## Assessment / Description

Malignant bowel obstruction is a recognised complication of advanced pelvic or abdominal malignancy. May be made worse by adhesions from previous surgery/ radiotherapy. Common symptoms associated with malignant bowel obstruction include abdominal pain, abdominal colic, nausea and vomiting.

The evidence base for management of malignant bowel obstruction is weak.

An individualised approach to management is recommended for each patient and specialist palliative care advice should be sought.

- The diagnosis is made clinically through history and examination
  This may be confirmed with imaging (abdominal X-ray or CT scan) depending on individual circumstance and preferences
- Consider if there are any surgical interventions possible
- Treat constipation if appropriate
- Consider absorption of modified medications when deciding route

## Pharmacology options for Symptom Control in Malignant Bowel Obstruction

***Dose adjustments may need to be made depending on renal and hepatic function***

| Indication (s) | Drug name | Dose (over 24 hours via CSCI unless other-wise stated) | Notes |
|---|---|---|---|
| Relief of constant pain | Opioid via CSCI/24 hours or transdermal Fentanyl patch | Dependent on previous dose | Absorption of oral formulation via gut may have been impaired, therefore when converting from oral to CSCI, consider adjusting the dose accordingly. |
| Relief of colic | Hyoscine butylbromide | 60 mg - 120 mg | **Do not combine with cyclizine in CSCI as can cause crystallisation** |
| | Glycopyrronium | 600 micrograms - 2.4 mg | Does not crystallise |
| Reduce volume of gastrointestinal secretions | Octreotide | 300 - 600 micrograms. Doses may be increased up to 1.2 mg in some cases under specialist guidance | Can be considered first line. Alternatively use hyoscine butylbromide but **do not combine with cyclizine in CSCI as can cause crystallisation** |
| | Hyoscine butylbromide | 60 mg - 120 mg | **Do not combine with cyclizine in CSCI as can cause crystallisation** |
| | Glycopyrronium | 600 micrograms - 2.4 mg | Does not crystallise with other common injectable drugs |
| | | | |
| Reduce tumour oedema. Reduce nausea and vomiting | Dexamethasone | 6.6 mg subcutaneously OD or 3.3 mg subcutane-ously BD (in morning) | Given as a single dose or divided into 2 doses (before 2 p.m.) Late administration may cause insomnia /agitation |
| Reduce nausea and vomiting | Levomepromazine | 2.5 mg - 25 mg | May cause sedation. Use the lowest effective dose. Higher doses may cause sedation. |
| | Metoclopramide *avoid in complete bowel obstruction* | 30 mg - 60 mg *There is an increased risk of neurological adverse effects at doses higher than 30mg/24hour and if used for longer than 5 days.* | Contraindicated in complete bowel obstruction. Dose may be increased under Specialist Palliative Care advice. Monitor for increased abdominal colic. |
| | Haloperidol | 1.5 mg - 5 mg | Watch for extra-pyramidal side effects. May cause sedation |
| | Cyclizine *be aware cyclizine is gut slowing* | 150 mg | **Do not combine with hyoscine butylbromide in CSCI as can cause crystallisation** |
| | Ondansetron *Not licenced for SC use* | **seek Specialist Palliative Care advice** | |

## IMPORTANT CONSIDERATIONS:

### Symptom Control

*Pain:*
- Opioid analgesia should be titrated to control continuous abdominal pain.
- Colic should be managed with the reduction in dose or discontinuation of prokinetic drugs such as metoclopramide followed by the commencement of an anti-spasmodic such as hyoscine butylbromide

*Reduction of secretions:*
- Patients experiencing large volume vomiting should be prescribed anti-secretory treatment.
- Octreotide is the recommended first line anti-secretory medication

*Reduction of nausea and vomiting:*
- Anti-emetics should be administered via the subcutaneous route.
  Prokinetics are not advised in a bowel obstruction affecting the small bowel or in a com-plete obstruction at lower levels of the bowel.

*Corticosteroids:*
- A five day trial of Dexamethasone 8 mg daily orally ,or similar dose, subcutaneously should be considered in all patients to reduce tumour related oedema

*Laxatives:*
- The use of stimulant laxatives should be avoided. The use of stool softeners may be appropriate.

### Interventions

*Medication Delivery:*
- Medication should be delivered via the subcutaneous route due to potential problems with absorption

*Nasogastric Tubes:*
- A wide bore nasogastric tube should be considered for patients with upper gastrointestinal obstruction or large volume vomiting.

*Venting Gastrostomies:*
- Venting gastrostomies or jejunostomies should be considered for patients with malignant bowel obstruction who have a prognosis of greater than 2 weeks.
- Venting gastronomies have been shown to be cost effective with low morbidity and mortality.