# Bowel Obstruction

## Introduction

Is due to mechanical obstruction (partial or complete) of the bowel lumen and/or peristaltic failure. Can be complex to manage and require specialist advice. Bowel Obstruction should be managed in a multidisciplinary way and it may be relevant to seek the views and review of a surgical team (if surgery is contemplated) oncologists and palliative care (dependent on the setting).

This can have a large impact on patients and carers, please refer to [Sub Acute Bowel Obstruction information leaflet (SABO)](https://www.scottishpalliativecareguidelines.org.uk/sub-acute-bowel-obstruction-information-leaflet-sabo).

Depends on the level, type and duration of bowel obstruction but may include:

- **Constipation**
- Intermittent *nausea*, often relieved by vomiting undigested food
- Worsening *nausea* and/ or faeculent vomiting (as obstruction progresses and small bowel contents are colonised by colonic bacteria)
- Continuous abdominal pain due to tumour and/ or nerve infiltration (eg. coeliac plexus involvement)
- Colic (in mechanical obstruction); altered bowel sounds
- Abdominal distension (may be absent in gastro-duodenal obstruction or patients with extensive peritoneal spread)
- Faecal incontinence.

## Assessment

Prioritise assessment for care either within hospice or for surgery.

- Exclude faecal impaction from history, rectal examination, abdominal X-ray. Can complicate or mimic any type of bowel obstruction.
- Some patients with a localised obstruction can benefit from surgery.
- Assess each patient on the basis of their clinical condition, likely benefits/ risks and patient preferences.

### Factors to take into consideration prior to surgery

- Diffuse intra-abdominal cancer seen at previous surgery, or shown radiologically.
- Diffuse, palpable intra-abdominal masses.
- Massive ascites which recurs rapidly after drainage.
- High obstruction involving the proximal stomach.
- Non-symptomatic but extensive metastatic disease outside the abdomen.
- Frail or elderly patient with poor performance status or nutritional status.
- Previous radiotherapy to the abdomen or pelvis.
- Small bowel obstruction at multiple sites.
Management

General
- Frequent mouth care is essential
- In the acute phase (2 to 3 days) conservative management and watchful waiting may be appropriate - the bowel may be rested, Nil by Mouth +/- NG tube.
- As this is a plumbing problem avoid overuse of anti-emetics as these can make the patient sleepy and potentially lead to aspiration.
- Offer ice to suck, small amounts of food and drinks as wanted. Low fibre diet.
- If the patient is dehydrated and not dying, IV rehydration may be appropriate initially.
- SC fluids may be required for longer-term management of symptomatic dehydration or for a patient not wanting hospital admission. Hydration of 1 to 1.5 litres/ 24hours may reduce nausea but more fluid than this can result in increased bowel secretions and worsen vomiting.
- Laxatives +/- rectal treatment for constipation.

Interventional treatment
- Stenting (gastric outlet, proximal small bowel, colon) or laser treatment can palliate localised obstruction.
- NG tube may be appropriate to control vomiting initially; try to avoid long-term use. However for some patients an NG tube may be preferable and more manageable at home than faecal vomiting.
- Venting gastrostomy in a fit patient with gastroduodenal or jejunal obstruction and persistent vomiting may relieve symptoms.
- TPN is only appropriate for a very small group of patients with a longer prognosis. Refer to specialist advice. A specific review date should be set which is discussed in advance with the patient prior to commencing TPN.

Medication¹

Peristaltic failure
May be due to autonomic neuropathy or intra-abdominal carcinomatosis. Partial obstruction, reduced bowel sounds, no colic.
- Stop medication reducing peristalsis. (cyclizine, hyoscine, 5HT3 antagonists, amitriptyline).
- Use a prokinetic antiemetic e.g. SC † metoclopramide 30 to120mg /24hrs; stop if colic develops. Caution in use of prolonged higher doses, monitor for extrapyramidal side effects.
- Laxatives are often needed. Refer to constipation guideline.
- Balance analgesic needs against the risk of poor oral absorption. If a syringe pump is considered in the first instance then morphine or diamorphine would be considered in the first instance. However in the longer term a fentanyl patch may provide a less invasive approach.
- Fentanyl patch for controlling stable, moderate to severe pain in patients with/ or at risk of peristaltic failure is less constipating than morphine or oxycodone.

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¹ † Indicates this use is off licence
†† Indicates this medication is associated with QT prolongation
### Mechanical obstruction

Target treatment at the predominant symptom(s).

- Laxatives (+/- rectal treatment) to treat/prevent co-existent constipation. Laxido (if volume of fluid is tolerated) is effective. Docusate sodium is an alternative. Avoid stimulant laxatives (senna, bisacodyl, danthron) if patient has colic. Stop all oral laxatives in complete obstruction.
- **Dexamethasone** (6 to 16mg) SC, IM or IV for 4 to 7 days may reverse partial obstruction.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Drug</th>
<th>24 hour SC dose</th>
<th>Comments (see practice points)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tumour pain/ colic</td>
<td>Morphine or diamorphine</td>
<td></td>
<td>Titrate dose See: <a href="#">Fentanyl patches</a></td>
</tr>
<tr>
<td></td>
<td>Fentanyl patch</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neuropathic pain</td>
<td>Adjuvant analgesic</td>
<td></td>
<td>Seek specialist advice.</td>
</tr>
<tr>
<td>Colic</td>
<td>Hyoscine butylbromide</td>
<td>40 to 120mg</td>
<td>Reduces peristalsis</td>
</tr>
<tr>
<td>Nausea</td>
<td>Cyclizine or hyoscine butylbromide</td>
<td>50 to 150mg 40 to 120mg</td>
<td>Anticholinergic antiemetic; reduces peristalsis. Add to the subcutaneous infusion or give as a single SC dose for persistent nausea. Use in a SC infusion or administer 24 hour dose as a once or twice daily SC injection. Monitor for hypotension.</td>
</tr>
<tr>
<td></td>
<td>Add haloperidol</td>
<td>2mg</td>
<td></td>
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<tr>
<td></td>
<td>Change to levomepromazine</td>
<td>5 to 25mg</td>
<td></td>
</tr>
<tr>
<td>Vomiting (If nausea and pain are controlled, the patient may cope with occasional vomits)</td>
<td>Hyoscine butylbromide Octreotide</td>
<td>40 to 120mg 250 to 500 micrograms</td>
<td>Anti-secretory action. Second line anti-secretory. More effective than hyoscine but expensive.</td>
</tr>
</tbody>
</table>
Practice Points

- When using sedating medication, consider starting at lower doses.
- Most patients need a SC infusion of medication as oral absorption is unreliable.
- Review treatment regularly; symptoms often change and can resolve spontaneously.
- Do not combine anticholinergic antiemetics (cyclizine, hyoscine) with metoclopramide. Caution in use of prolonged higher doses, monitor for extrapyramidal side effects. See related guidelines for Subcutaneous medication, Nausea/ Vomiting, Levomepromazine.

Resources

- Professional: Palliative Care Drug Information online (http://www.palliativedrugs.com)

References


