Palliative Management of Bowel Obstruction

Disclaimers: This algorithm has been developed for MD Anderson using a multidisciplinary approach considering circumstances particular to MD Anderson’s specific patient population, services and structure, and clinical information. This is not intended to replace the independent medical or professional judgment of physicians or other health care providers in the context of individual clinical circumstances to determine a patient’s care. This algorithm should not be used to treat pregnant women.

**PRESENTATION**
Patient with incurable cancer\(^1\) seen in ACCC or inpatient with one or more symptoms of bowel obstruction:
- Abdominal pain and distention
- Nausea and/or vomiting
- Constipation or inability to pass stool or flatus

**INITIAL EVALUATION**
- History and physical exam
- Assess ECOG performance status\(^2\)
- CT abdomen and pelvis with or without contrast
- CBC, comprehensive metabolic panel, PT, PTT, and INR
- Establish IV access
- IV hydration as clinically indicated
- Insert naso-gastric tube (NGT) and place on low intermittent suction (LIS) after initially evacuating content with continuous suction
  - Monitor NGT output
- Consider consult to Nutrition Services

- Admit to Hospital Medicine and inform Primary Oncology Team to help with plan management or
- Admit to Primary Oncology Team

**FINDINGS**
- Admitting service to:
  - Consider consulting Supportive Care Service
  - Initiate a Goal Concordant Care (GCC) conversation\(^3\) with the patient or if clinically indicated, with Patient Representative and the Primary Oncologist/Primary Team/Attending Physician.
  - The Advance Care Planning (ACP) note should be used to document GCC discussion.

- Diagnostic Imaging (DI) service to determine the type of bowel obstruction

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ACCC = Acute Cancer Care Center
ECOG = Eastern Cooperative Oncology Group

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1. This algorithm excludes patients with a new oncologic diagnosis and those without a current oncologic treatment plan. Clinicians may refer to primary oncologist’s note for details on prognosis and Goal Concordant Care.
2. Patients with a poor performance status (ECOG score of 3 or 4) are not surgical candidates
3. Refer to GCC home page (for internal use only)
PRESENTATION

Consult Gastroenterology (GI) to evaluate treatment options

EVALUATION

Endoscopic management best option?

Yes

No

Endoscopic palliation¹
  ○ Duodenal stent² for short term palliation
  ○ Consider endoscopic ultrasound guided gastrojejunostomy³ for patients with good performance status (ECOG score 0-2)

Surgical candidate⁴?

Yes

No

Surgical options?

Consult Surgical Oncology

Consult Interventional Radiology (IR) for percutaneous venting gastrostomy⁵ or gastrojejunostomy catheter placement⁵

Surgical gastrojejunostomy

TREATMENT

¹ Optimize patient before endoscopic procedure:
   ● NGT with LIS for 24 hours prior to the procedure
   ● Electrolyte replacement if indicated
   ● Lab parameters: Platelet count > 50 K/microliter, INR < 1.5, Hgb > 8 g/dL

² Duodenal stents are a good option for short term palliation. Duodenal stents have high rates of delayed adverse events and require re-interventions.

³ Discuss with Surgical Oncology prior to procedure, as complications may lead to surgery

⁴ Patient with good performance status (ECOG score of 0-2), and expected survival > 6 months

⁵ Optimize patient before IR procedure: Platelet count > 50 K/microliter, INR < 1.5, Hgb > 8 g/dL
1 Patient with good performance status (ECOG score 0-2), and expected survival > 6 months
2 Lab parameters: Platelet count > 50 K/microliter, INR < 1.5, Hgb > 8 g/dL

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PRESENTATION

Unifocal/intraluminal

Consult Acute Surgery Service

Multifocal/extrinsic/metastatic

Consult Colorectal Surgery

EVALUATION

Surgical candidate 1?

Yes

Bowel resection and/or diversion

No

Consult GI for possible stent

TREATMENT

No

Stent candidate 2?

Yes

Palliative intervention
• Colonic stent placement 2

No

Best supportive care

1 Patient with good performance status (ECOG score 0-2), and expected survival > 6 months

2 Lab parameters: Platelet count > 50 K/microliter, INR < 1.5, Hgb > 8 g/dL

Consult GI for possible stent

Colonic stent placement 2

Best supportive care

Lab parameters: Platelet count > 50 K/microliter, INR < 1.5, Hgb > 8 g/dL
SUGGESTED READINGS


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DEVELOPMENT CREDITS

This practice consensus statement is based on majority expert opinion of the Palliative Management of Bowel Obstruction workgroup at the University of Texas MD Anderson Cancer Center for the patient population. These experts included:

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