

## Intestinal Obstruction in Advanced Cancer <sup>17,19-21</sup>

### Introduction

Frequently incomplete, intermittent and with multiple sites of obstruction  
High incidence in ovarian and bowel cancer.

### Causes of bowel obstruction

- **Cancer**
- **Treatments:** Adhesions, radiation, ischaemic fibrosis
- **Drugs:** Opioids, anticholinergics, anticoagulants, corticosteroids
- **Combination of factors**

### Types of obstruction

- Mechanical or functional
- High or low obstruction
- Single or multiple levels
- Partial or complete
- Transient or persistent
- Acute or chronic

### Clinical features - may include :

- Nausea and vomiting
- Deep seated dull aching pain
- Gripping /Colic
- Abdominal distension
- Diarrhoea and/or constipation

### Diagnosis

- Usually clinical
- Abdominal x-rays/CTscan may help
- Differential diagnosis is constipation

### Management

Most patients will require medical management but surgical intervention should be considered initially.

#### ➤ **Surgical Management:**

If medically fit and reasonably nourished patient – seek opinion of surgeon  
If not appropriate for surgery refer for palliative care opinion.

#### ➤ **Medical Management**

IV Fluid and NG tube

These regimens are indicated while surgery is being considered but are rarely appropriate for long term management.

#### ➤ **Symptomatic treatment**

With appropriate symptomatic treatment patients may survive several months. Good symptom control can usually be achieved & greatly improves quality of life.

**i. Colic**

- **Stop** stimulant laxatives (e.g. senna, bisacodyl)
- **Stop** prokinetic drugs (metoclopramide, domperidone)
- Antispasmodics via syringe driver
- **Hyoscine butylbromide ( Buscopan) 40 -100mg/24 hours** s/c via syringe driver)

**ii. Tumour pain**

- Titrate with diamorphine s/c via syringe driver
- SC or rectal NSAIDs may help

**iii. Nausea and vomiting**

- Set realistic goals.
- Nausea can usually be eliminated but vomiting may continue once or twice daily
- Give antiemetics s/c via syringe driver:

1. Start **cyclizine 150mg/24hrs**

**Note** Cyclizine may precipitate with Buscopan.

2. If 1 not effective add **haloperidol 3- 5mg/24hrs**,

3. If 1&2 not effective stop them & switch to **levomepromazine 6.25-25mg/24hrs**  
(which is more compatible with **hyoscine hydrobromide (Buscopan)**)

**iv. High volume vomits**

- In addition to reducing colic, hyoscine butylbromide (Buscopan) will also reduce the volume of gastric secretions and leads to fewer or smaller volume vomits
- If high volume vomits are not controlled by hyoscine butylbromide (Buscopan) try **Octreotide 300 - 600 mcg/ 24 hours (max 1000mg)** s/c via syringe driver

**v. Constipation**

- May need a bowel softener **Docusate 100 - 500mg daily**

**vi. Nutrition - IV Fluids are rarely necessary**

- Oral intake of food and drink can continue for the patient's enjoyment and is often surprisingly well tolerated - the patient will decide if the risk of vomiting outweighs the pleasure of eating!

**Note:**

- **Dexamethasone 8mg od** for 3 days (orally or s/c via syringe driver)  
May resolve obstruction or help symptoms
- **Metoclopramide 30-120mg / 24 hours** a prokinetic drug, may be helpful where there is no colic and obstruction is incomplete. At the same time review any drugs with anticholinergic activity which slows peristalsis.
- **Octreotide 300 - 600mcg/ 24 hours (max 1000mcg)** s/c via syringe driver to reduce GI secretions and GI motility. Useful in patients with diarrhoea and high output fistulae
- Very occasionally **venting gastrostomy** may be considered when vomiting cannot be controlled.