Review disease

status,

patient's

biological

prospect,

informed,

shared

decisions



## Approach to upper GI obstruction

Is it due to a co-morbidity? History/ examination suggestive of peptic ulcer, chronic pancreatitis -manage or refer to internal medicine -using appropriate guidelines

Patient with pancreatic / gastric/ ovarian/ advanced cervical / retroperitoneal/ peritoneal cancer/ post RT with epigastric pain, nausea/ vomiting, early satiety, abdominal distension or bloating, weight loss, + constipted

Presence of succussion spalsh after 3 hours of meal (48%), endoscopy, or plain xray - large gastric bubble/dilated duodenum, pausity of gas in bowels; imaging with watersoluable barium (after decompression)- gastric distension, food retension, +nce of air-fluid level

Initial supportive care - gastric decompressio, I.V hydration, high-dose proton pump inhibitors.

Full assessment and management of symptoms, psychological status, and social supports as early as possible

Red Flags - L/F signs of dehydration, tachycardia, hypotension, oliguria, OR if patient is toxic, abdominal tenderness, guarding, rigidity - initiate fluid support & naso-gastric tube, assess futher or refer if the ECOG < 3 with good pre-morbid status Disease is well localised, patient's functionality is high, ECOG<3, optimised systemic co-morbidities, patient willing, no peritoneal disease, Prognosis > 12 weeks

Palliative

Poor GC, ECOG ≥3, locally invasive or metastasised, comorbidities non-optimal, &/OR patient preferences

Oncosurgical
interventions Ensure alignment
with expectations Goals & outcomes
of care

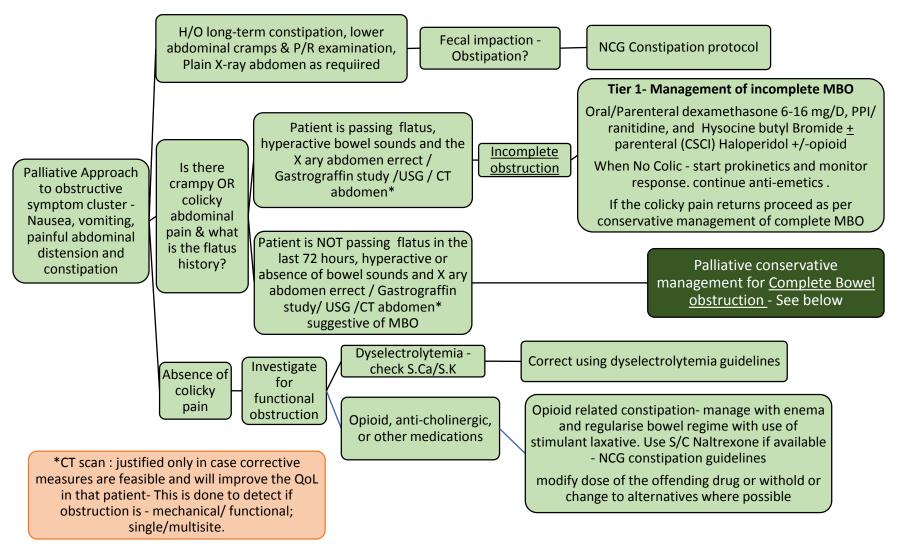
Palliative Chemo/ radio therapy

Unable to retain feeds, comorbidities optimal, patiet prefers & single site, - consider enteral stent

If not amenbale to above interventions-Palliative Approach and management of obstructive symptoms



# Palliative Approach, assessment and Management bowel obstruction which is incomplete





# Palliative Care approach and management of Complete Malignant Bowel obstruction

Palliative conservative management of complete gastric / bowel obstruction or refractory symptoms Manage symptoms, activate components When indicated activate End of Life Care - refer to NCG guidelines of Best supportive care -as listed below. Single site not amenable to surgical correction - OR Resolve reversible mutlisite obstruction. components of the distress colostomy, ileostomy, & symptoms - background Poor GC and poor performance status, peritoneal disease, H/O Abd. RT, iejunostomy feeding pain, colicky pain, nausea, cachexia, bed-riddent patient with ECOG >= 3, prognosis < 12 weeks as appropriate vomiting, & distension, Or...the patient/family makes informed decision on minimal invasive / (patient's functionality conservative treatment is high, ECOG<3, optimised co-Bowel-wall swelling Establish goals of care; assess patient GC, review morbidities, & reversible If patient is advance care records - Tier 2 package patient/family willing, component of moribund, in the minimal peritoneal obstruction with terminal stage disease, Prognosis > Medical management -in-patient admission, corticosteroids naso-gastric tube to 12 weeks naso-gastric tube to decompress use antikeep the stomach emetic without pro-kinetic action, use CSCI decompressed, anti-muscarinics +/- opioids. Parenteral Treat pain, nausea, S/C route saline to octreotide 300-600 ug/D,PPI / ranitidine / vomiting; reduce the hydrate as shared hyoscine butryl Bromide inj as additional luminal secretions decision with family antisecretary. + RT aspiration as per shared analgesics, anti-emetics, - not > 500decisions. Maintain hydration, pain relief. anti-histaminics, anti-1000ml/24 hours Sips of clear fluids ,licking favorite foodssecretory drugs permitted Patient wishes to continue oral intake consider venting gastrostomy along with medical management listed above

### NCG Palliative Care Guidelines - Malignant Bowel Obstruction



#### Medications

## Analgesics: Opioids – for the persisting pain due to cancer infiltration

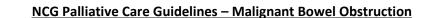
- 1. Oral morphine- Start with 5mg fourth hourly and SOS in opioid naïve patients
- 2. Injection morphine titration- e.g.:-1.5 mg iv or s/c fourth hourly or equivalent dose of continuous infusion and titrate accordingly
- 3. Injection Fentanyl titration-e.g.:- 10mcg iv or s/c every hourly, titrate and convert to continuous infusion
- 4. Transdermal fentanyl patch- Controlling pain initially with injection fentanyl or morphine and convert to equivalent dose of patch
- 5. Oral / injection Tramadol- Start with 50mg sixth hourly up to 400mg/day

## Anticholinergics/Antisecretory drugs – to reduce the distension & the colicky, spasmodic intermittent pain

- 1. Injection Hyoscine butyl bromide- 10mg sixth hourly or as Continuous S/C infusion Max: 120 mg / 24 hours OR as Transdermal patch
- 2. Hyoscine Hydrobromide Injection- 0.2- 2.0 mg S/C
- 3. Injection Glycopyrrolate 0.1 0.4 mg per day
- 4. Octreotide injection as continuous infusion- 300-800 mcg/day
- 5. Injection Ranitidine as infusion 150-200mg per day- to reduce upper GI secretion & distension

## **Anti-inflammatory - Steroids**

- 1. Injection Dexamethasone 8-16mg OD (slow iv or 6 mg S/C) Per oral once N/V abates.
  - a. Stop Dexamethasone if there is no improvement in 5 days or side effects appear
  - b. If obstructive symptom relieves wean gradually over 2 weeks
- 2. Gastrografin (amidotrizoate) oral contrast medium per oral in selected patients to shift fluids from wall into the lumen and relieve obstruction





#### **Antiemetics**

- 1. Prokinetic antiemetics Stop if there is colic, or vomiting worsens → complete obstruction
  - a. Oral/injection metoclopramide- 10mg 4-8th hourly optimal up to 30 mg / 24 hours Max: up to 40 mg / 24 hours
  - b. Domperidone mouth-dissolving, rectal suppositories
- 2. Antiemetic without prokinetic action
  - a. Oral/injection Haloperidol- 0.5 mg once daily to start with and slowly titrate up Max up to 5 mg / 24 hours
  - b. Cyclizine 50 150 mg / 24 hours as Continuous S/C infusion or as intermittent S/C injection
  - c. Combine Haloperidol + Cyclizine
  - d. 5HT3 antagonists parenteral Ondansetron 8mg three times a day

Laxatives - Refer protocol for Palliative care management of constipation

Fluids, electrolytes – for correction of Dyselectrolytemia / hydration (only if significantly dehydrated monitored for 3<sup>rd</sup> space expansion

## Supportive care

# **Symptom management**

 Demonstration and education on mouth care using luke-warm water with salt & soda – for thirst, oral symptoms & nausea

#### NCG Palliative Care Guidelines - Malignant Bowel Obstruction



### Communication

- Check insight. Communication with patient and family members regarding prognosis, and care options
- Informed supported, shared decision making and documentation
  - a. Palliative surgery
  - b. Preferred place for care, benefit/risk of parenteral hydration, nutrition,

### **MDT** referrals

- Emotional support to patient/family
- End of life care symptom relief, emotional, legal required preparation of patient, family unfinished business, religious / spiritual care
- Dietician small volume, low -residue food, drink; jejunal feeds
- Nursing care of bed ridden patient, enteral / parenteral feeds, procedures

### **Procedures**

- Palliative Surgical interventions colostomy, ileostomy, feeding jejunostomy, venting gastrostomy as appropriate
- For associated Ascites judicious decision on paracentesis refer to the NCG guidelines
- Minor Nursing procedures
  - o P/R Examination and rectal suppositories done in OPD, or during day-care admission
  - Regular enema Few hours of day-care admission may be needed in OPD. Using local anesthetic,
     lubricate the end of phosphate enema fluid and administer inside the rectum



### NCG Palliative Care Guidelines - Malignant Bowel Obstruction

- High up enema Few hours of bed needed. 2 sachets of Phosphate enema is placed high up beyond the rectum after connecting to well lubricated 16G catheter
- Naso-gastric tube insertion and aspiration 14 G Nasogastric tube aspirate the contents from the stomach.
- o Intravenous or subcutaneous injections and infusions Procedure done during admission. Use the recommended dosage of medications through syringe pump, syringe driver or normal IV drip set.