

Table 1. Summary and strength of recommendations*Epidemiology and public health*

1. Diagnostic evaluation using stool culture and culture-independent methods if available should be used in situations where the individual patient is at high risk of spreading disease to others, and during known or suspected outbreaks. (Strong recommendation, low level of evidence)

Diagnosis

2. Stool diagnostic studies may be used if available in cases of dysentery, moderate–severe disease, and symptoms lasting >7 days to clarify the etiology of the patient's illness and enable specific directed therapy. (Strong recommendation, very low level of evidence)
3. Traditional methods of diagnosis (bacterial culture, microscopy with and without special stains and immunofluorescence, and antigen testing) fail to reveal the etiology of the majority of cases of acute diarrheal infection. If available, the use of FDA-approved culture-independent methods of diagnosis can be recommended at least as an adjunct to traditional methods. (Strong recommendation, low level of evidence)
4. Antibiotic sensitivity testing for management of the individual with acute diarrheal infection is currently not recommended. (Strong recommendation, very low level of evidence)

Treatment of acute disease

5. The usage of balanced electrolyte rehydration over other oral rehydration options in the elderly with severe diarrhea or any traveler with cholera-like watery diarrhea is recommended. Most individuals with acute diarrhea or gastroenteritis can keep up with fluids and salt by consumption of water, juices, sports drinks, soups, and saltine crackers. (Strong recommendation, moderate level of evidence)
6. The use of probiotics or prebiotics for the treatment of acute diarrhea in adults is not recommended, except in cases of postantibiotic-associated illness. (Strong recommendation, moderate level of evidence)
7. Bismuth subsalicylates can be administered to control rates of passage of stool and may help travelers function better during bouts of mild-to-moderate illness. (Strong recommendation, high level of evidence)
8. In patients receiving antibiotics for traveler's diarrhea, adjunctive loperamide therapy should be administered to decrease duration of diarrhea and increase chance for a cure. (Strong recommendation, moderate level of evidence)
9. The evidence does not support empiric anti-microbial therapy for routine acute diarrheal infection, except in cases of TD where the likelihood of bacterial pathogens is high enough to justify the potential side effects of antibiotics. (Strong recommendation, high level of evidence)
10. Use of antibiotics for community-acquired diarrhea should be discouraged as epidemiological studies suggest that most community-acquired diarrhea is viral in origin (norovirus, rotavirus, and adenovirus) and is not shortened by the use of antibiotics. (Strong recommendation, very low-level evidence)

Evaluation of persisting symptoms

11. Serological and clinical lab testing in individuals with persistent diarrheal symptoms (between 14 and 30 days) are not recommended. (Strong recommendation, very low level of evidence)
12. Endoscopic evaluation is not recommended in individuals with persisting symptoms (between 14 and 30 days) and negative stool work-up. (Strong recommendation, very low level of evidence)

Prevention

13. Patient level counseling on prevention of acute enteric infection is not routinely recommended but may be considered in the individual or close contacts of the individual who is at high risk for complications. (Conditional, very low level of evidence)
14. Individuals should undergo pretravel counseling regarding high-risk food/beverage avoidance to prevent traveler's diarrhea. (Conditional, very low level of evidence)
15. Frequent and effective hand washing and alcohol-based hand sanitizers are of limited value in preventing most forms of traveler's diarrhea but may be useful where low-dose pathogens are responsible for the illness as for an example during a cruise ship outbreak of norovirus infection, institutional outbreak, or in endemic diarrhea prevention. (Conditional recommendation, low level of evidence)

Prophylaxis

16. Bismuth subsalicylates have moderate effectiveness and may be considered for travelers who do not have any contraindications to use and can adhere to the frequent dosing requirements. (Strong recommendation, high level of evidence)
17. Probiotics, prebiotics, and synbiotics for prevention of TD are not recommended. (Conditional recommendation, low level of evidence)
18. Antibiotic chemoprophylaxis has moderate to good effectiveness and may be considered in high-risk groups for short-term use. (Strong recommendation, high level of evidence)

TD, traveler's diarrhea.

updated the estimates of infectious gastroenteritis caused by a myriad of viruses, bacteria, and parasites (1,2). Based on empirical modeling of active, passive, and outbreak surveillance data ~47.8 million foodborne-related illnesses occur annually (one out of every six persons) in the United States. Furthermore, it was estimated each year that 31 major pathogens acquired in the United

States caused 9.4 million episodes of diarrheal illness, 55,961 hospitalizations, and 1,351 deaths. In addition, unspecified agents resulted in 71,878 hospitalizations and 1,686 deaths, caused ~38.4 million episodes of domestically acquired foodborne illnesses. In addition to domestically acquired infections, over 44 million US residents traveled abroad to non-Canadian and non-European