated: 10 November 2026 · Fasting, travel and medicine planning

Plan with your team before Ramadan or travel. Fitness to fast, dose timing and storage depend on your condition and treatment.

Your next step

Write down your medicine schedule, food and fluid plan, reasons to stop fasting or seek help, and treatment arrangements during travel with your team.

Is fasting suitable for me?

You need an individual assessment; this page is not general clearance to fast. Tell your doctor about disease activity, diarrhea or vomiting, weight loss, kidney disease or diabetes, and all your medicines. Active IBD, dehydration or poor nutrition may mean postponing fasting.

With cirrhosis, especially ascites, confusion or muscle loss, prolonged fasting may worsen nutrition or fluid balance. After liver transplantation, do not change anti-rejection medicine timing or skip a dose to fast. Your team will advise what is suitable for you.

Before Ramadan: get a written schedule

- Review your plan well before Ramadan. Ask for each medicine’s timing, its relationship to meals, and instructions for missed doses or illness. Do not squeeze daytime doses into the hours between iftar and suhoor or alter intervals yourself.
- If your team supports fasting, spread permitted food and fluids through the non-fasting hours. Eat moderate meals and avoid lying down immediately after eating if you have reflux. Fluid and fiber advice must fit your condition, particularly bowel narrowing or fluid restriction.

Before travel: arrange treatment and follow-up

- Arrange a review about 4–6 weeks before departure if possible, earlier for vaccinations or complex plans. Check infusion, injection and blood-test dates, and get a written dosing schedule for changes in time zone.
- Carry a diagnosis and medicine list with generic names and allergies, plus prescriptions or a letter for injections and equipment. Check medicine entry rules at your destination and transit countries. Pack enough supplies with extra for delays, and identify local medical care and insurance coverage.

How should I transport medicines?

- Keep medicines in your hand luggage in their original labeled packaging. Ask a pharmacist about your exact product’s refrigeration requirements and permitted time outside the refrigerator. Keep injections away from direct ice contact and hot cars. Check with a pharmacist before using medicine that has frozen or exceeded its permitted temperature.

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Travel vaccines and infections

- Tell the travel clinic if you take an immunosuppressant or have had a transplant. Some live vaccines, such as yellow fever vaccine, may be unsuitable; your treatment and destination need individual review. Do not stop treatment yourself to receive a vaccine.
- Use safe food and water and wash your hands. New fever or diarrhea, especially with blood or after travel, may be an infection rather than only an IBD flare. Do not start antibiotics, steroids or antidiarrheal medicine without an appropriate plan.

Getting help while traveling

- For non-urgent inquiries: WhatsApp only at 0556696019; no calls. Replies may be delayed and the doctor is not always available. For urgent problems, attend the clinic promptly if it is open and can assess you without delay; otherwise go to the emergency department. For an emergency, go to the emergency department immediately without waiting for a WhatsApp reply.

When to get help

Get urgent medical care / go to the emergency department

Stop fasting and go to the emergency department immediately for fainting or confusion, significant bleeding, severe abdominal pain, persistent vomiting preventing drinking, or severe dehydration with markedly reduced urine. Do not wait until sunset or for a WhatsApp reply.

Contact your care team promptly

Increasing diarrhea or vomiting, recurrent dizziness, difficulty taking medicines, or fever while immunosuppressed need same-day assessment at the clinic if promptly available; otherwise attend the emergency department. Do not continue fasting while your condition worsens pending assessment.

Related guides: Liver cirrhosis (F4) · IBD medicine safety · Care after liver transplantation · My treatment and follow-up plan · My IBD flare plan · Gastroenteritis and food poisoning

Sources and further information Crohn’s & Colitis UK: Food and fasting Saudi Ministry of Health: Digestive symptoms during Ramadan Saudi Ministry of Health: Dehydration during Ramadan NIDDK: Nutrition in cirrhosis CDC Yellow Book 2026: Immunocompromised travelers CDC Yellow Book: Travelers with chronic illnesses CDC: Traveling abroad with medicine Crohn’s & Colitis UK: Traveling and biologic storage

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After colon polyp removal and biopsy results

Last updated: 10 November 2026 · After polyp removal and biopsy results

Follow your individual discharge instructions. Keep the endoscopy report, medicine restart plan and appointment for reviewing tissue results.

Your next step

Before leaving, record when to restart medicines, when and with whom to review the tissue result, and the next appointment or step.

What was removed, and does it mean cancer?

A polyp is a growth in the colon lining. Removing and examining polyps helps prevent cancer and guides follow-up. Finding a polyp or taking a biopsy does not itself mean cancer. A pathologist examines the tissue under a microscope; the final result can differ from the first impression during endoscopy.

The first hours and days

- Mild bloating or cramps may occur and should gradually improve. Small traces of blood may follow a biopsy or removal; repeated or increasing bleeding needs assessment and should not be assumed normal. Follow the team’s instructions for food, activity and returning to work.
- After sedation, you need a companion and must not drive, operate machinery or make important decisions for 24 hours. Removal of a large polyp may require extra instructions for activity, diet or travel; ask before leaving.

Medicines after removal

- Get a written date and time for restarting any anticoagulant or antiplatelet medicine that was adjusted. This depends on bleeding and clotting risks and the removal technique. Do not extend the interruption or restart early yourself. If instructions are missing, ask the endoscopy unit to clarify them before you leave.
- Use only pain relief approved for you. Do not start ibuprofen, diclofenac or new supplements without checking, particularly with liver or kidney disease or blood thinners.

Bleeding can be delayed

- Bleeding may start days later, sometimes within two weeks of removal, even if you initially feel well. Tell your doctor about upcoming travel, particularly after a large polyp is removed, and agree how you will access care. One fixed activity or travel restriction does not suit everyone.

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How do I follow up the tissue result?

- Before discharge, ask whether tissue was sent, when the result is expected, who will review it with you and how to obtain a copy. If it has not arrived by the agreed date, follow up with the clinic. No news does not mean a normal result.
- After the result, ask what type of polyp it was, whether removal was complete and whether the removal site needs rechecking or further treatment. Your next colonoscopy depends on polyp number and size, tissue findings, preparation quality and completeness of removal, alongside personal and family history. There is no single interval for everyone.

Getting help

- For non-urgent inquiries: WhatsApp only at 0556696019; no calls. Replies may be delayed and the doctor is not always available. For urgent problems, attend the clinic promptly if it is open and can assess you without delay; otherwise go to the emergency department. For an emergency, go to the emergency department immediately without waiting for a WhatsApp reply.

When to get help

Get urgent medical care / go to the emergency department

Heavy or persistent bleeding or large clots, severe dizziness or fainting, severe or worsening abdominal pain, breathlessness, or repeated vomiting preventing drinking: go to the emergency department immediately with your endoscopy report. Do not wait for a WhatsApp reply.

Contact your care team promptly

For fever or chills after polyp removal, seek immediate medical assessment through the endoscopy unit or a service able to assess you without delay; otherwise go to emergency care. Fever with worsening pain or feeling very unwell needs emergency care directly. Do not wait for WhatsApp.

Related guides: Colon polyps · Colonoscopy · My treatment and follow-up plan · Gastrointestinal bleeding

Sources and further information US Multi-Society Task Force: Follow-up after colonoscopy and polypectomy ASGE: Polyps and their treatment NIDDK: Colonoscopy and recovery NHS: Colonoscopy

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My IBD flare plan

Complete with your care team. Your unit’s instructions and individual plan take priority.

Name / record number: .....

Crohn’s / ulcerative colitis / plan date: .....

My usual bowel frequency / bleeding / pain: .....

Maintenance treatment: .....

Clinician-written plan if symptoms flare

Blood and stool tests / result review date: .....

Contact route / follow-up date: .....

Important reminders

- Do not start steroids or antibiotics or change treatment yourself; infection can resemble a flare.
- Record symptoms, temperature and ability to drink. Contact your team early for increasing diarrhoea, blood or pain compared with baseline.

> Heavy bleeding, severe or persistent abdominal pain, marked swelling, fainting, severe dehydration or fever with worsening illness: seek urgent assessment; do not wait for WhatsApp.

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My cirrhosis monitoring plan

Complete with your care team. Your unit’s instructions and individual plan take priority.

Name / record number: .....

Diagnosis / plan date / treating team: .....

Usual weight / clinician-set change requiring contact: .....

Prescribed medicines

Medicine / dose	When to take it	Clinician notes
.....	.....	.....
.....	.....	.....
.....	.....	.....

Blood tests / result review: .....

Next liver surveillance scan if prescribed: .....

Varices review / clinic appointment: .....

What to monitor at home

- Weight, abdominal or leg swelling, alertness and sleep according to your plan. Do not adjust diuretics or restrict fluids without advice.
- Record any new medicine or supplement and check its liver safety with your team.

> Vomiting blood or black stools, new confusion or sleepiness, fever or new abdominal pain with ascites, or severe breathlessness: seek urgent assessment.

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My medicines before endoscopy

Last updated: 10 November 2026 · Medication planning before gastroscopy or colonoscopy

A practical guide to medicines that often continue and those needing an individual plan. Review your full medicine list with the endoscopy team at least one week before the appointment, and earlier when a longer interruption is needed.

Your next step

Send a full medicine list, including supplements, and ask for a written plan before starting preparation.

Medicines that can often continue

- Examples include certain blood-pressure medicines such as amlodipine or bisoprolol, levothyroxine for the thyroid, and epilepsy medicines such as levetiracetam. Bring your asthma inhalers. These examples are not permission to continue every heart or blood-pressure medicine; follow the approved plan.
- Do not stop epilepsy medicines, long-term steroids or transplant medicines yourself. The team must arrange dose times or an alternative if swallowing or absorption will be a problem. A permitted tablet is usually taken with a small sip of water. If it is due after the drinking cutoff, obtain specific instructions rather than skipping it or drinking a full glass.
- Bowel cleansing can reduce the absorption of oral medicines. Ask the pharmacist to specify the gap from your actual preparation product; do not assume the same interval suits every medicine. Some antibiotics, iron and digoxin need particular spacing with magnesium-containing preparations.

Medicines that need an adjustment plan

- Insulin and other diabetes medicines need a plan for fasting, glucose checks and restarting treatment. Never stop all insulin yourself. SGLT2 medicines such as dapagliflozin and empagliflozin usually require a 3-day interruption before planned procedures; ertugliflozin requires 4 days. The team must confirm the plan, including for people taking them for heart or kidney disease.
- GLP-1 medicines such as semaglutide and tirzepatide need individual assessment, especially during dose escalation or with nausea, vomiting or persistent fullness. They are not automatically stopped for everyone.
- Water tablets such as furosemide, some blood-pressure medicines such as ramipril or losartan, lithium and anti-inflammatory painkillers need review because bowel preparation can affect hydration, kidneys or salts. Do not stop important heart-failure treatment yourself.
- Before colonoscopy, the team may ask you to stop oral iron about 5–7 days beforehand. Anti-diarrhea medicines and fiber supplements may also need temporary interruption. The exact plan depends on the product and reason for treatment.

Acid medicines and H. pylori testing

- PPIs, such as omeprazole, esomeprazole and pantoprazole, can make H. pylori harder to detect on biopsy histology or a rapid urease test, as well as on a breath or stool antigen test. A result may be negative even though infection is present.
- For planned H. pylori testing, the usual preparation is 14 days off PPIs and 4 weeks without antibiotics or bismuth, if clinically safe and approved by the doctor. Do not stop essential

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treatment or interrupt an antibiotic course yourself; arrange testing around the treatment plan. Acid blockers such as vonoprazan also need review.

- PPIs do not need to be stopped before every gastroscopy. They may be needed for an ulcer, severe esophagitis or bleeding prevention. The doctor may request a different interruption when diagnosing reflux or eosinophilic esophagitis. Do not delay urgent endoscopy to complete a washout period.
- If H. pylori testing is negative while you are taking these medicines, a repeat breath or stool test after the appropriate interval may be needed. A negative result alone may not exclude infection. Ask about temporary symptom relief and follow the laboratory's instructions.

Blood thinners: do not stop them on your own

- Tell the team about aspirin, clopidogrel, ticagrelor, warfarin, apixaban, rivaroxaban, dabigatran and any similar medicines. Review the plan jointly with the prescribing clinician and gastroenterologist; involve the cardiology or anticoagulation team when needed.
- A diagnostic examination with small biopsies has a different bleeding risk from removing a polyp or another therapeutic procedure. The plan also depends on kidney function and clotting risk, especially a recent heart stent, a mechanical valve or a recent clot. Low-dose aspirin is usually continued for most endoscopic procedures.
- If interruption is appropriate, obtain the exact last dose and restart time in writing. There is no single stopping period for all blood thinners. Do not replace tablets with injections yourself; bridging is only used for selected patients.

What to confirm before preparation starts

- For every affected medicine, record: name and dose; continue or pause; last dose; any permitted dose with a sip of water; and restart date/time. Keep the plan from the hospital performing your procedure.
- If instructions conflict, you vomit an important medicine, or you have taken a dose you were told to pause, contact the endoscopy unit. Do not double or repeat a dose yourself. Tell the team exactly what you took and when.

When to get help

Get urgent medical care / go to the emergency department

Severe weakness, fainting, significant bleeding, severe breathing difficulty or symptoms of very low glucose require prompt medical help. Do not wait for a WhatsApp reply.

Contact your care team promptly

Contact the endoscopy unit early if any medicine, fasting or restart instruction is unclear.

Related guides: Gastroscopy · Colonoscopy · Gastroscopy preparation checklist · Acid medicines: proton pump inhibitors (PPIs) · Helicobacter pylori infection · Safe use of blood thinners (anticoagulants) · Anti-rejection medicines after liver transplantation: a practical guide · Spironolactone for ascites · Furosemide for ascites

Sources and further information ASGE: bowel preparation and regular medicines BSG/AUGIS 2026: upper endoscopy best practice Saudi H. pylori Working Group recommendations ACG 2024: H. pylori testing and treatment BSG/ESGE: antiplatelets and anticoagulants before endoscopy NHS: essential medicines on the day of endoscopy NHS: medicines requiring individual preparation instructions Picolax/Picoprep: manufacturer medicine-interaction information ACG: diagnostic endoscopy for reflux ASGE: Diabetes and weight-management medicines before endoscopy 2025 Multisociety recommendations: Individualizing the GLP-1 plan

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Sofosbuvir + daclatasvir for hepatitis C

Last updated: 11 November 2026 · Sofosbuvir + daclatasvir

Two antiviral medicines used together to cure hepatitis C. This is a usual first choice in our clinic for suitable patients.

How to use

- The usual adult prescription is sofosbuvir 400 mg plus daclatasvir 60 mg once daily, commonly for 12 weeks in previously untreated patients without cirrhosis. Daclatasvir can be taken with or without food; some sofosbuvir products require food, so follow your leaflet. Complete both medicines as prescribed. For a missed or vomited dose, follow each product's leaflet or ask the pharmacist; never double.

Storage

- The SFDA-listed Sovira and Levera packs specify below 30°C. Follow your own packs, retain original packaging and keep away from children and heat.

Tests and follow-up

- Before treatment: assess liver scarring, blood count, liver/kidney function, HCV RNA, HIV and hepatitis B. HBV can reactivate during or after treatment and needs a follow-up plan. Undetectable HCV RNA at least 12 weeks after completion confirms cure.

Possible side effects: what to expect

- Not everyone gets side effects. Tiredness, headache or nausea may occur and are usually mild. Plan rest and regular meals; contact your team if symptoms persist or interfere with treatment rather than stopping either medicine yourself.
- Interactions need review before treatment, especially amiodarone, which can dangerously slow the heartbeat. Hepatitis B screening and follow-up when needed help detect reactivation. Added ribavirin requires extra precautions for anaemia and pregnancy.

Important

- Cirrhosis or previous treatment failure may require longer treatment, ribavirin or a different regimen. Check every medicine and supplement: amiodarone can cause dangerous slowing of the heartbeat; rifampicin, some seizure medicines and St John's wort can undermine treatment. Some HIV medicines, antibiotics and antifungals may require a different daclatasvir dose; never adjust it yourself. Discuss pregnancy and breastfeeding.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Get urgent help for fainting, a slow heartbeat, chest pain, breathlessness, new jaundice or confusion.

Contact your care team promptly

Contact the clinic for persistent headache, fatigue or nausea, repeated missed doses, or a new medicine.

Related guides: Hepatitis C · Hepatitis B · Liver cirrhosis (F4) · Ribavirin for hepatitis C · Pregnancy and breastfeeding with bowel and liver disease

Sources: 1 · 2 · 3 · 4 · 5 · 6 · 7 · Source details and full guide online

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Linaclotide

Last updated: 11 November 2026 · Linaclotide

Linaclotide increases bowel fluid and can relieve IBS with constipation (IBS-C), including pain. Alvotay is a registered Saudi brand; check your prescribed pack and strength.

How do I use it?

- Take the prescribed strength once daily on an empty stomach, at least 30 minutes before a meal. IBS-C and chronic constipation may need different strengths. Do not swap 145 and 290 microgram capsules yourself.
- Swallow intact; do not crush or chew. Ask a pharmacist before opening a capsule if swallowing is difficult. Skip a missed dose; never double it.

How do I store it?

- Follow the pack's limit: SFDA lists Alvotay below 30°C. Keep the original bottle tightly closed, dry and away from children. Leave the drying canister inside; do not swallow it. Avoid heat and damp.

What follow-up do I need?

- Review stool consistency, pain and benefit with your clinician. Bowel movements may improve before pain. Agree when to review ineffective treatment; persistent diarrhea or dehydration may need blood tests.

Possible side effects: what to expect

- Not everyone gets side effects. Diarrhoea is most common, often starting within two weeks; persistent mild symptoms need advice.
- Severe diarrhoea affected about 2 in 100 adults in trials of 145 or 290 micrograms. If it occurs, stop treatment and seek prompt advice about rehydration; do not wait for dehydration. Fainting or very little urine needs emergency care.

Important points

- Do not use with known or suspected bowel obstruction. Diarrhea is the main adverse effect. Discuss other laxatives, pregnancy, breastfeeding and medicines that could worsen dehydration.
- This card is for adults. Children need specialist advice and the local leaflet; age approvals vary by country. Do not use an adult prescription for a child.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Stop the medicine and seek urgent care for severe diarrhea with fainting or very little urine, severe new abdominal pain, or bloody or black tarry stools.

Contact your care team promptly

Stop and contact your clinician promptly if severe diarrhea develops, even without dehydration. Ask for review if milder diarrhea persists or the agreed treatment trial does not help.

Related guides: Medicines for irritable bowel syndrome (IBS) · Irritable bowel syndrome · Constipation, difficult evacuation and bowel leakage · PEG / macrogol for constipation · Eating with irritable bowel syndrome

Sources: 1 · 2 · 3 · 4 · 5 · Source details and full guide online

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Low-dose amitriptyline for IBS

Last updated: 11 November 2026 · Low-dose amitriptyline for IBS

Low-dose amitriptyline can reduce gut pain and overall IBS symptoms, especially when diarrhoea predominates. This is an off-label use: IBS is not among the approved uses of the local product. Your doctor may prescribe it for gut pain even if you do not have depression.

How do I use it?

- For adults, your clinician may start 5–10 mg once nightly, with or without food, and adjust gradually; IBS doses usually do not exceed 30 mg. Check before splitting tablets. Benefit takes several weeks. Do not stop suddenly or double a missed dose.

How do I store it?

- Keep tablets in their original packaging, away from children. Follow the temperature limit on your own pack.

What tests do I need?

- Review benefit and side effects after about four weeks. Your clinician may request an ECG or blood salts if heart history, symptoms or interacting medicines increase risk.

Possible side effects: what to expect

- Not everyone gets side effects. Sleepiness, dry mouth, constipation or dizziness on standing may occur. Avoid driving if affected, rise slowly and discuss persistent symptoms.
- Heart rhythm problems, urinary retention or mood changes can occur; risk depends on health, dose and interacting medicines. Selected patients need an ECG. Fainting, severe palpitations or inability to urinate requires urgent help; do not increase doses yourself.

Important points

- Sleepiness, dry mouth and constipation can occur. Avoid driving if sleepy or dizzy. Tell your clinician about heart disease, glaucoma, difficulty urinating, seizures, pregnancy or breastfeeding. Check all medicines, especially other antidepressants, sedatives and medicines affecting heart rhythm. Do not increase the dose yourself.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Seek urgent help for fainting, severe or persistent palpitations, severe chest pain, inability to urinate, thoughts of harming yourself, or taking more than prescribed.

Contact your care team promptly

Contact your team for troublesome constipation, persistent daytime sleepiness, mood changes or no meaningful improvement in symptoms after the agreed trial period.

Related guides: Medicines for irritable bowel syndrome (IBS) · Irritable bowel syndrome · Chronic diarrhea · Pregnancy and breastfeeding with bowel and liver disease

Sources: 1 · 2 · 3 · 4 · 5 · 6 · 7 · Source details and full guide online

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Liver transplantation: when is evaluation needed?

Last updated: 10 November 2026 · Liver transplant evaluation

Not everyone with F4 cirrhosis needs a transplant. Referral allows timely assessment of your options; it does not automatically mean joining a waiting list or having surgery.

Your next step

Ask: is transplant evaluation appropriate now, and which reports and tests should I bring?

What is a liver transplant?

Surgery replaces the diseased liver with a liver from a deceased donor or part of a living donor's liver. The team balances likely benefit against surgery and long-term treatment risks, while continuing treatment of the underlying disease and its complications.

When should referral be discussed?

- Discuss referral after complications such as abdominal fluid (ascites), bleeding varices or hepatic encephalopathy causing confusion, or when liver and kidney function deteriorate. Waiting for repeated episodes or critical illness may lose valuable preparation time.
- Transplantation may suit selected liver cancers, depending on tumor features, and certain other conditions. Acute liver failure can develop without previous cirrhosis and requires urgent assessment at a transplant center.

What does MELD mean?

- MELD combines laboratory results and other information to estimate disease severity and help prioritize care. It is not a stand-alone acceptance or rejection rule: complications or cancer may warrant evaluation despite a lower score. Your team interprets it alongside your condition and the center's allocation system.

What happens during evaluation?

- The team reviews liver reports, blood tests, scans and medicines, and assesses the heart, lungs, kidneys, nutrition and muscle strength. Infection, vaccinations, screening needs, emotional and social support, and practical help from family are also reviewed.
- Evaluation may lead to continued care without transplantation for now, further tests or treatment of correctable problems, or acceptance. The team explains its criteria and possible waiting time. There is no guaranteed date, and age alone does not determine the decision.

How can I prepare while waiting?

- Maintain nutrition, protein intake and activity suited to your ability, and review vaccinations and medicines. Avoid alcohol, stop smoking and do not start herbal remedies or crash diets. Arrange a support person, transport, a medicine list and the transplant coordinator's contact details.
- Tell the team about hospital admissions, infection, bleeding or other changes, and keep laboratory and imaging assessments up to date. Do not wait for a WhatsApp reply during acute deterioration.

What should I know about surgery and afterwards?

- Transplantation can improve survival and quality of life, but it is major surgery. Risks include bleeding, infection, blood-vessel or bile-duct problems, rejection and failure. Individual risks

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differ. Recipients usually need lifelong anti-rejection medicines and regular follow-up; discuss benefits, alternatives and concerns before deciding.

The evaluation journey at a glance

Step	What does it mean?
Referral	Discuss possible benefit and arrange a transplant-centre visit. This is not final approval for surgery.
Assessment	Review liver disease, general health, nutrition and recovery potential, and explain options.
Team decision	The plan may be monitoring and treatment, further tests or listing, depending on the assessment.
Preparation and follow-up	A waiting-list or living-donor evaluation plan, complication treatment and preparation if the centre recommends transplantation.

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When to get help

Get urgent medical care / go to the emergency department

New confusion, difficulty waking, vomiting blood, black stools, severe breathlessness or rapidly worsening jaundice with significant illness: seek emergency care rather than waiting for transplant assessment.

Contact your care team promptly

Increasing fluid, poor intake, reduced activity or repeated hospital admissions: contact your liver team promptly to review referral timing.

Related guides: Liver cirrhosis (F4) · Living liver donation: a guide for donors and families · Care after liver transplantation · Liver cancer: diagnosis and treatment · Ascites: abdominal fluid and drainage · Hepatic encephalopathy: confusion and altered awareness · Eating well with cirrhosis · Portal vein thrombosis · Budd-Chiari syndrome: blocked liver outflow · Anti-rejection medicines after liver transplantation: a practical guide

Sources and further information AASLD/AST: liver transplant candidate evaluation NIDDK: the liver transplant process NHSBT: preparing for transplantation NHSBT: risks of liver transplantation Saudi Center for Organ Transplantation: liver transplantation

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Living liver donation: a guide for donors and families

Last updated: 10 November 2026 · Living liver donation

Donating part of a liver may help someone who needs transplantation, but it is major surgery for a healthy person. Donor safety and a freely made decision come first; no one should feel rushed or pressured.

Your next step

Request a private donor-coordinator appointment and written information on risks, tests and recovery.

How is donation possible?

A suitable liver portion is transplanted into the recipient while enough liver remains for the donor’s safety. Both the remaining and transplanted tissue can increase in size and function over time. This does not remove surgical risks or mean the removed lobe returns in its original shape.

Who can request assessment?

- In Saudi Arabia, assessment begins at an approved transplant center under Saudi Center for Organ Transplantation rules. Age, overall health, blood group, liver size and anatomy, and liver fat are reviewed. Being at least 18 or having a compatible blood group does not by itself establish suitability.
- Disclose all medicines, supplements, operations and previous illnesses, including pregnancy or pregnancy plans. Evaluation may include blood tests, imaging and additional assessments, with psychological and social review that gives the donor’s interests separate attention from the recipient’s needs.

The decision is yours, including the right to withdraw

- Donation requires informed, voluntary consent without family, social or financial pressure. You may withdraw before surgery. Ask for a private discussion with the donor coordinator about questions and confidentiality; you do not need to justify your choice to other people.
- Agreeing to assessment is not a commitment to donate. Medical unsuitability or deciding against donation does not mean you have failed the recipient. Their team continues to discuss other treatment options.

What are the risks?

- Pain, fatigue, infection, bleeding, bile leakage or blood clots can occur, sometimes requiring another procedure or a longer admission. Rare serious risks include liver failure and death. The team should explain your individual risk, considering the liver portion, your health and the center’s experience.

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- A successful recipient outcome is not guaranteed, and a poor outcome may cause emotional distress for the donor and family. Discuss psychological support, time away from work, travel costs and help at home before agreeing.

After donation

- Recovery and return to work, driving and exercise depend on the operation and your progress. Obtain written instructions for wound care, activity, pain relief and blood tests rather than relying on one timetable for everyone.
- Donors do not usually need anti-rejection medicines; those are for recipients. Donors still need postoperative monitoring and continuing health reviews under the center's program, even when feeling well.

When to get help

Get urgent medical care / go to the emergency department

After donation: breathlessness, chest pain, fainting, bleeding, severe abdominal pain or a painful swollen leg require emergency assessment.

Contact your care team promptly

Contact the donor team the same day for fever, jaundice, persistent vomiting, wound changes or difficulty eating or drinking.

Related guides: Liver transplantation: when is evaluation needed? · Care after liver transplantation

Sources and further information SCOT: conditions for donation and transplantation Saudi Center for Organ Transplantation: liver transplantation NHSBT: living donor liver transplantation NIDDK: liver transplantation NIDDK: the liver transplant process

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Ascites: abdominal fluid and drainage

Last updated: 10 November 2026 · Ascites and paracentesis

Ascites is more than gas or weight gain. New abdominal fluid needs assessment of its cause and a clear plan for kidney function, blood salts and nutrition.

Your next step

Write down your weight, salt and medicine plan and dates for kidney and electrolyte tests.

What is ascites?

Ascites is fluid inside the abdominal cavity. In cirrhosis, portal hypertension and salt and water retention contribute. Other causes exist, so not every swollen abdomen should be attributed to the liver. Ascites can cause early fullness, breathlessness and swollen legs.

Why take a fluid sample?

- A sample may be needed for new ascites, hospital admission or suspected infection. It helps identify the cause and detect infection, which can occur without obvious pain or fever. Blood tests alone cannot exclude infection in the fluid.

Your home plan

- Your doctor may recommend around 2 grams of sodium daily, roughly 5 grams of salt from all sources. Reduce salty pickles, canned foods and stock cubes without compromising nutrition. Not everyone needs fluid restriction; follow an individual limit if prescribed.
- Diuretics such as spironolactone or furosemide may be prescribed with kidney and blood-salt monitoring. Record weight at a consistent time and report changes according to your plan. Do not change doses or self-medicate with ibuprofen or diclofenac.

What happens during drainage?

- After explanation and medicine review, a small abdominal area is numbed and a thin tube drains the fluid, sometimes with ultrasound guidance. Removing a large volume may require intravenous albumin to protect circulation and kidneys. Do not stop blood thinners without team instructions.
- Leakage or discomfort can occur; bleeding, infection, organ injury or circulation problems are uncommon risks. Obtain aftercare instructions. Fluid returning does not mean drainage failed; treatment may need review, with TIPS or transplant assessment considered in selected cases.

When to get help

Get urgent medical care / go to the emergency department

Fever, new abdominal pain, confusion, markedly reduced urine, bleeding or severe breathlessness: seek urgent emergency assessment.

Contact your care team promptly

Rapidly increasing abdominal swelling or weight, poor intake, dizziness or persistent drainage-site leakage: contact your team promptly.

Related guides: Liver cirrhosis (F4) · A family guide to cirrhosis · My cirrhosis monitoring plan · Liver transplantation: when is evaluation needed? · Portal hypertension and esophageal or gastric varices · Eating well with cirrhosis · Spironolactone for ascites · Furosemide for ascites · Budd-Chiari syndrome: blocked liver outflow

Sources and further information AASLD: ascites, infection and hepatorenal syndrome AASLD: outpatient management of cirrhosis Cambridge University Hospitals: paracentesis North Tees NHS: paracentesis NIDDK: cirrhosis and its complications

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Hepatic encephalopathy: confusion and altered awareness

Last updated: 10 November 2026 · Hepatic encephalopathy

New confusion in someone with liver disease needs urgent assessment. Simply increasing lactulose at home is not enough. Family members often notice the first changes.

Your next step

Keep the written lactulose plan, medicine list and instructions for altered awareness readily available.

What is hepatic encephalopathy?

Brain function can be disturbed when the liver cannot adequately process substances coming from the bowel, or blood bypasses it through other vessels. This may occur with advanced cirrhosis or after TIPS, causing slow thinking, altered sleep or behavior, confusion and drowsiness.

Not all confusion is caused by the liver: infection, stroke, low glucose, electrolyte problems or medicines are other possibilities. An ammonia result alone neither establishes the diagnosis nor determines its severity.

What can trigger an episode?

- Triggers include infection, gastrointestinal bleeding, constipation, dehydration, kidney problems and sedating medicines. The team looks for and treats the trigger rather than focusing only on ammonia. Do not add sleeping tablets, strong painkillers or herbal products without review.

How are preventive medicines used?

- If lactulose is prescribed, the usual goal is 2–3 soft stools daily under your written plan, not watery diarrhea. Severe diarrhea and dehydration can worsen the problem. Your team should explain dose adjustment and what to do for constipation or diarrhea.
- Rifaximin may be added to reduce recurrence in selected patients. Do not stop preventive treatment simply because concentration improves, or wait for a dose to work when new confusion appears.

How can family members help?

- Record changes in sleep and concentration, bowel movements and medicines. Maintain regular meals and adequate protein; do not restrict protein because of confusion. Someone with altered awareness must not drive or be left alone.
- If the person is difficult to wake or cannot swallow safely, give nothing by mouth and call emergency services. After recovery, review the recurrence-prevention plan; episodes may warrant transplant evaluation.

When to get help

Get urgent medical care / go to the emergency department

Any new confusion or unusual drowsiness needs urgent assessment. Difficulty waking, sudden limb weakness, seizures or breathing difficulty require emergency services immediately.

Contact your care team promptly

Persistent constipation or diarrhea without confusion, difficulty following treatment or running out of medicine: contact the team the same day.

Related guides: A family guide to cirrhosis · Lactulose · Rifaximin · Liver transplantation: when is evaluation needed? · Portal hypertension and esophageal or gastric varices · Eating well with cirrhosis

Sources and further information ACG: hepatic encephalopathy guideline EASL: hepatic encephalopathy guideline AASLD: understanding hepatic encephalopathy AASLD: ammonia and hepatic encephalopathy NIDDK: treatment of cirrhosis

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Portal hypertension and esophageal or gastric varices

Last updated: 10 November 2026 · Portal hypertension and varices

Varices are enlarged blood vessels that can bleed; they are not cancer. Prevention and follow-up reduce risk. Vomiting blood or passing black stools is an emergency.

Your next step

Record your preventive medicine and next endoscopy date, and ensure your family knows the bleeding warning signs.

How are the liver and varices connected?

The portal vein brings blood from the bowel to the liver. Cirrhosis can obstruct flow, raising pressure and enlarging alternative vessels, particularly in the esophagus and stomach. This differs from arm blood-pressure readings and can have other causes, such as portal-vein blockage.

How is risk assessed?

- Blood tests, liver stiffness and imaging, and sometimes endoscopy, help assess risk. Your doctor determines whether and when endoscopy is needed according to your condition and treatment; one schedule does not fit everyone. Varices may cause no symptoms before bleeding.

How is bleeding prevented?

- Medicines such as carvedilol or propranolol may reduce portal pressure when suitable. Treatment depends on blood pressure, pulse, kidney function and tolerance. Do not start or change them yourself, and report dizziness or fainting.
- Esophageal varices may be treated with small bands during endoscopy, sometimes across several sessions. Gastric varices may require different treatment in a specialist center. After previous bleeding, medicines and banding may be combined to prevent recurrence.

What is TIPS?

- TIPS is a channel created within the liver by an interventional radiologist to lower portal pressure. It can help selected bleeding or ascites cases, but requires assessment of heart and liver function and encephalopathy risk. It may worsen confusion and needs ongoing follow-up.

After banding or hospital discharge

- Follow the team’s food, medicine and repeat-endoscopy instructions, and obtain a written plan for blood thinners and pain relief. Treating varices does not remove the underlying liver disease; a bleeding episode may prompt transplant evaluation.

When to get help

Get urgent medical care / go to the emergency department

Vomiting blood or black tarry stools, even without pain or dizziness: seek emergency care immediately and do not drive yourself. Severe pain, inability to swallow or fever after banding also needs urgent assessment.

Contact your care team promptly

Repeated dizziness on treatment, inability to take medicines or no follow-up appointment after banding: contact the team promptly.

Related guides: Liver cirrhosis (F4) · Gastrointestinal bleeding · Gastroscopy · Ascites: abdominal fluid and drainage · Hepatic encephalopathy: confusion and altered awareness · Liver transplantation: when is evaluation needed? · Portal vein thrombosis · Carvedilol for portal hypertension · Safe use of blood thinners (anticoagulants)

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Sources and further information AASLD: portal hypertension and varices AASLD: TIPS and other interventions for variceal bleeding AASLD: outpatient management of cirrhosis NIDDK: cirrhosis and its complications NIDDK: treatment of cirrhosis

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Barrett’s esophagus

Last updated: 10 November 2026 · Barrett’s esophagus

Barrett’s is a change in the esophageal lining, not cancer. Most people do not develop cancer, but biopsy findings guide monitoring or treatment.

Your next step

Bring your endoscopy and biopsy reports, record your next appointment, and list your acid medicines and how you take them.

What changes in the esophagus?

The esophagus carries food to the stomach. In Barrett’s, cells lining part of this tube become more like intestinal cells. It is often associated with longstanding reflux but may be found without obvious heartburn. Most people with reflux do not develop Barrett’s.

Further abnormal cell changes, called dysplasia, can sometimes develop before cancer. Risk depends on whether dysplasia is present, its grade and the length of affected tissue. Symptoms alone cannot determine the follow-up plan.

Confirming the diagnosis

- Upper endoscopy examines the lining and obtains biopsies: small tissue samples examined under a microscope. The segment length and biopsy result matter. Redness or a slightly irregular junction between the esophagus and stomach does not automatically confirm Barrett’s.
- Dysplasia should be reviewed by an expert gastrointestinal pathologist before treatment decisions. Inflammation can make findings uncertain, sometimes requiring acid treatment followed by reassessment according to the plan.

Monitoring or endoscopic treatment?

- Without dysplasia, endoscopy and biopsies are usually used for surveillance; tissue is not routinely removed. Many patients have examinations roughly every three to five years, depending on segment length, findings, general health and the quality of the previous examination.
- Confirmed dysplasia or selected very early superficial cancers may be treated by removing or ablating abnormal tissue endoscopically at a specialist center. The grade determines urgency and options; a diagnosis does not automatically mean surgery.

Acid medicines and daily habits

- Your doctor may recommend a daily proton pump inhibitor, or acid-reducing medicine, even with little heartburn. Follow your medicine’s timing and dose rather than stopping solely because symptoms improve.
- Stopping smoking, addressing excess weight and adjusting meals and sleep support health and reflux control. Reflux surgery does not automatically replace Barrett’s surveillance or guarantee cancer prevention.

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Make follow-up clear

- Keep the endoscopy and biopsy reports. Ask whether there is dysplasia and when the next examination is due. Very short changes under one centimeter may not need Barrett’s surveillance; your doctor determines whether that applies to your findings.
- Changes may recur after successful endoscopic treatment, so follow-up remains important. New swallowing difficulty, weight loss or bleeding needs assessment without waiting for the routine surveillance appointment.

When to get help

Get urgent medical care / go to the emergency department

Food stuck or liquids unable to pass, vomiting blood, black tarry stool, or new severe chest pain: seek urgent care.

Contact your care team promptly

Increasing swallowing difficulty, unintentional weight loss, or a biopsy showing dysplasia without a clear follow-up plan.

Related guides: Gastroesophageal reflux disease · Gastroscopy · Difficulty swallowing and food getting stuck · Acid medicines: proton pump inhibitors (PPIs)

Sources and further information AGA: surveillance guideline (2025) ACG: Barrett’s guideline (2022) NIDDK: diagnosis NIDDK: treatment AGA: patient guide

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Pancreatic cysts

Last updated: 10 November 2026 · Pancreatic cysts

A pancreatic cyst does not automatically mean cancer. Many are incidental findings, and follow-up depends on the type and features rather than size alone.

Your next step

Gather earlier scan images and record the next scan date and how its result will be reviewed.

What is a pancreatic cyst?

A cyst is a fluid-containing space within or near the pancreas. It may be a collection following pancreatitis, a benign cyst, or a mucus-producing type that can change over time. These types have different risks and management.

Your report may use IPMN, a type associated with the pancreatic ducts that can involve the main duct or its branches. This name does not mean cancer; imaging details and changes over time guide the plan.

Which tests might be needed?

- Your doctor reviews symptoms, family history and earlier scans. MRI with MRCP to show the ducts, or a dedicated CT scan, may be requested. Comparing the images themselves, not only reports, helps establish whether a cyst has truly changed.
- Endoscopic ultrasound, or EUS, may provide more detail. Sometimes fluid is sampled if the result could change management. Not every cyst needs a needle sample or biopsy, and one test cannot exclude every possibility.

Choosing surveillance or intervention

- Assessment considers cyst type, size and growth, nodules or solid areas, duct widening, and symptoms such as jaundice or pancreatitis. An incidental cyst is not automatically the cause of abdominal pain.
- Many cysts are monitored with imaging. Concerning features may warrant discussion with a specialist team and pancreatic surgeon. Surgery carries important risks; the decision balances cyst risk, surgical risk and overall health rather than removing every cyst.

When should imaging be repeated?

- There is no single schedule for everyone. Test type and timing depend on cyst features, age, health and whether a future intervention could help. Ask why the interval changes if your plan is revised.
- Some confidently benign cysts need no long-term surveillance; other types need ongoing or closer monitoring. Do not stop follow-up yourself simply because a cyst is stable or you feel well.

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Useful questions for your visit

- Ask which type is most likely, whether there are concerning features, whether EUS is needed, and when the next scan is due. Bring earlier images and results and report pancreatic cancer in the family or a known inherited syndrome.
- No diet or herbal remedy is proven to dissolve pancreatic cysts. Avoid smoking, maintain suitable nutrition and report unexplained weight loss, new diabetes or suddenly worsening glucose control rather than assuming the cyst explains every change.

When to get help

Get urgent medical care / go to the emergency department

Severe upper abdominal pain with persistent vomiting, or fever with jaundice or marked illness: seek urgent assessment.

Contact your care team promptly

New jaundice, weight loss, recurring pain, or a significant imaging change without a clear plan.

Related guides: Pancreatitis and pancreatic enzyme insufficiency · Endoscopic ultrasound · Pancreatic cancer

Sources and further information ACG: pancreatic cysts, updated August2026 ACG: pancreatic cyst guideline AGA: asymptomatic pancreatic cyst guideline WGO: pancreatic cystic lesions

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C. difficile infection

Last updated: 10 November 2026 · C. difficile infection

This infection can cause diarrhea and inflammation of the colon, especially after antibiotics. Early assessment matters; a positive test alone does not always mean infection needing treatment.

Your next step

Record stool frequency and antibiotic names and dates; use soap and water and arrange medical follow-up.

What is this infection?

Clostridioides difficile, or C. diff, can produce toxins that damage the colon lining. It may grow after antibiotics disturb normal gut bacteria. Hospital stays and weakened immunity increase risk, but infection also occurs outside hospitals.

People can carry the bacteria without symptoms, which differs from infection with compatible diarrhea and illness. Typical symptoms include repeated watery stool and cramps, sometimes fever or nausea. Not all diarrhea following antibiotics is caused by C. diff.

When is stool testing appropriate?

- Report new repeated diarrhea, particularly during or after antibiotics. Testing is often considered with at least three unformed stools in a day without a clear explanation such as laxatives; the team decides whether testing is appropriate.
- Results are interpreted with symptoms and test type. Testing is not usually done in well people without symptoms or to prove cure after diarrhea resolves: results may stay positive after recovery. Report laxatives and other medicines before sampling.

How is it treated?

- Your doctor prescribes an antibiotic specifically for this infection, such as fidaxomicin or oral vancomycin, considering severity, recurrence and availability. The need for preceding antibiotics is also reviewed. Do not stop prescribed medicines or start antibiotics yourself.
- Fluids and monitoring of kidney function and salts may be needed, sometimes in hospital. Do not take antidiarrheals such as loperamide without medical approval. Recurrence may need specialist treatments; never attempt fecal transfer treatments at home.

Protecting your household

- Wash hands with soap and water after using the toilet and before eating, including carers. Do not rely on alcohol hand gel alone to remove these spores. Use a separate bathroom during diarrhea if possible; otherwise clean frequently touched surfaces before others use it.
- Clean soiled laundry, towels and surfaces according to product instructions, using a suitable spore-killing disinfectant when needed. Never mix cleaning products. Wash hands after handling laundry even when gloves were worn.

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After treatment

- Complete treatment as prescribed and watch for returning diarrhea. Contact your doctor if it recurs rather than automatically restarting an old medicine; recurrence or a different cause may need assessment.
- Tell doctors and dentists about this infection when future antibiotics are considered. Avoid unnecessary antibiotics and do not start probiotics or preventive supplements yourself, particularly with weakened immunity.

When to get help

Get urgent medical care / go to the emergency department

Severe abdominal pain or swelling, fever with marked illness, fainting, very little urine or inability to drink: seek urgent care even if diarrhea has decreased.

Contact your care team promptly

New diarrhea during or after antibiotics, or diarrhea returning after treatment: contact the team promptly, particularly with weakened immunity.

Related guides: Chronic diarrhea · Ulcerative colitis · IBD medicine safety · Gastroenteritis and food poisoning

Sources and further information CDC: clinical overview CDC: about C. diff CDC: after treatment CDC: prevention NHS: C. difficile

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Achalasia: a swallowing movement disorder

Last updated: 10 November 2026 · Achalasia

Achalasia affects esophageal movement and makes it difficult for food to enter the stomach. Effective treatments exist, but not all swallowing difficulty or regurgitation is achalasia.

Your next step

Record what is difficult to swallow and bring endoscopy, manometry and previous treatment reports.

What happens during swallowing?

Normally, coordinated contractions move food down the esophagus while the muscle at the stomach entrance relaxes. In achalasia, the nerves controlling these actions are affected, contractions become abnormal and the lower muscle does not relax properly.

Solids and liquids may become difficult to swallow. Undigested food may return to the mouth, with nighttime coughing, weight loss or chest discomfort. This can resemble reflux, but excess acid is not the underlying problem and symptoms alone cannot diagnose it.

Confirming the diagnosis

- Upper endoscopy helps exclude a narrowing, tumor or another condition resembling achalasia. Early endoscopy findings may be subtle; a previous normal examination does not end the assessment if swallowing difficulty continues.
- High-resolution esophageal manometry confirms the diagnosis and identifies its type. A timed barium swallow can assess esophageal emptying. The test sequence depends on the case; acid monitoring and manometry measure different things.

Treatment options

- Treatment helps food cross the lower esophageal muscle but does not restore damaged nerves to normal. Options include specialized pneumatic balloon dilation, surgical Heller myotomy, or peroral endoscopic myotomy, called POEM.
- Choice depends on the movement pattern, overall health, center expertise and your preferences. Botulinum toxin injections may suit people unable to tolerate more durable procedures. Discuss recurrence and possible further treatment rather than expecting identical results for everyone.

Benefits, risks and follow-up

- Bleeding, a tear or perforation, and other complications can occur depending on the procedure. Unusual symptoms afterward need assessment. Acid reflux may increase, particularly after POEM; acid medicines and follow-up tests may be needed even when swallowing improves.

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- Returning swallowing difficulty does not automatically mean treatment failure. Recurrent functional obstruction, inflammation or a reflux-related narrowing may be responsible. Reassessment guides further treatment. Follow your center’s specific fasting and food instructions before and after the procedure.

Eating while treatment is arranged

- If swallowing is safe, choose small meals and soft, moist foods you tolerate, chew slowly and sit upright. Avoid lying down after eating. Seek nutritional support if weight or food intake falls.
- If food becomes stuck or liquids will not pass, do not force it down with more food or water; seek emergency care. Repeated coughing or choking during meals needs assessment, not continued eating despite symptoms.

When to get help

Get urgent medical care / go to the emergency department

Food stuck, inability to swallow saliva or liquids, breathing difficulty or new severe chest pain. After a procedure, severe pain, fever or breathlessness also needs urgent assessment.

Contact your care team promptly

Worsening swallowing, repeated nighttime cough or choking, weight loss or symptoms returning after treatment.

Related guides: Difficulty swallowing and food getting stuck · Gastroscopy · Gastroesophageal reflux disease · Acid medicines: proton pump inhibitors (PPIs)

Sources and further information ACG: achalasia guideline ASGE: achalasia guideline AGA: achalasia patient guide, September2026 ACG: patient information

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Drug-induced liver injury

Last updated: 10 November 2026 · Drug-induced liver injury

A medicine or supplement can injure liver cells or interfere with bile flow. Raised enzymes alone do not establish the cause; prompt assessment and a clear plan are needed.

Your next step

Prepare a dated medicine and supplement list, including cold remedies and herbal mixtures.

What is drug-induced liver injury?

Injury may follow an overdose, such as excess paracetamol (acetaminophen), or an unexpected reaction to a prescribed dose. It may appear after weeks or months, sometimes after treatment has ended. A supplement labelled “natural” is not necessarily safe.

Tests may become abnormal without symptoms, or you may develop nausea, fatigue, itching, jaundice or dark urine. Viral hepatitis, blocked bile ducts and other conditions can look similar; symptoms or timing alone cannot confirm the cause.

What should I bring?

- List all medicines, supplements and herbs, including antibiotics, painkillers, weight-loss and bodybuilding products. Bring packaging or ingredient photos, with doses, start and stop dates and any dose changes.
- Bring previous and recent results. Your doctor may check liver function, clotting, alternative causes and imaging; not everyone needs a liver biopsy.

What happens when a product is suspected?

- Contact your doctor the same day for jaundice or new symptoms after a medicine or supplement. When the team suspects a cause, they promptly stop the responsible product and arrange alternatives and monitoring. Do not stop all long-term medicines indiscriminately.
- Do not take another dose of a suspected non-essential supplement or herbal mixture before assessment. Do not restart a medicine known to have injured your liver without specialist advice; repeat exposure can be more severe.

Paracetamol: check for duplicate ingredients

- Cold remedies and painkillers may contain paracetamol under different names. Check ingredients and your permitted dose, particularly with liver disease; do not combine products containing it without advice.
- For a possible overdose, go to the emergency department immediately even if you feel well. Symptoms may be delayed, and early treatment matters. Bring the package and the time and amount taken if known.

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After you improve

- Tests may take weeks or months to improve. Continue follow-up until your team confirms recovery or a need for longer monitoring. Avoid products advertised as “liver cleanses”.
- Keep the responsible product in your medical record and medicine list. Tell any prescriber or pharmacist before starting something new. Ask your team to document and report the adverse reaction appropriately.

When to get help

Get urgent medical care / go to the emergency department

Possible overdose of paracetamol or another medicine, jaundice with new confusion or unusual drowsiness, bleeding, persistent vomiting or rapid deterioration: go to emergency care; do not wait for WhatsApp.

Contact your care team promptly

New jaundice, dark urine, severe itching or new abnormal liver tests during or after treatment: contact your team the same day for assessment and medicine advice.

Related guides: Herbs, mixtures and supplements: benefits and risks · Raised liver enzymes: what do they mean? · Liver transplantation: when is evaluation needed?

Sources and further information AASLD: drug and supplement-related liver injury NIH LiverTox: diagnosis and clinical course FDA: acetaminophen safety

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Pancreatic enzymes: pancreatin / Creon

Last updated: 11 November 2026 · Pancreatic enzyme replacement · PERT

These replace missing digestive enzymes in pancreatic insufficiency. They are not a general bloating remedy; the prescription and dose must fit your meals.

Your next step
Confirm your capsule strength and meal-specific dose, and carry it when eating out.

How do I take them?

- Take them with meals and snacks requiring enzymes under your plan, starting with the first food. Several prescribed capsules may be spread through the meal. Strength is measured in lipase units; do not change the strength or number yourself.
- Swallow capsules whole; do not crush or chew the granules. If swallowing is difficult, ask the pharmacist how to open your specific product and mix it with suitable food. Do not use hot food or store the mixture for later.

If I miss a dose

- Do not double the next dose. Resume with the next meal as prescribed; ask your team if missed doses recur or your plan is unclear.

Storage and follow-up

- Follow the temperature and after-opening expiry on your supplied package; products differ. Protect from heat and moisture, and do not leave it in a car.
- Weight, stools, nutrition and vitamins are monitored as needed. Persistent oily stools do not automatically mean you should increase the dose; timing, strength and other causes need review.

Possible side effects: what to expect

- Not everyone gets side effects. Abdominal discomfort, nausea or bowel changes are usually mild or moderate; pancreatic disease itself can contribute. Persistent symptoms need review of timing and response.
- Bowel narrowing is reported particularly with high doses in cystic fibrosis; severe allergy is also reported, with frequency unknown. Do not increase doses yourself. New severe pain, vomiting or distension needs urgent assessment; breathing difficulty or facial swelling needs emergency care.

Before starting

- Do not start it with a known allergy to its ingredients. Tell the team about pregnancy, breastfeeding, immunosuppression or pork-product allergy; many preparations come from pig pancreas. Discuss any concerns to agree a suitable plan. Creon is registered with the Saudi regulator, but pharmacy stock and available strengths vary.

My prescribed plan - complete with the team
Brand / device: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department
Breathing difficulty or swelling of the face or throat, or new severe abdominal pain with vomiting or marked distension: seek urgent care.

Contact your care team promptly
Persistent oily stools, weight loss, increasing pain or an unavailable medicine: contact your team to review the plan.

Related guides: Pancreatitis and pancreatic enzyme insufficiency · Pancreatic cancer

Sources: 1 · 2 · 3 · 4 · Source details and full guide online

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Alcohol-related liver disease

Last updated: 10 November 2026 · Alcohol-related liver disease · ALD

Alcohol can cause liver fat, inflammation and scarring. Early treatment and stopping alcohol with appropriate support improve recovery and reduce complications. A diagnosis does not mean it is too late for treatment.

Your next step

Prepare your medicine list, drinking pattern and last-drink time, and request a clear safe-cessation and follow-up plan.

What is it? Does every fatty liver mean alcohol use?

Alcohol-related liver injury may start without symptoms. It includes fat buildup, hepatitis and scarring: fibrosis at F1–F3 and cirrhosis at F4. Not everyone passes through these stages in the same order.

Fatty liver does not automatically imply alcohol use: diabetes or excess weight can contribute. Causes may coexist, and alcohol can worsen other liver diseases. Assessment considers the whole picture without assumptions or blame.

Assessing liver health

- Explain the amount, frequency, last drink and any symptoms when stopping. You can ask to speak privately. This information guides safe care, not judgment. Bring your medicine, supplement and previous test records.
- Tests may include liver enzymes, bilirubin, clotting, platelets, kidney function, imaging and liver stiffness. Active inflammation can temporarily raise stiffness; enzymes alone do not establish the stage. Other causes, including viral hepatitis, may need testing. Not everyone needs a biopsy.

Stopping safely: when is supervision needed?

- Complete abstinence is the goal with alcohol-related liver disease. If you drink heavily every day, or previously developed shaking, sweating, palpitations or seizures when stopping, seek urgent assessment for supervised cessation. Unmonitored withdrawal can be dangerous.
- If withdrawal symptoms begin after reducing or stopping alcohol, seek medical care immediately. Seizures, hallucinations or severe confusion need emergency care. Do not devise your own taper or use sedatives or someone else’s medicines. The team selects appropriate treatment and monitoring.

Help to sustain recovery

- Difficulty controlling alcohol use is a treatable health problem, not a character flaw. Care may combine liver, addiction and psychological services, involving someone you trust if you wish.
- Behavioral treatments and medicines help some people manage cravings and prevent returning to alcohol. The specialist considers liver and kidney function and other medicines. If drinking resumes, tell the team early so support can change; do not miss follow-up because of embarrassment.

Nutrition, medicines and follow-up

- Eat regularly with adequate calories and protein; malnutrition can occur even with excess weight. Dietitian support and replacement of thiamine (vitamin B1) or other deficiencies may be needed. Avoid prolonged fasting, “liver cleanses” and self-prescribed high-dose vitamins.

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- Fat, inflammation and fibrosis may improve when the cause is treated, but F4 cirrhosis does not necessarily return to normal. Continue complication monitoring and liver cancer surveillance when advised, even after symptoms or tests improve.

Severe hepatitis and transplantation

- New or rapidly worsening jaundice, especially with poor intake, fever or marked illness, may indicate severe hepatitis and needs urgent assessment, sometimes in hospital. Steroids are not suitable for everyone; the team assesses severity, infection, contraindications and treatment response.
- Transplantation may help selected patients with liver failure or advanced cirrhosis. Referral is not automatic acceptance. The center evaluates medical needs, treatment readiness and psychosocial support under its criteria. Do not delay assessment because of an abstinence period you have heard about.

When to get help

Get urgent medical care / go to the emergency department

Seizures, hallucinations, severe confusion, difficulty waking, vomiting blood, black stools, breathlessness or rapidly worsening jaundice with marked illness: seek emergency care immediately; do not wait for WhatsApp.

Contact your care team promptly

New jaundice, increasing abdominal swelling, poor intake or a need for supervised cessation: seek same-day assessment. Withdrawal symptoms after reducing or stopping require immediate care.

Related guides: Fatty liver and steatohepatitis · Liver cirrhosis (F4) · Liver transplantation: when is evaluation needed? · Pancreatitis and pancreatic enzyme insufficiency · Liver cancer surveillance · Eating well with cirrhosis

Sources and further information ACG: alcohol-associated liver disease guideline, 2024 ACG: guideline summary AASLD: alcohol-associated liver disease AGA: metabolic dysfunction and alcohol-associated liver disease, 2026 NIAAA: treatment and recovery support MedlinePlus: alcohol withdrawal NIDDK: cirrhosis treatment AASLD: nutrition in alcohol-associated liver disease

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About Dr. Ibrahim Albedaiwi

Last updated: 10 November 2026 · Ibrahim Albedaiwi, MD, DRCPSC, MRCP(UK)



Ibrahim Saleh Albedaiwi

MD, DRCPSC, MRCP(UK)

Adult gastroenterology and liver care

Consultant in gastroenterology, hepatology and internal medicine, with a focus on advanced liver disease and liver transplantation.

Qualifications and training

- Bachelor of Medicine and Bachelor of Surgery, King Saud University, Riyadh (2012).
- Saudi Board in Internal Medicine (2017), and Saudi Fellowship in Gastroenterology and Hepatology (2021).
- Canadian fellowship in Advanced Hepatology and Liver Transplantation (AFC), London Health Sciences Centre / Western University, Ontario, Canada (2023), through a Royal College-accredited program.
- Membership of the Royal Colleges of Physicians of the United Kingdom — MRCP(UK).
- European Specialization Certificate in Gastroenterology and Hepatology.

Previous leadership roles

- Chief Medical Officer (CMO), Diriyah Hospital — May 2025 to April 2026.
- Chairman, Department of Internal Medicine, Diriyah Hospital — October 2023 to May 2025.
- Internal Medicine Service Line Lead, Riyadh Third Health Cluster — September 2024 to December 2025.

Care interests

- Adult digestive and liver care, including reflux, IBS, Crohn’s disease, ulcerative colitis, coeliac disease, constipation and chronic diarrhea.
- Endoscopy, viral hepatitis, fatty liver disease, advanced liver disease and liver-transplant follow-up. This guide helps patients understand their condition and prepare for a consultation.

A book for patients

- Co-author, with Professor Ibrahim bin Hamad Altraif, of the Arabic book “Hepatitis C Virus,” first edition 2023. More information is available in the hepatitis C guide.

How to use this guide

- Choose the topic relevant to your condition and write down questions before your visit. General information does not replace your diagnosis or personal treatment plan. Each topic includes references and a review date.

Related guides: Hepatitis C · Content rights and permitted use

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- Suitability depends on diagnosis, age, pregnancy, other conditions, kidney and liver function, and medicine interactions. Do not start, stop or change medicines based on the guide alone. Follow your written individual plan and product leaflet; ask your team to clarify any conflict before acting.

Calculator and preparation instructions

- The calculator organizes a plan already approved by your endoscopy unit. It does not determine suitability for a product or anesthesia and is not a prescription. Enter the actual procedure start time, not arrival time, and check the result against your unit’s instructions. Some appointments and conditions need a tailored plan. Check with the unit if the appointment changes or instructions conflict.

Emergencies and urgent problems

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Related guides: Privacy, contact and feedback · Content rights and permitted use

Sources and further information Saudi Health Professions Practice Law — Article 27

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Minimize personal information

- For feedback, suggestions and error reports, the topic and comment are enough. Do not enter a patient’s name, record number, diagnosis or reports in feedback. For a non-urgent medical inquiry, identify yourself, your care provider and record number and give a brief summary when needed to identify your case. Prefer your hospital’s approved channel for sensitive reports where available and check the recipient number. Do not share another person’s information without appropriate authority.

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Portal vein thrombosis

Last updated: 10 November 2026 · Portal vein thrombosis · PVT

This is a clot in the vein carrying blood from the intestines and spleen to the liver. It does not automatically mean cancer. Treatment depends on how recent and extensive the clot is and on liver health.

Your next step

Bring your scan report and medicine list. Ask about clot extent, whether anticoagulation is needed and when imaging should be repeated.

What happens in the portal vein?

Clotted blood partly or completely blocks the vein and may extend into intestinal or splenic veins. It may be found incidentally on imaging or cause pain and complications related to increased portal pressure.

A recent clot differs from an old blockage with collateral vessels carrying blood through alternative routes. These vessels on a report do not alone mean an immediate emergency or that treatment cannot help; the specialist interprets the full findings.

Why did it happen? Does it mean cancer?

- Causes include cirrhosis with slow blood flow, abdominal inflammation or surgery. It can also occur without liver disease. Blood disorders or a tendency to clot may need investigation, especially with other clots or a family history.
- An ordinary blood clot differs from tumor growing into the vein. They require different plans; the word “thrombosis” alone does not establish the type. Contrast imaging helps distinguish them. A clot does not automatically imply cancer.

Confirming the diagnosis

- Doppler ultrasound can assess blood flow. Contrast CT or MRI may then define the location, degree of blockage, extent and any mass. Severe pain also prompts assessment for impaired intestinal blood supply.
- The team reviews older scans, liver and kidney tests, platelets and medicines. Not everyone needs the same clotting-disorder tests; cirrhosis and other risk factors influence which investigations help.

Will I need anticoagulants?

- Some limited, stable clots can be monitored with imaging. Others need anticoagulants (“blood thinners”) to prevent extension and help restore flow. Timing, extent, progression, bleeding risk and possible transplantation guide the decision.
- Recent clots without cirrhosis usually need anticoagulation. Older blockages require different consideration; “chronic” does not automatically mean stop treatment. Suspected intestinal injury is an emergency requiring specialist care.

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Varices and bleeding risk

- Assessment for enlarged esophageal or stomach veins, called varices, and prevention of bleeding may be needed. Varices do not automatically rule out anticoagulation; the team balances bleeding against clot-extension risk and coordinates both treatments.
- Do not delay prescribed anticoagulation yourself while waiting for an endoscopy. Do not start anticoagulants, aspirin or herbal mixtures to treat the clot. Tell the team about previous or current bleeding.

If an anticoagulant is prescribed

- Treatment may involve injections or tablets. Choice depends on liver and kidney function, interactions and pregnancy where relevant. Do not substitute products. Ask what to do about a missed dose and which tests and reviews are needed.
- Tell every clinician and pharmacist, particularly before endoscopy, dental extraction or surgery. Do not stop treatment yourself or add ibuprofen or supplements without advice; they may increase bleeding or interact with treatment.

Follow-up and liver transplantation

- Repeat imaging shows whether the clot has improved or progressed. Some plans use three-monthly scans; your team sets the schedule and treatment duration. Less pain is not a reason to stop anticoagulation.
- Selected patients may benefit from procedures to reopen the vein or a TIPS shunt. A clot does not automatically exclude transplantation but may change planning. Inform the transplant team promptly.

When to get help

Get urgent medical care / go to the emergency department

Sudden severe or worsening abdominal pain, especially with vomiting or bloody stool, vomiting blood, black stools or fainting: seek emergency care immediately. Severe pain may indicate impaired intestinal blood supply. Do not wait for WhatsApp.

Contact your care team promptly

A new scan report describing portal vein thrombosis, persistent new pain, or unusual bruising or bleeding while anticoagulated needs prompt contact with the team for assessment and a plan.

Related guides: Liver cirrhosis (F4) · Portal hypertension and esophageal or gastric varices · Ascites: abdominal fluid and drainage · Liver transplantation: when is evaluation needed? · Liver cancer: diagnosis and treatment · Liver biopsy and FibroScan · My medicines before endoscopy · Budd-Chiari syndrome: blocked liver outflow · Safe use of blood thinners (anticoagulants)

Sources and further information EASL: vascular diseases of the liver (2025/2026) AGA: portal vein thrombosis in cirrhosis (2024/2025) AASLD: vascular liver disorders guidance AASLD: portal vein thrombosis without cirrhosis NHS: anticoagulant medicines

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Gastroenteritis and food poisoning

Last updated: 10 November 2026 · Acute gastroenteritis and food poisoning

Sudden diarrhea or vomiting may follow infection or contaminated food. Many cases improve within days. Replacing fluids and recognizing dehydration and warning signs are priorities. This guide is for adults; children need age-specific advice.

Your next step

Start fluid replacement, monitor urine and ability to drink, and record symptom onset, medicines and meals shared with others.

Are gastroenteritis and food poisoning the same?

Gastroenteritis affects the digestive tract, causing diarrhea, cramps, nausea or vomiting, sometimes with fever. Infection can spread between people or through food and water. Food poisoning follows food or drink contaminated with microbes or toxins.

Symptoms may begin hours or days later; the last meal is not necessarily responsible. Not all diarrhea is an infection, and gastroenteritis differs from H. pylori. Severe pain, bleeding or persistent symptoms need assessment for other causes.

Replace fluids and salts first

- Take frequent small sips, especially when vomiting. Oral rehydration solution (ORS) replaces water and salts in appropriate proportions, particularly with repeated diarrhea or dehydration. Soft drinks and very sugary juices are not suitable substitutes.
- Use ready-made ORS as directed, or dissolve the whole sachet in exactly the safe-water volume on its label. Sachet sizes differ: do not assume every packet needs one liter. Do not add sugar or salt, or mix with milk or juice. Follow storage and use-by instructions.

Eating during recovery

- Fasting or a highly restrictive diet is unnecessary. As nausea settles and appetite returns, start small portions and return to usual foods as tolerated, such as rice, potatoes, bread, soup and thoroughly cooked food.
- Temporarily reduce foods that worsen symptoms, such as fried food, caffeine and very sweet drinks. Milk may be harder to digest after infection; reduce it if it worsens diarrhea or bloating rather than permanently excluding all dairy.

Antibiotics and medicines to stop diarrhea

- Antibiotics are not routine treatment, do not help viral infections and may harm some infections. A clinician selects them when appropriate. Do not use leftover antibiotics or another person’s prescription.
- Loperamide may suit some adults with short-lived watery diarrhea after checking suitability; it does not replace fluids. Avoid it with bloody stool, fever, severe swelling or pain, suspected active colitis or C. difficile infection, and seek assessment.

When are tests needed?

- Mild, short illnesses usually need neither stool testing nor endoscopy. Tests may be appropriate with blood, high fever, dehydration, persistent illness, weakened immunity or several people becoming ill after a shared meal.

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- Mention travel, shared food, sick contacts, recent antibiotics and hospital stays. With Crohn’s or ulcerative colitis, do not assume every episode is a flare; infection may need excluding before treatment changes.

Protecting others and preventing recurrence

- Wash hands with soap and water after the toilet and before food; sanitizer alone works less well against norovirus. Clean vomit and diarrhea with a suitable disinfectant according to its label, without mixing cleaning products. Avoid preparing food for others until 48 hours after symptoms stop.
- Separate raw and ready-to-eat food, cook meat thoroughly and avoid unpasteurized milk. Refrigerate perishable food within two hours, or one hour above 32°C. Smell alone cannot establish safety.

Chronic illness or transplantation

- Seek advice early during pregnancy, older age, kidney disease, cirrhosis, weakened immunity or after transplantation. Fluid replacement and testing may need tailoring, especially with an existing fluid or salt restriction.
- Do not stop transplant medicines or randomly alter diabetes medicines or diuretics. If vomiting prevents keeping medicines or fluids down, contact the team the same day. Deterioration needs emergency care; do not wait for messages.

When to get help

Get urgent medical care / go to the emergency department

Fainting, confusion, very little urine, inability to keep fluids down, severe or worsening abdominal pain, significant bleeding or black stools, or swallowing/breathing difficulty or muscle weakness after suspect food: seek emergency care immediately.

Contact your care team promptly

Bloody diarrhea, high fever or dehydration needs same-day assessment. Seek review if improvement has not begun within two days or diarrhea lasts over three days. People at higher risk should contact the team earlier.

Related guides: Chronic diarrhea · C. difficile infection · Care after liver transplantation · My IBD flare plan · Fasting, travel and medicine planning

Sources and further information IDSA: infectious diarrhea guideline NIDDK: food poisoning overview NIDDK: food poisoning treatment NIDDK: eating during recovery CDC: oral rehydration and travelers’ diarrhea CDC: food poisoning warning signs CDC: preventing norovirus spread CDC: preventing food poisoning

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Eating well with cirrhosis

Last updated: 10 November 2026 · Food guide · Cirrhosis

Protect strength and muscle while meeting your nutritional needs. Salt and fluid advice should fit your condition; there is no single restrictive diet for everyone with cirrhosis.

Your next step

Write down a typical day of food and ask for your protein and salt goals, and whether you actually need a fluid limit.

Is this the same as a fatty-liver diet?

Not always. Malnutrition and muscle loss can occur with cirrhosis even when someone is overweight. Abdominal fluid and swelling may hide true weight loss, so the scale alone does not tell the whole story.

The plan considers appetite, muscle, diabetes, kidneys and ascites. Weight loss may still be appropriate for some people, but crash diets and prolonged fasting can harm muscle. Ask for a dietitian referral if eating is difficult or strength declines.

Regular meals and an evening snack

- Spread food across small meals and snacks, usually every 3–4 hours while awake, rather than only two large meals. Have an early breakfast and a late-evening snack to shorten the overnight period without food.
- Combine carbohydrate and protein in a snack, such as oats with pasteurized milk or bread with yogurt. Discuss timing if troublesome reflux is present. Discuss Ramadan or intermittent fasting with your team beforehand.

Protein protects muscle

- Include protein with meals: fully cooked eggs, poultry, fish, pasteurized milk or yogurt, or cooked lentils and beans as tolerated. Vary the sources; some people tolerate dairy and plant proteins more easily.
- Do not restrict protein because of hepatic encephalopathy, or confusion. Restriction can increase muscle breakdown. A dietitian sets your daily amount using an appropriate weight after allowing for retained fluid and your condition. Prescribed nutritional supplements may help inadequate intake; do not choose a supplement without review.

Salt: a practical plan without under-eating

- With ascites or swelling, your team may set a target around 2 g of sodium daily, equivalent to about 5 g of salt from all sources. This is not an allowance to add on top of salt already in food. Restrictions differ between patients.
- Limit pickles, stock cubes, instant soups, processed meats, salty cheeses and ready-made meals. Check sodium and serving size on labels; use lemon and spices for flavor. If reducing salt prevents you from eating enough, ask the team to review the plan.

Should I limit water or use a salt substitute?

- Do not restrict water simply because you have cirrhosis or ascites. A fluid limit may be needed for low blood sodium or particular circumstances. Your team should specify the amount and what counts, including soups, milk and drinks.
- Some salt substitutes contain potassium and may be unsuitable with spironolactone or kidney disease. Check before using them. Do not change diuretic doses or supplements based only on weight.

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Food safety and supplements

- Avoid raw or undercooked shellfish, fish and meat, and unpasteurized milk or dairy products. Wash produce, keep raw and cooked foods separate, and refrigerate food safely. Infections may be more serious with cirrhosis.
- Avoid alcohol. Do not use “liver cleanses”, herbal mixtures or high-dose vitamins without review. Replace proven deficiencies according to the plan; good nutrition supports treatment but does not replace it.

Flexible examples using familiar foods

This is not an individually calculated meal plan. Adjust portions for nutritional needs, diabetes, kidney health and tolerance.

Meal	Practical example
Breakfast	Bread with fully cooked eggs or homemade lower-salt fava beans, plus washed vegetables.
Lunch	Rice or jareesh with chicken or fish and cooked vegetables; prepare without salty stock cubes.
Dinner	Lentils or chicken with bread or potatoes, and pasteurized laban suited to your salt plan.
Evening snack	Oats with pasteurized milk, or yogurt and bread; agree portions and timing with the team.

If you fill up quickly, make meals smaller and eat more often instead of skipping meals or having only tea.

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When to get help

Get urgent medical care / go to the emergency department

New confusion, vomiting blood, black stools, fainting, severe breathlessness, or fever and abdominal pain with ascites: seek emergency care. Do not wait for a diet change or WhatsApp reply.

Contact your care team promptly

Poor intake, declining strength, ongoing weight loss or rapidly increasing weight and swelling: contact the team to assess nutrition and fluids. Difficulty keeping food or drink down needs prompt assessment.

Related guides: Liver cirrhosis (F4) · Ascites: abdominal fluid and drainage · Hepatic encephalopathy: confusion and altered awareness · My cirrhosis monitoring plan · A family guide to cirrhosis · Liver transplantation: when is evaluation needed? · Herbs, mixtures and supplements: benefits and risks · Spironolactone for ascites · Furosemide for ascites

Sources and further information AASLD: nutrition, frailty and muscle loss in cirrhosis (2021) EASL: nutrition in chronic liver disease ESPEN: practical guideline on nutrition in liver disease ACG: malnutrition and nutritional recommendations (2025) AGA: ascites, fluid overload and low sodium NIDDK: food and nutrition with cirrhosis NHS: spironolactone and potassium-containing salt substitutes ACG: hepatic encephalopathy guideline

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Spironolactone for ascites

Last updated: 11 November 2026 · Spironolactone for ascites

Spironolactone, also sold as Aldactone, helps remove excess salt and water while retaining potassium. It treats ascites, meaning fluid in the abdomen, and may be prescribed alone or with furosemide.

How do I use it?

- Take your prescribed dose with or just after food, at a consistent time, usually in the morning. Do not start or increase it because swelling worsens: its effect takes several days, and safe dosing depends on blood tests, weight and blood pressure.
- Take a missed dose when remembered unless the next dose is nearly due; then skip it. Never double up. Follow your product leaflet and ask your pharmacist if the timing is unclear.

How do I store it?

- Keep it in its original packaging, away from moisture, heat and children, at the labelled temperature. Ask about storage, measuring and expiry after opening for liquid products.

What tests do I need?

- Kidney function, sodium and potassium are checked before treatment, after starting or changing the dose, and regularly thereafter. Record your weight each morning after passing urine and before breakfast, consistently. Check blood pressure if requested. Your team sets the weight-loss target and when to report changes; do not adjust doses automatically.

Possible side effects: what to expect

- Nausea, dizziness, cramps or breast tenderness/enlargement can occur. Stand up slowly and mention troublesome symptoms; the team can review treatment while continuing to manage the fluid buildup.
- Important risks include high potassium, dehydration and worsening kidney function, sometimes without early symptoms. Planned blood tests, weight and blood-pressure checks help your team adjust treatment. Follow the contact advice below rather than changing the dose yourself.

Important points

- Potassium can rise to levels that affect the heart rhythm. Avoid potassium supplements and potassium-containing salt substitutes unless prescribed. Have other medicines checked, especially ibuprofen, diclofenac, certain blood-pressure medicines and trimethoprim/sulfamethoxazole. Do not automatically exclude all fruit and vegetables; dietary advice depends on your results.
- Breast tenderness or enlargement, dizziness and cramps can occur. Discuss pregnancy or breastfeeding with your team. Do not restrict or increase fluids to compensate for urination without a plan; follow your ascites salt advice.

My prescribed plan - complete with the team
Brand: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Seek emergency care for fainting, palpitations with severe weakness, new confusion, severe breathlessness, or sudden tongue or throat swelling. Fever with abdominal pain in someone with ascites needs urgent assessment.

Contact your care team promptly

Contact your team the same day for reduced urine, persistent vomiting or diarrhoea, worsening dizziness, or rapid weight change. The team may need to adjust or temporarily withhold treatment.

Related guides: Ascites: abdominal fluid and drainage · Furosemide for ascites · Eating well with cirrhosis · Liver cirrhosis (F4)

Sources: 1 · 2 · 3 · Source details and full guide online

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Furosemide for ascites

Last updated: 11 November 2026 · Furosemide for ascites

Furosemide, also sold as Lasix, helps the kidneys remove excess salt and water. It may be added to spironolactone for ascites and leg swelling. Dosing depends on kidney function, blood salts and response.

How do I use it?

- Take it as prescribed, usually in the morning. If a second dose is prescribed, it is generally taken earlier in the day to reduce night-time urination. Follow your product instructions about food. Measure liquid medicine with the supplied device, not a kitchen spoon.
- Take a missed dose when remembered unless the next is nearly due; then skip it without doubling. Ask your pharmacist if you remember late in the evening. Do not add a dose yourself for swelling or weight gain.

How do I store it?

- Keep it in its supplied packaging, away from children, heat and moisture. Follow labelled temperature and light-protection instructions. Ask your pharmacist about expiry after opening a liquid product.

What tests do I need?

- Blood pressure, weight, kidney function, sodium and potassium are monitored; magnesium may also be checked. Tests are repeated after starting or changing treatment, sooner if risk is higher. Record morning weight consistently, after passing urine and before breakfast, and share the record. Losing weight as quickly as possible is not the goal.

Possible side effects: what to expect

- Passing more urine is expected; dizziness on standing, thirst or muscle cramps can occur. Rise slowly and keep to your prescribed fluid plan rather than drinking extra water automatically.
- Excess fluid loss can lower sodium or potassium and worsen kidney function. Weight, blood-pressure and blood-test checks help guide safe dosing. Report persistent cramps or dizziness; reduced urine or ongoing vomiting/diarrhoea needs same-day advice. Hearing changes also need prompt review.

Important points

- Frequent urination, dizziness on standing, cramps, dehydration and low blood salts can occur. Stand up slowly. Do not automatically take potassium supplements, especially with spironolactone; blood tests determine whether you need them.
- Have all medicines checked, especially ibuprofen, diclofenac, lithium and blood-pressure drugs. Do not stop prescribed medicines yourself. Follow your salt and fluid plan; ascites does not mean everyone needs fluid restriction, or that increased urination requires drinking large amounts.

My prescribed plan - complete with the team
Brand: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Seek emergency care for fainting, new confusion, palpitations with severe weakness, severe breathlessness, or sudden tongue or throat swelling. Fever with abdominal pain in someone with ascites needs urgent assessment.

Contact your care team promptly

Contact your team the same day for reduced urine, persistent vomiting or diarrhoea, worsening dizziness, rapid weight loss, or hearing changes. The team may adjust or temporarily withhold treatment.

Related guides: Ascites: abdominal fluid and drainage · Spironolactone for ascites · Eating well with cirrhosis · Liver cirrhosis (F4)

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Carvedilol for portal hypertension

Last updated: 11 November 2026 · Carvedilol for portal hypertension

Carvedilol is a non-selective beta-blocker. Liver specialists may prescribe it to lower pressure in the portal vein, which carries blood from the gut to the liver, and reduce variceal bleeding or other cirrhosis complications in selected patients. Not everyone with cirrhosis needs it.

How do I use it?

- Take the prescribed dose with food, at consistent times. A portal-hypertension plan may differ from a heart-treatment plan. Do not copy someone else’s dose or adjust yours from one blood-pressure reading.
- Take a missed dose when remembered unless the next is nearly due; then skip it without doubling. Do not stop suddenly yourself or restart your old dose after a prolonged interruption without consulting your team.

How do I store it?

- Keep it in its original packaging, away from moisture, heat and children, following the label. Ask before splitting tablets; not every formulation can be divided.

What tests do I need?

- Blood pressure, pulse and symptoms are monitored. Kidney function and blood salts are reviewed, particularly with ascites or diuretics. Diabetes may require closer glucose monitoring because carvedilol can mask some low-glucose warning signs. There is no single reading everyone should use to adjust their own dose.

Possible side effects: what to expect

- Dizziness, headache or tiredness can occur, especially at the start; these are often mild. Rise slowly, take it with food as prescribed, and avoid driving if dizzy.
- Too-low blood pressure or a slow heartbeat can require a dose review. Breathing difficulty or wheezing is important, especially with asthma. Pulse, blood pressure and kidney checks help select a tolerated dose. Follow the warning signs below; do not adjust or stop treatment on your own.

Important points

- Dizziness and tiredness can occur, especially initially; stand slowly and avoid driving when dizzy. Tell your doctor about asthma, a very slow pulse, heart-conduction problems, pregnancy or pregnancy plans.
- Have all medicines checked, especially other drugs that slow the heart or lower blood pressure. Infection with low blood pressure, dehydration or kidney deterioration may require urgent clinician-led dose reduction or temporary withholding. Infection alone does not mean automatically stopping treatment; feeling better does not mean treatment is no longer needed.

My prescribed plan - complete with the team
Brand: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Seek emergency care for fainting, severe breathlessness or wheezing, chest pain, vomiting blood or black stools, or sudden tongue or throat swelling. Do not wait for WhatsApp.

Contact your care team promptly

Contact your team the same day for persistent dizziness, a slow pulse with fatigue, blood pressure much lower than usual, reduced urine, or vomiting, diarrhoea or fever affecting intake. The team decides what to do about the next dose.

Related guides: Portal hypertension and esophageal or gastric varices · Ascites: abdominal fluid and drainage · Liver cirrhosis (F4) · Spironolactone for ascites · Furosemide for ascites

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Tacrolimus: preventing transplant rejection

Last updated: 11 November 2026 · Tacrolimus

Tacrolimus reduces immune activity to protect your transplant from rejection. Your transplant team adjusts your individual dose using blood tests; do not change it because results improve or you feel well.

How do I use it?

- Immediate-release products such as Prograf are usually taken twice daily; some prolonged-release products, such as Advagraf, are taken once each morning. Brands and formulations are not automatically interchangeable, even when both contain tacrolimus. Changes require transplant-team supervision and level monitoring.
- Follow your written product, timing and food instructions. These vary by product; for example, Advagraf is taken on an empty stomach according to its leaflet. Keep your relationship to meals consistent. Swallow tablets or capsules whole as directed; do not crush or open them without advice.

How do I store it?

- Use the original packaging and its temperature and after-opening expiry instructions. Protect from moisture and children; never leave it in a hot car. Check the name and strength with every refill; ask the pharmacist about any change in appearance.

What tests do I need?

- The trough level is measured just before the scheduled dose, at the time arranged by your team. Bring your dose to take after sampling as instructed, and record your last dose time. Do not delay it all day or automatically withhold other morning medicines.
- Monitoring also includes kidney and liver function, potassium, magnesium, blood glucose and blood pressure. Target levels and test intervals differ between patients and stages of follow-up.

Possible side effects: what to expect

- Hand tremor, headache or stomach upset can occur. Mention bothersome symptoms to the transplant team: checking levels and adjusting treatment may help while protecting the transplant.
- Important risks include kidney problems, high blood sugar and infection. Regular levels and blood tests help guide dosing. Long-term immunosuppression also raises some cancer risks, especially skin cancer, so follow sun-protection and screening advice. Do not stop it yourself.

Interactions and missed doses

- Avoid grapefruit, grapefruit juice and St John’s wort. Some antibiotics, antifungals and antivirals markedly change tacrolimus levels. Check every new medicine or supplement with your transplant team or pharmacist before use.
- For a missed dose, follow your product instructions; contact the team if unclear. Never double a dose. Contact the team the same day for vomiting or diarrhoea, which may change absorption and drug levels. Do not automatically repeat a vomited dose.

My prescribed plan - complete with the team
Brand: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Seek emergency care for a seizure, sudden confusion, breathing difficulty, or swelling of the face or tongue. Do not wait for a WhatsApp reply.

Contact your care team promptly

Contact your transplant team the same day for fever, vomiting or diarrhoea, reduced urine, a new severe tremor, inability to take the medicine, or a supply running out.

Related guides: Anti-rejection medicines after liver transplantation: a practical guide · Care after liver transplantation · Mycophenolate: CellCept and Myfortic · Pregnancy and breastfeeding with bowel and liver disease

Sources: 1 · 2 · 3 · 4 · 5 · 6 · 7 · Source details and full guide online

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Mycophenolate: CellCept and Myfortic

Last updated: 11 November 2026 · Mycophenolate (CellCept and Myfortic)

Mycophenolate suppresses certain immune cells and is combined with other medicines to prevent transplant rejection. Your transplant team selects the product and dose.

How do I use it?

- Mycophenolate mofetil (CellCept) differs from enteric-coated mycophenolate sodium (Myfortic). Never exchange them milligram for milligram or convert doses yourself. Take it as prescribed, commonly twice daily, following your product’s food instructions.
- Swallow tablets whole; do not crush them or open capsules. Ask about another formulation if swallowing is difficult. For missed doses, follow your leaflet or team’s instructions. Never double or automatically repeat a vomited dose.

How do I store it?

- Store in its packaging at the labelled temperature, away from children. Avoid powder from opened capsules or broken tablets; ask your pharmacist about handling. Liquid products have different storage and expiry instructions.

What tests do I need?

- Blood counts monitor white cells, haemoglobin and platelets; your team also checks liver and kidney function. Tests are frequent initially and after treatment changes. Low cell counts may precede symptoms.

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Possible side effects: what to expect

- Diarrhoea, nausea or vomiting are common problems. Tell your transplant team if they persist; they can review the dose or formulation and check other causes. Do not reduce it yourself.
- Low blood-cell counts and infections also occur and require blood-test monitoring. Longer-term immunosuppression increases some cancer risks, including skin cancer; follow sun protection and recommended screening. The pregnancy precautions below are essential because mycophenolate can seriously harm an unborn baby.

Pregnancy and breastfeeding: essential warning

- Mycophenolate causes miscarriage and birth defects. Women who could become pregnant need pregnancy testing as advised and reliable contraception before, during and for 6 weeks after medically supervised discontinuation; two complementary methods are preferred. Men or their partners need reliable contraception during treatment and for 90 days afterwards.
- Plan pregnancy or fatherhood with your specialist; treatment may need changing. Contact the team the same day if pregnancy is possible or contraception fails. Do not stop treatment yourself. Avoid breastfeeding on this medicine; arrange alternatives beforehand.

Infection and interactions

- Report diarrhoea or infection rather than stopping treatment yourself. Some antacids, cholestyramine and other medicines affect absorption. Ask for a medication review and spacing plan where needed.

My prescribed plan - complete with the team
Brand: ..... | Dose and how I take or use the medicine: .....
Next dose: ..... | Next blood tests: .....
Team contact: .....

When to get help

Get urgent medical care / go to the emergency department

Seek emergency care for breathing difficulty, major bleeding, or fainting or confusion with serious illness. Do not wait for a WhatsApp reply.

Contact your care team promptly

Contact the team the same day for fever, severe sore throat, unusual bruising, ongoing diarrhoea or vomiting, possible pregnancy, or inability to take or obtain doses.

Related guides: Anti-rejection medicines after liver transplantation: a practical guide · Care after liver transplantation · Tacrolimus: preventing transplant rejection · Pregnancy and breastfeeding with bowel and liver disease

Sources: 1 · 2 · 3 · 4 · 5 · Source details and full guide online

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Budd-Chiari syndrome: blocked liver outflow

Last updated: 10 November 2026 · Budd-Chiari syndrome

This rare condition obstructs blood drainage from the liver, suddenly or gradually. Treatment depends on the obstruction and liver function; not everyone needs a transplant.

Your next step

Bring imaging reports and your medicine list. Ask about the obstruction, anticoagulation, specialist review and the next scan.

How does it differ from portal vein thrombosis?

The portal vein brings blood into the liver. The hepatic veins carry blood out toward the heart through the inferior vena cava. Budd-Chiari obstructs this outflow, causing congestion and increased pressure. A portal vein clot is different, although both may coexist.

Hepatic veins or the inferior vena cava may be blocked by a clot, narrowing or membrane inside, or by external pressure. Liver congestion caused by heart failure is a different condition. Budd-Chiari is unrelated to Chiari malformation of the brain.

What symptoms can occur?

- Upper abdominal pain, liver enlargement or abdominal swelling from ascites, meaning fluid accumulation, may occur. Leg swelling, jaundice or fatigue may occur. Some cases are found without obvious symptoms.
- Severity ranges from stable chronic disease to rapidly worsening liver function. Varices with bleeding or confusion may develop in advanced cases.

Why does the obstruction occur?

- A tendency to clot may relate to blood or immune disorders or inherited factors. Pregnancy, postpartum changes or hormones may contribute. Finding one cause does not exclude others.
- A hematologist may investigate, sometimes with JAK2 testing for blood-cell production disorders. An initially unknown cause does not prevent appropriate treatment.

Confirming the diagnosis

- Doppler ultrasound usually assesses blood flow first. Contrast CT or MRI then defines the obstruction and helps plan treatment. Liver and kidney function, blood counts and clotting tests are also reviewed.
- Liver biopsy is unnecessary when imaging clearly establishes the diagnosis. It may be considered for suspected disease of small hepatic veins that imaging cannot show. Investigations are individualized.

Medicines and management of complications

- Primary Budd-Chiari, caused by a problem inside the veins, usually needs anticoagulation unless contraindicated. Treatment is generally long term and may be lifelong. Do not stop when pain or imaging improves without a specialist decision.
- Underlying conditions also need treatment, with plans for ascites or varices when necessary. Anticoagulant choice considers organ function, bleeding, interactions and pregnancy. Do not start aspirin or a herbal “clot dissolver”, or change treatment yourself.

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Will I need an intervention or transplant?

- A short narrowing may suit balloon widening with or without a stent. If treatment is insufficient or reopening is unsuitable, a channel inside the liver called TIPS may reduce congestion. Liver, hematology and interventional-radiology specialists select the sequence according to anatomy and response.
- Transplantation is considered when disease cannot be controlled, or earlier with severe acute liver failure. Intervention or transplantation does not automatically remove the need to treat a clotting tendency.

Follow-up and pregnancy

- Follow-up checks symptoms, blood tests, imaging and any stent or shunt. Benign nodules can develop, but chronic disease still needs a liver-cancer surveillance plan, often every six months. Not every nodule is cancer.
- Pregnancy may be possible with coordinated liver, hematology and maternity care. Discuss plans and contraception beforehand. If pregnancy occurs while taking an anticoagulant, contact the team the same day to arrange appropriate treatment without an unplanned interruption.

When to get help

Get urgent medical care / go to the emergency department

Severe or worsening abdominal pain, rapidly increasing swelling with breathlessness, vomiting blood, black stools, fainting, confusion or unusual drowsiness: seek emergency care immediately. Do not wait for WhatsApp.

Contact your care team promptly

A new diagnosis or suspected Budd-Chiari, increasing ascites or jaundice, reduced urine or difficulty taking anticoagulation needs prompt team contact. Pregnancy while anticoagulated needs same-day advice.

Related guides: Portal vein thrombosis · Safe use of blood thinners (anticoagulants) · Ascites: abdominal fluid and drainage · Portal hypertension and esophageal or gastric varices · Liver transplantation: when is evaluation needed? · Liver biopsy and FibroScan · Pregnancy and breastfeeding with bowel and liver disease

Sources and further information EASL: vascular diseases of the liver (2025/2026) Baveno VIII: portal hypertension consensus (2026) AASLD: hepatic vein thrombosis and Budd-Chiari syndrome Orphanet / ERN RARE-LIVER: Budd-Chiari syndrome NHS: anticoagulants and pregnancy

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Safe use of blood thinners (anticoagulants)

Last updated: 10 November 2026 · Safe use of blood thinners · Anticoagulants

Anticoagulants help prevent clots forming or growing, but can increase bleeding. Instructions differ between medicines and between regimens for the same medicine. Follow your written plan. This guide supports safe use; it does not select treatment or replace follow-up.

Your next step

Carry a card showing your medicine, reason and dose. Arrange tests before the prescription runs out. Print the plan below for your team to complete.

Print this form and complete it with your care team.

Are all blood thinners the same?

Anticoagulants include warfarin, direct oral medicines such as apixaban, rivaroxaban, dabigatran and edoxaban, and injections such as enoxaparin. Aspirin and clopidogrel act on platelets and cannot replace an anticoagulant. A doctor may prescribe a combination for a specific reason. Do not switch or combine them yourself.

How do I take it?

- Follow the prescribed dose and times; do not stop because symptoms improve. Food instructions vary: rivaroxaban 15 mg and 20 mg tablets must be taken with food. These strengths illustrate administration, not a dose recommendation. Ask the pharmacist about your specific product.
- For enoxaparin injections, receive practical training before injecting under the skin at home. Rotate sites as instructed, avoid rubbing afterwards, and place used needles in a sharps container away from children.

What if I miss a dose?

- Request written instructions for your medicine, dose and frequency: there is no single rule for all anticoagulants. Contact the pharmacist or treating team promptly after a missed or extra dose, or vomiting after a dose. Do not guess how to compensate or follow another medicine's instructions.

What monitoring is needed?

- Warfarin needs INR blood tests to guide dosing by measuring how quickly blood clots. Direct oral anticoagulants are not usually adjusted using INR, but still need reviews, blood counts, and kidney and liver tests. Your team sets the schedule; illness, medicine changes or kidney problems may require closer monitoring.

Medicines, food and storage

- Check new medicines, including antibiotics, herbs and supplements, with your pharmacist. Do not add ibuprofen, diclofenac or aspirin yourself: bleeding may increase. If aspirin or clopidogrel is already prescribed, do not stop it without an agreed plan.
- With warfarin, keep vitamin K-rich vegetables reasonably consistent rather than avoiding them. Follow pack storage instructions; protect medicines from heat, moisture and children. Dabigatran capsules need their original packaging for moisture protection; ask before transferring them into a pill organiser.

Liver disease, kidneys, pregnancy and breastfeeding

- Tell your team about cirrhosis or kidney impairment: not every anticoagulant suits every disease stage, and the medicine or dose may need changing. Seek early advice when planning pregnancy,

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becoming pregnant or breastfeeding. Do not stop or substitute treatment yourself; stopping may restore the risk of clotting.

Before endoscopy or dental treatment

- Inform the prescriber and gastroenterologist or dentist early. Decisions depend on clotting and bleeding risk, the procedure and kidney function. Diagnostic endoscopy with simple biopsies is usually lower risk than removing polyps; anticipated treatment during endoscopy may change the plan.
- There is no universal stopping interval. Get the last dose and restart time in writing, or confirmation to continue when appropriate. Temporary replacement with injections is not needed for everyone and must not be arranged yourself. Bring your medication card and mention coronary stents, mechanical heart valves or recent clots.

Your plan: complete with the treating team

Print, complete by hand, and keep with your medicines list.

Medicine and reason: _____

Dose, times and food: _____

Missed-dose instructions: _____

Tests and follow-up: _____

Procedure and date: _____

Continue or last dose before procedure: _____

Restart time and team approving plan: _____

Team or pharmacy telephone: _____

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When to get help

Get urgent medical care / go to the emergency department

Vomiting blood, black stools, uncontrolled bleeding, fainting, sudden severe headache or new weakness: go to emergency care immediately. A head injury needs urgent assessment even if you feel well. Do not wait for WhatsApp. Bring the medicine name and last-dose time.

Contact your care team promptly

Contact the team promptly for new large bruises, repeated minor bleeding, heavier periods, or an extra or missed dose. Heavy bleeding or bleeding with dizziness requires emergency care.

Related guides: Portal vein thrombosis · Budd-Chiari syndrome: blocked liver outflow · Gastrointestinal bleeding · My medicines before endoscopy · Gastroscopy · Colonoscopy · Pregnancy and breastfeeding with bowel and liver disease

Sources and further information NHS: anticoagulant considerations NHS: bleeding and adverse effects NHS SPS: direct oral anticoagulant monitoring (2026) BSG/ESGE: anticoagulants and endoscopy Rivaroxaban leaflet: food and missed doses Enoxaparin leaflet: training and safe injection Dabigatran product information: storage NICE: head injury and anticoagulants

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Anti-rejection medicines after liver transplantation: a practical guide

Last updated: 10 November 2026 · Anti-rejection medicines after liver transplantation

Anti-rejection medicines protect your transplanted liver by reducing the immune response against it. They are essential to transplant success and usually continue lifelong, even when blood tests are normal.

Your next step

Keep your transplant prescription, team contact number and missed-dose plan accessible. Confirm your next blood test and refill.

Why do I need more than one medicine?

- Combining medicines with different actions provides protection while reducing high-dose side effects. Treatment differs between patients and changes with time after transplantation, kidney function, infections and adverse effects. Later dose reductions do not remove the need for follow-up.
- Options include tacrolimus or ciclosporin, mycophenolate and corticosteroids. Everolimus or azathioprine may be selected in particular circumstances. This is not a list everyone should take together: follow your transplant team’s prescription.

What monitoring should I expect?

- Tacrolimus and ciclosporin may affect kidney function and blood pressure; tacrolimus may raise glucose or cause tremor. Mycophenolate can cause diarrhoea or low blood-cell counts; azathioprine also requires blood counts and liver tests. Your team assesses symptoms and adjusts treatment safely.
- Selected patients taking everolimus need monitoring of its level, blood lipids, urine protein and wound healing; mouth ulcers can occur. Steroids can affect glucose, blood pressure and bones. Separate cards cover steroids, azathioprine and the main transplant medicines.

A daily routine that protects your transplant

- Keep an updated list of brands, strengths, doses and times; use reminders. Arrange refills early and plan travel or fasting with your team. Do not change products, manufacturers or dose frequency yourself, or stop treatment because you feel well.
- For a missed or vomited dose, check product instructions and contact the team if uncertain. Never automatically double or repeat it. Vomiting or diarrhoea may prevent you retaining medicines or change drug levels, so contact the team that day.

Blood-test days and new medicines

- Some medicines need their level checked immediately before the next dose. Confirm which medicine and timing; bring the dose to take after sampling as instructed. Do not withhold all morning medicines or delay them all day. Rejection may cause no symptoms, so feeling well does not replace testing.

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- Tell every clinician and pharmacist about your transplant. Check new medicines and supplements with the transplant team. Avoid grapefruit with medicines it interacts with, and herbs without review; these can alter treatment levels. Never borrow medicines or copy another patient’s dose.

Prevention and pregnancy

- Review vaccinations, food safety and sun protection with the team. Do not receive live vaccines without their approval. Some infection-prevention medicines are temporary, whereas anti-rejection treatment usually continues long term; keep these plans separate.
- Discuss pregnancy, fatherhood and breastfeeding in advance. Mycophenolate particularly can harm an unborn baby and requires specialist planning. If pregnancy is possible, contact the transplant team immediately without stopping immunosuppression yourself.

When to get help

Get urgent medical care / go to the emergency department

Seek emergency care for breathing difficulty, confusion or fainting, major bleeding, or rapid deterioration with fever. Do not wait for a clinic or WhatsApp reply.

Contact your care team promptly

Contact the transplant team the same day for fever, new jaundice, vomiting or diarrhoea, reduced urine, missed doses with an unclear plan, or a supply running out.

Related guides: Care after liver transplantation · Tacrolimus: preventing transplant rejection · Mycophenolate: CellCept and Myfortic · Corticosteroid medicine card · Azathioprine / Imuran · Pregnancy and breastfeeding with bowel and liver disease · Fasting, travel and medicine planning

Sources and further information NHS Blood and Transplant: liver transplant medicines NIDDK: living with a liver transplant Certican (everolimus): manufacturer patient leaflet SFDA: tacrolimus product safety alert card SFDA-approved CellCept pregnancy-risk guidance

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