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

Review disease status, patient's biological Prognosis > 12 weeks Palliat radi

Poor GC, ECOG <a>\(\) locally invasive or metastasised, comorbidities non-optimal, &/OR patient preferences

Oncosurgical
interventions Ensure alignment
with expectations Goals & outcomes
of care

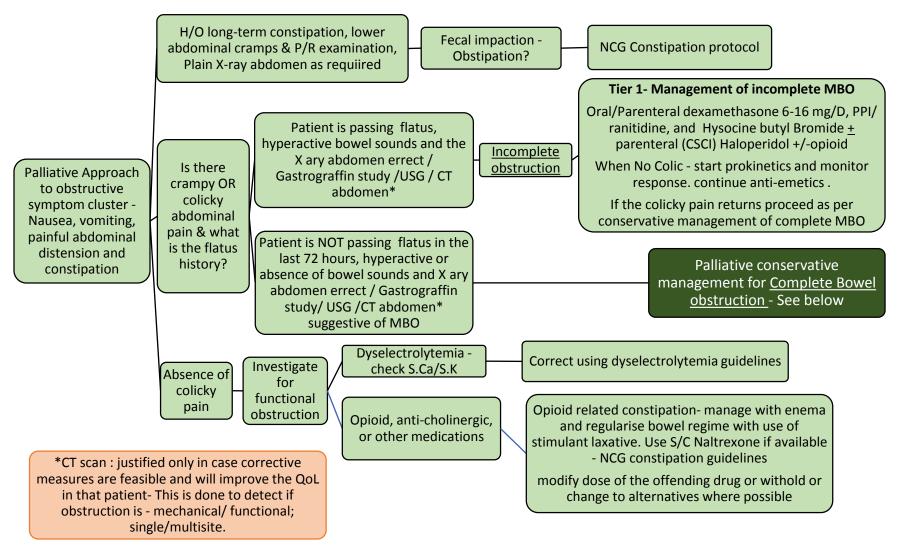
Palliative Chemo/ radio therapy

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

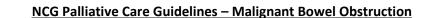
- 1. Oral morphine- Start with 5mg fourth hourly and SOS in opioid naïve patients
- 2. Injection morphine titration- e.g.:-1.5 mg iv or s/c fourth hourly or equivalent dose of continuous infusion and titrate accordingly
- 3. Injection Fentanyl titration-e.g.:- 10mcg iv or s/c every hourly, titrate and 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 3rd 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.