Alberta Health Services

Palliative Care Tip – Issue #10 Bowel Obstruction in Advanced Cancer – June, 2018.

Step 1. Assess characteristics

- Etiology (mechanical vs. functional, malignant vs. non-malignant)
- Level (high vs. low, single vs. multiple)
- Degree (partial vs. complete)
- Reversibility

Step 2. Determine if surgical intervention is feasible/desirable

- Take life expectancy and goals of care into account
- Procedures (most to least aggressive)
  - Bowel resection with anastomosis
  - Internal bypass
  - Ileostomy/colostomy
  - Stent insertion (gastroduodenal, colonic)
  - Venting gastrostomy (consider when obstruction is irreversible; allows for oral fluid intake for comfort)
- Consult General Surgery, Gastroenterology as appropriate

Step 3. Consider supportive measures

- NPO
- Medications and hydration by parenteral route (subcut/IV)
- Parenteral nutrition (if longer survival anticipated – see Tip #24)
- NG tube (for short-term relief of intractable nausea and vomiting)
- Antiemetic
  - Partial obstruction: metoclopramide 10 mg subcut qid
  - Complete obstruction: haloperidol 0.5-1 mg subcut bid

Step 4. If surgery not indicated, then initiate medical management

- Dexamethasone 4-10 mg subcut daily-bid (may reverse obstruction; discontinue if no improvement within 1 week)
- Octreotide 100-200 mcg subcut bid-tid (reduces intestinal secretions and peristalsis; conflicting evidence re efficacy; discontinue if no improvement in symptoms within 1 week)
- H2 blocker, PPI (reduce gastric secretions)
- Hyoscine butylbromide 10 mg subcut tid-qid (reduces colic)

References:

1. Feuer DJ et al. Corticosteroids for the resolution of malignant bowel obstruction in advanced gynaecological and gastrointestinal cancer. Cochrane Database Syst Rev. 2000;(2):CD001219.
2. Obita GP et al. Somatostatin analogues compared with placebo and other pharmacologic agents in the management of symptoms of inoperable malignant bowel obstruction: a systematic review. J Pain Symptom Manage. 2016; 52(6):901-919.

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