

OUHFT Guidelines for the medical management of the symptoms of malignant bowel obstruction v.5.1

These guidelines are for the medical management of malignant bowel obstruction (MBO). Clinicians should also:

- Consider possible causes of bowel obstruction, ordering investigations as appropriate (e.g., CT abdomen).
- Correct electrolyte abnormalities which may contribute to peristaltic failure (e.g., low potassium, low magnesium)
- Consider disease modification (e.g., surgery, chemotherapy, or stenting)
- Consider resting the GI tract for several days. This may allow an obstruction to spontaneously settle.
- Use a subcutaneous (SC) or parenteral route to ensure absorption of medication.
- Review the patient and medications used every 24 hours. A combination of analgesics, anti-emetics and anti-secretory drugs may be needed.
- Consider referral to specialist palliative care team.

PARTIAL OBSTRUCTION WITHOUT COLIC	PARTIAL OBSTRUCTION WITH COLIC/ COMPLETE BOWEL OBSTRUCTION
Promoting resolution of obstruction	
<p><u>1st line (prokinetic drugs):</u></p> <ul style="list-style-type: none"> • Metoclopramide* SC – starting at 30-60mg over 24 hours, then increasing to a maximum of 100mg in 10-30mg increments. • Reduce or stop metoclopramide* if patient develops colic. • Docusate 100mg BD up to maximum of 500mg in 24 hrs. • PR glycerine and bisacodyl suppository if indicated. <i>(NB: As far as possible, rectal interventions should be avoided in patients who are neutropenic or thrombocytopenic because of the risk, respectively, of infection or bleeding)</i> <p><u>If no response after 24 hours, refer to HPCT:</u></p> <ul style="list-style-type: none"> • Add dexamethasone base 6.6mg OD SC or IV (may take up to 5 days to have effect) 	<ul style="list-style-type: none"> • Dexamethasone base 6.6mg OD SC or IV for 5-day trial. • Docusate in partial obstruction with colic- maximum 100mg BD PO. Discuss with senior colleague re. use of laxative in complete bowel obstruction. • Glycerine suppositories if PR intervention indicated. Avoid stimulant PR suppositories <i>(NB: As far as possible, rectal interventions should be avoided in patients who are neutropenic or thrombocytopenic because of the risk, respectively, of infection or bleeding).</i>
Control of nausea and vomiting	
<ul style="list-style-type: none"> • <u>If metoclopramide* is partially effective despite incremental titration</u>, add regular SC levomepromazine starting at 5mg nocte. If needing PRN levomepromazine doses greater than 10mg, place in 24-hour syringe-driver titrating up to 25mg if necessary • <u>If metoclopramide* ineffective</u>, stop and switch to SC levomepromazine* starting at 5mg nocte, titrating if indicated. If needing doses over 10mg place levomepromazine in 24-hour syringe-driver. • Use PRN levomepromazine* 2.5-5mg SC (TDS) for breakthrough nausea. • Add famotidine** 40mg over hours via CSCI in NaCl 0.9%. • If above agents are ineffective and large volume vomits present, consider adding anti- secretory drugs e.g. hyoscine butylbromide, octreotide etc. → 	<ul style="list-style-type: none"> • Stop metoclopramide* as may add to colic. • <u>1st line:</u> Cyclizine 75-150mg SC over 24 hours in syringe-driver with PRN SC haloperidol* 0.5-1.5mg TDS. If required, haloperidol* can be added to cyclizine in syringe driver at 1.5-5mg over 24 hours. • <u>2nd line:</u> Stop cyclizine and haloperidol* and switch to SC levomepromazine* starting at 5mg nocte. If needing doses greater than 10mg place in 24-hour syringe-driver titrating up to 25mg if necessary. <p><u>If large volume vomiting or repeated vomiting, consider:</u></p> <ul style="list-style-type: none"> • Ryles nasogastric tube. • 1st line: Hyoscine butylbromide 60mg SC over 24 hours in CSCI, titrating to a maximum of 120mg over 24 hours • 2nd line: Famotidine** 40mg over 24 hours in CSCI in NaCl 0.9%. • 3rd line: Octreotide 600-800 micrograms SC over 24 hours in CSCI. Higher doses may be required. • Discuss with gastroenterology re venting gastrostomy if symptom ongoing.
Control of pain and discomfort	
<p><u>Managing Pain:</u></p> <ul style="list-style-type: none"> • If c/o colicky pain, stop metoclopramide. • Use SC opioid and titrate to pain relief (OUHFT 1st line opioid is morphine sulfate). For constant background pain, give opioid via CSCI/24hrs. • If opioid is ineffective for colic, use SC hyoscine butylbromide PRN 20mg SC QDS. If ongoing symptoms, consider a CSCI with 60mg hyoscine butylbromide over 24 hours, to maximum of 120mg. Be mindful hyoscine butylbromide will slow gut motility. <p><u>Managing Dyspepsia:</u></p> <ul style="list-style-type: none"> • Famotidine to reduce acid / raise pH. • Consider decompression with Ryles tube. 	
Hydration and Nutrition	
<ul style="list-style-type: none"> • Low residue diet and referral to dietician. • IV hydration must be considered carefully on a case-by-case basis. If required, 1-1.5 litres/24 hours is often sufficient. Be mindful, parenteral fluids may be a barrier to returning home and can increase gastric secretions. • Regular mouth care, ice chips, water spray and saliva substitutes can provide symptomatic relief of dry mouth. • TPN generally has no role in patients with limited options for anti-cancer treatments or poor performance status. <u>However, this needs to be judged on an individual basis.</u> 	

- **Caution:** * Do not use haloperidol, metoclopramide or levomepromazine in patients with **Parkinson's disease**. Please discuss with Hospital Palliative care team in this instance.
- **Famotidine - Please note this is an unlicensed product and should only be prescribed on advice of the palliative care team, currently for inpatient use only.
- **Advance Care Planning:** Once surgical and oncology treatment are no longer an option, the median survival for patients with complete bowel obstruction is 3 months. Consider the patients preferred place of care and management of symptoms in the community if desired by the patient and family.
- Refer to 'OUHFT Continuous Subcutaneous Administration of Medicines via the T34/Bodyguard T Syringe Driver for Adult Palliative Care Patients: a clinical protocol' for further information on medication combination compatibility.
- Although we have subdivided medications into categories, there can be multiple effects of single drugs, for example, dexamethasone can have anti-emetic properties as well as effects on tumour oedema.
- PO=oral; SC=subcutaneous; IV=intravenous; CSCI: Continuous subcutaneous infusion; OD=once daily; BD=twice daily; QDS=four times daily, TPN=Total Parenteral Nutrition.

Guideline reviewed and agreed by:

Dr Mary Miller, Consultant in Palliative Medicine
 Melinda Presland, Consultant Pharmacist in Palliative and End of life care
 Amelia Sayce, Senior specialist nurse, Hospital Palliative Care Team
 Palliative care Medicines Management Group

Useful References:

Wilcock A., Howard P., Charlesworth S. (editors) (2022) Palliative Care Formulary (PCF8) Pharmaceutical Press

Palliative Care Formulary can be accessed via the internet: Search for Medicines Complete (using your browser) > Log in:
 User name: pcfonline@ouh.nhs.uk > Password: palliative1

Evidence base in review (2023/2024) > guidelines will be updated 2027