Medical Management of Malignant Bowel Obstruction

Malignant Bowel Obstruction can occur in up to 15% of patients with advanced malignancy. Most commonly it is due to ovarian and GI malignancies. In the advanced stages of malignancy it may not be possible to resect the obstruction, however, in all cases the advice of a surgeon should be obtained. There are a number of interventions which may be considered depending on circumstances:

•Bowel resection / bypass + ostomy
•Gastrostomy
•Venting PEG placement
•Stents – esophageal, gastric outlet, proximal small bowel, colonic
•Laser ablation
•Surgery following chemotherapy

Medical palliative ("conservative") management of bowel obstruction brings the focus on the goals of care of the patient and family. Broadly these are:

<u>Pain management:</u>
Principles:
- Consider parenteral routes early on
- Anxiety is often prominent
- Opioids are the cornerstone (Fentanyl patch)

Colicky pain responds well to anticholinergics:
- Hyoscine butylbromide 20 mg SC tid
- Scopolamine patch
- Glycopyrrolate 0.1-0.2 mg SC q4h

<u>Stop nausea and vomiting:</u>
Principles:
- Avoid NG tubes
- Don't use pro-motility drugs if there is complete bowel obstruction. Metoclopramide 10-20 mg SC qid may be helpful in cases of partial obstruction.

Antiemetics:
- Haloperidol 0.5 – 5mg SC or IV q 6-8 hrly
- Prochlorperazine
- Dimenhydrate
- Dexamethasone 6-16mg SC or IV daily (use gastric cytoprotection agent)

<u>Alleviate obstruction if possible:</u>
Dexamethasone 6-16 mg IV or SC qam may bring about the resolution of malignant bowel obstruction in addition to palliating symptoms of nausea and vomiting. It is reasonable to discontinue steroids if there is no response within 4-5 days.

<u>Reduce GI secretions:</u>
Octreotide
- Decreases GI secretions and increases absorption of fluids in bowel
- Helpful for large volume emesis
- Painful injections
- Start at 150 mcg SC tid

Allow eating and drinking:

Principles:

- Good mouth care
- Hydration – what goals does the patient have at this point?
- Consider Hypodermoclysis, IV fluid “resuscitation”
- Enjoyment of taste / eating
- Low roughage / residue diets
- Patients can actually go on for many weeks sometimes

Emotional support:

Patients know they are now facing death and are mainly anxious about how, when, who will be there.
There may be a request terminal sedation (consult palliative care physician)
Prompt and vigorous attention to symptoms gives a lot of reassurance
Intensive psychosocial and spiritual support is often required

Family support:

Much time has to be spent at every step of the decision making processes to “check-in” with the family members/ caregivers
Family often need re-clarification of events/ details
Family often experience terrible distress in this situation
They may avoid coming to visit
Family members will need bereavement support