# Bowel Obstruction: is there an alternative to the hospital bed?

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# Case Presentation

- 64F - recurrent high grade serous ovarian cancer
- 3 cycles NACT (carbo/taxol), IDS followed by 3 cycles adjuvant carbo/taxol
- Now on second line Carboplatin/Caelyx
- Presents to local A&E with 5 day history vomiting, loose stool and abdominal pain
    - Has had similar attendances to GP over the past few weeks
- C3 carbo/caelyx 8 days prior to presentation
- **What questions do you want to ask her?**
- **What features in her history would point towards bowel obstruction vs chemotherapy-induced nausea and vomiting?**

# MBO Screening Tool

*(Morgan et al., 2019 - ESMO Open)*

1. Tummy Pain
2. Tummy swelling/bloating
3. Rumbling noises in your tummy
4. Feeling sick
5. Being sick
6. Constipation
7. Diarrhoea
8. Loss of appetite
9. Weight loss

# Next steps

- What would your immediate management be in this patient?

*Resolve the obstruction:*

- Dexamethasone (8-16mg IV with PPI cover); review after 5/7
- Bowel rest - NBM, IV fluids
- Consider ascitic drain if contributing to symptoms

*Symptom control:*

- Ryle’s tube (12-14ch)
- Anaglesia
- Laxatives - which?
- Antiemetics

# Antiemetics

## Which to use?

### Functional/partial obstruction

- Metoclopramide 10mg TDS PO/IV or 30mg/24hr via CSCI
- Stop if precipitates colic

### Complete obstruction

- Cyclizine 50mg TDS IV/IM or 75-150mg/24hr via CSCI (max dose 200mg/24hr)
- Haloperidol 0.5-1.5mg SC PRN or via CSCI (max dose 5mg/24hr)
- Cyclizine and Haloperidol can be used in combination
- Alternatively, Levomepromazine (25mg/24hrs or 6.25mg SC 4hrly)

### Persistent/high volume GI losses

- Antisecretory drugs
- Hyoscine butylbromide
- Octreotide (300-1200mcg/24hr)
- Avoid loperamide

# CT report

## What now?

**CT-widespread peritoneal dissemination**. Right **adnexal thickening has increased** as has periuterine disease with **new thickening seen adjacent to the sigmoid colon** in keeping with likely **serosal** involvement. **No bowel obstruction is identified. Disease progression.**

## Does this change management?

- MBO - clinical diagnosis
    - AXR not sensitive 45% cases; 64% CT scans report ‘no evidence bowel obstruction’
- **What CT scan findings would prompt a discussion with surgeons?**

# Back to our case

## 7 days later…

- Remains an IP but no signs of improvement - high output from Ryle’s, bowels still not open

### What do you need to consider now?

- Nutrition
- Venting gastrostomy
- Further SACT? IP vs OP?
    - What are you trying to achieve?
    - Reversal of BO? Symptom control and QoL? Overall survival?

# TPN

## Things to consider

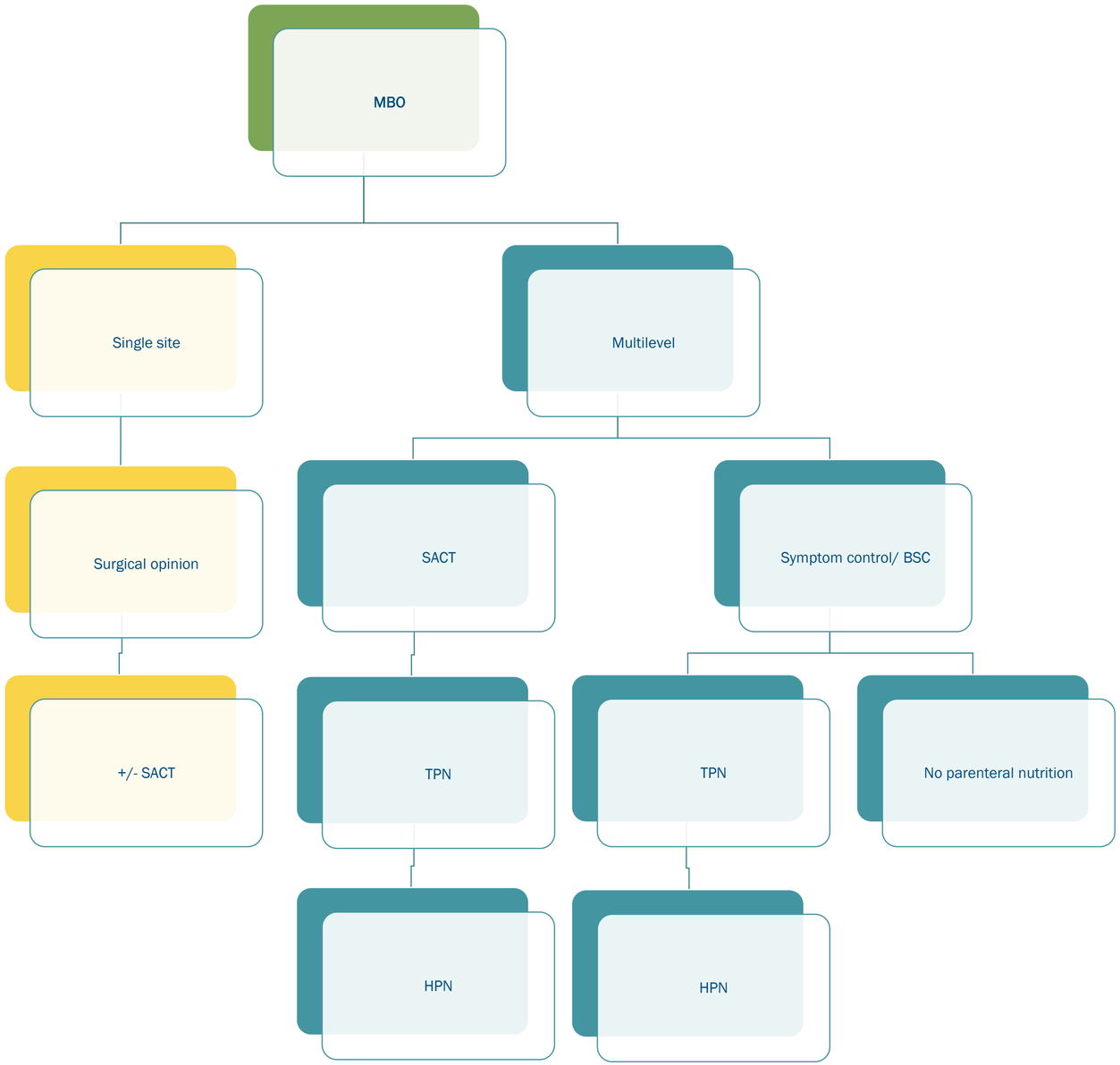
- Which patients?
    - **Avoid:** liver mets, deranged LFTs, pelvic mass, visceral mets, peripheral oedema, ECOG PS 4, Modified Glasgow Prognostic Score
- Long stay in hospital
- Complications - infections, peripheral oedema, electrolyte imbalance
- Impact on QoL
- ?Survival benefit

| 60 year old Female | 52 year old Female |
|---|---|
| Stage 4b High-grade Serous Ovarian Cancer (liver mets) | Stage 4b High-grade Serous Ovarian Cancer (lung mets) |
| 2 prior lines SACT | 2 prior lines SACT |
| Multilevel MBO Jan 2022 | Multilevel MBO May 2021 |
| ECOG 3 prior to admission | ECOG 1 prior to admission |
| Weight loss 15% on admission | Weight loss 7% on admission |
| mGPS (2) on admission | mGPS (0) on admission |
| Referred for HPN/ ryles | Referred for HPN/ ryles |
| 3rd line Carboplatin/ Caelyx | 3rd line Paclitaxel |
| Died in hospital PS 4 February 2022 | Died at home PS 4 May 2022 |
| Survival with HPN 1 month | Survival with HPN 12 months |

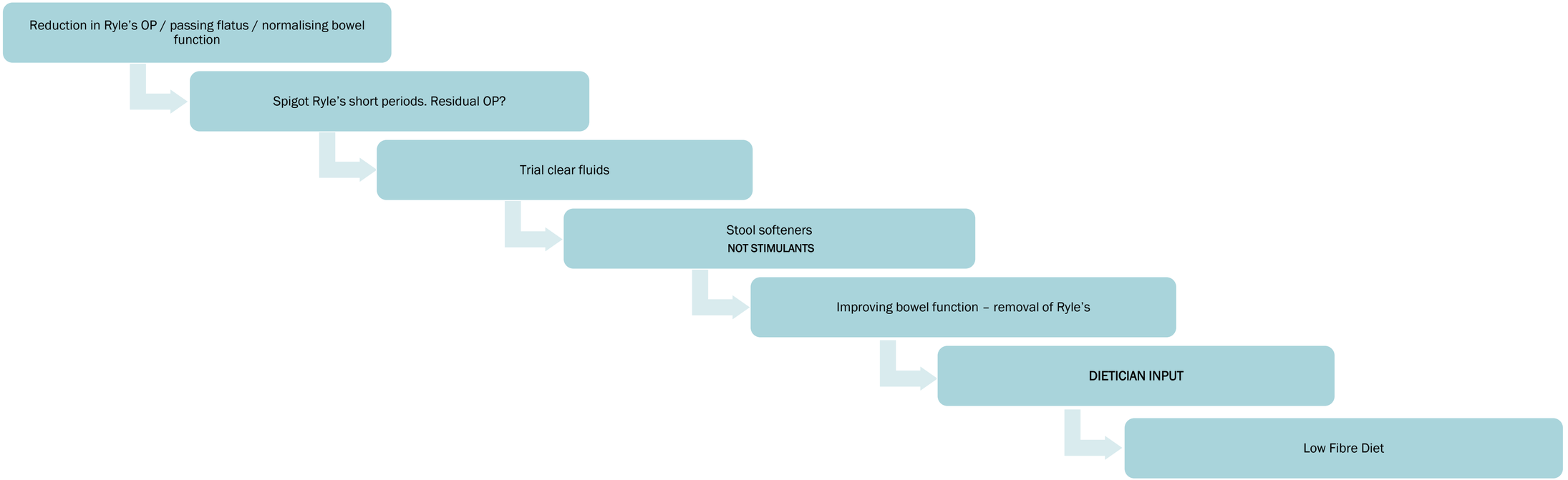
# Case continued

- Our patient has now gone home on PN
- Ryle’s was removed prior to discharge and she is due in OP clinic in a couple of weeks to discuss further SACT
- Contacts GP with abdo pain, vomiting and BNO 4/7
    - They phone you for advice - what would you suggest?
- Often recurrent problem / remain in SABO
    - What alternatives are there to hospital admission?
    - What discussions would help guide management?

# Clinical Considerations in MBO



# Resolving obstruction?




## REMEMBER:

**MBO is often a progressive and irreversible condition in around 90% cases**

# Summary

## Malignant Bowel Obstruction

- Clinical diagnosis
- Early symptomatic management
- Early nutrition plan if no signs of resolution - consider who is appropriate for TPN
- Unless treatment naive, chemo is unlikely to help BO
- Often progressive and irreversible
- Community management plays important role - ACP

# CAReGO: Complex And Recurrent Gynaecology Oncology

The Christie NHS Foundation Trust

**New, UK-first, MDT-led service for gynae patients with current bowel dysfunction at high risk of developing Malignant Bowel Obstruction (MBO) or in established MBO**


- Early recognition and management
- Pre-admission assessment and optimisation
- Specialist OP clinics / rapid access
- Specialist dietetic input
- Dedicated Macmillan palliative care input
- Accelerated discharge pathway for HPN
- Improve patient experience, QoL and survival
- Reduce IP bed days

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