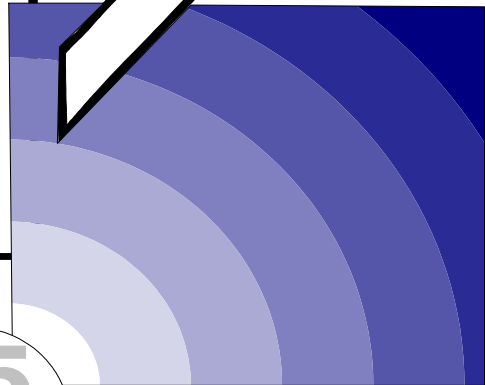
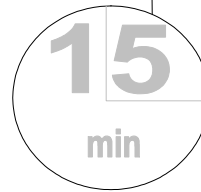


# CLIP

15 minute Worksheet



## Helping patients with symptoms other than pain

### 6: Bowel obstruction

Intermediate level

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#### Aim of this worksheet

To learn how to assess and manage bowel obstruction due to cancer.

#### How to use this worksheet

- You can work through this worksheet by yourself, or with a tutor.
- Read the case study below, then work on the questions overleaf.
- The work page is on the right side, the information page is on the left.
- Work any way you want: you can try answering from your own knowledge (in which case fold over the information page), you can use the information page (this is not cheating- you learn as you find the information), or you can use other sources of information
- It should take you about 15 minutes. If anything is unclear, discuss it with a colleague.
- If you think any information is wrong or out of date let us know
- Take this learning into your workplace using the activity on the back page.

#### Case study

**John is a 54 year old man who had a surgery for a carcinoma of the colon.**

**He has been having problems with nausea and vomiting. At first this responded to cyclizine, but he calls you because the nausea has returned and he has started having bouts of colic. He is normally opens his bowels every few days but has not opened his bowels for nearly a week. He has noticed that his abdomen is swollen today.**

### Is this bowel obstruction?

It may seem strange to ask this question, but many of John's symptoms could have other causes:

- other causes of nausea and vomiting (see CLiP worksheet on *Nausea and Vomiting*)
- colic due to infection or stimulant laxatives
- constipation, which can reduce the frequency of opening bowels, cause nausea and vomiting and may even cause a physical obstruction if severe enough.
- ascites which can cause abdominal swelling.

Obviously reversible causes (such as constipation) need to be treated. However, it can be difficult to decide the cause and it may be necessary to use investigations (ultrasound, abdominal X-ray) or to keep John under observation.

### Clinical decisions

- **Is a physical blockage absent or unlikely?** A bowel obstruction is not always due to a physical blockage. If the bowel slows or stops working (an 'ileus') this will have a similar effect to a bowel obstruction (absent bowel sounds, distension, no bowel motions). Several conditions can cause ileus such as peritonitis, septicaemia or recent cord compression. Drugs that slow the bowel can be a cause such as antimuscarinics (eg. amitriptyline, hyoscine).
- **Is thirst present?** In bowel obstruction fluid is secreted into the bowel lumen. This fluid is effectively lost and makes the patient dehydrated. If a patient feels thirsty they will have lost at least 1 litre and this needs to be replaced.
- **Is surgery or stenting possible?** This should always be considered. It may only require a loop colostomy or dividing adhesions, but surgery can have a significant mortality and morbidity. An understanding surgical opinion can be helpful, although it can be difficult to decide if there is a single level obstruction that is amenable to surgery. Stenting of duodenal or colonic obstructions can be an alternative.
- **Is nausea or vomiting present?** Patients find that the most distressing problem is nausea. Vomiting may remain but at a reduced volume or frequency and patients perceive it as much less distressing than constant nausea. Vomiting is less of a problem in more distal obstructions. Patients with distended colons may later restart with nausea, possibly since bacterial toxins are now adding to the nausea.
- **Is pain present?** The commonest cause of pain is colic caused by the bowel trying to push bowel contents against the obstruction. It usually comes in regular waves each lasting several minutes. Colic does not respond well to opioids and needs a drug to relax the bowel such as hyoscine butylbromide (Buscopan).
- **Is this complete or partial bowel obstruction?** In partial obstruction it is important to keep the bowel moving with laxatives while avoiding colic- drugs such as hyoscine have to be used sparingly to avoid slowing the bowel too much. With a complete obstruction that is inoperable, any bowel movements have no benefit and laxatives should be stopped, while colic can be safely treated with hyoscine butylbromide.

### Treatment

- **Ileus:** Stop antiperistaltic drugs (eg. antimuscarinics) and osmotic laxatives. A stimulant laxative such as senna may help to stimulate the bowel. Metoclopramide SC infusion 30-90mg per 24 hours may also encourage the bowel to function.
- **Feeding and hydration:** In advanced disease there is no advantage in restricting fluids or snacks. Cups of tea when wanted are preferable to 25ml water each hour! Troublesome dehydration is best treated orally, but if the patient is nauseated or vomiting it will need to be replaced intravenously or subcutaneously.
- **Surgery:** Surgery is possible if the patient agrees and they are in good or reasonable nutritional and medical condition. The prognosis is poor if there are abdominal masses or ascites, multiple blockages, a small bowel blockage, or there has been previous abdominal radiotherapy.
- **Nausea and vomiting:** cyclizine 25-50mg PO 8-hourly (or SC infusion 75-150mg/24hours) is the first choice. Some patients need to have haloperidol added 1.5-3mg SC at night. If this is ineffective, replace both antiemetics with levomepromazine 5mg SC at night. If the vomiting persists then antisecretory drugs such as hyoscine butylbromide or octreotide can be used. Nasogastric tubes are very inefficient at easing the symptoms of bowel obstruction, but can help in reducing distress due to faeculant vomiting caused by infected small bowel contents.
- **Pain:** if this is colic give hyoscine butylbromide 20mg SC (it is ineffective given orally). In inoperable complete obstruction, this can be given as a continuous SC infusion 30-90mg/24hours. Some patients have abdominal distension pain which usually responds to analgesics on the WHO analgesic ladder. Coeliac plexus pain will need gabapentin 100mg 8-hourly and then titrated to achieve a response.
- **Laxatives:** in partial obstruction a gentle laxative such as docusate can be continued- lactulose may cause bloating while senna or danthron can cause colic. In inoperable complete obstruction, all laxatives should be stopped.

With medical management, it is possible to manage inoperable bowel obstruction at home.

Questions: 1)T 2)F 3)T 4)F 5)F 6)T

Treatment-symptom links: colic-hyoscine; nausea-cyclizine; vomiting-bucket; dehydration-IV or SC fluids; thirst-cup of tea; faeculant vomiting-nasogastric tube.

**Q What are the features of bowel obstruction?  
Think of other possible causes for these features.**

Feature of bowel obstruction	Alternative cause

**Consider the following statements about bowel obstruction**

- |  |      |       |
|--|------|-------|
| 1. A physical obstruction does not have to be present to cause bowel obstruction | True | False |
| 2. The pain of bowel obstruction usually responds to morphine                    | True | False |
| 3. Laxatives should be continued in partial bowel obstruction                    | True | False |
| 4. Restricted oral fluids are a key part of treatment                            | True | False |
| 5. Nasogastric tubes are an effective treatment for vomiting                     | True | False |
| 6. Patients with inoperable bowel obstruction can be managed at home             | True | False |

**Match the following treatments to the symptoms they can treat**  
The first has been done for you.

Colic		Nasogastric tube
Nausea		Cup of tea
Vomiting		Cyclizine
Dehydration		Hyoscine butylbromide
Thirst		Bucket
Faeculant vomiting		IV or SC fluids

## FURTHER ACTIVITY: Bowel obstruction

Find a patient who is troubled with nausea and/or vomiting:

- can you identify a pattern suggesting gastric stasis?

– what possible causes are there in this patient?

## FURTHER READING: Bowel obstruction

### Journal articles

- Agra Y, Sacristan A, Gonzalez M, Ferrari M, Portugues A, Calvo MJ. Efficacy of senna versus lactulose in terminal cancer patients treated with opioids. *Journal of Pain & Symptom Management*. 1998; **15**(1):1-7.
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- Sykes NP. The relationship between opioid use and laxative use in terminally ill cancer patients. *Palliative Medicine*. 1998; **12**(5):375-82.
- Wiesel PH, Norton C, Brazzelli M. Management of faecal incontinence and constipation in adults with central neurological diseases *The Cochrane Database of Systematic Reviews*, 2002; **2**.

### Resource books and websites

- A Guide to Symptom Relief in Palliative Care*, 5<sup>th</sup> ed. Regnard C, Hockley J. Abingdon: Radcliffe Medical Press, 2004
- Oxford Textbook of Palliative Medicine* 3rd ed. Doyle D, Hanks G, Cherny NI, Calman K eds. Oxford : Oxford University Press, 2003.
- PCF2- Palliative Care Formulary*, 2<sup>nd</sup> ed. Twycross RG, Wilcock A, Charlesworth S. Abingdon: Radcliffe Medical Press, 2003.
- Also on [www.palliativedrugs.com](http://www.palliativedrugs.com)
- Symptom Management in Advanced Cancer*, 3rd edition. 2001. Twycross RG, Wilcock A. Abingdon: Radcliffe Medical Press.

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**Current  
Learning  
In  
Palliative care  
An accessible  
learning programme  
for health care  
professionals**

### Fifty seven 15 minute worksheets are available on:

- An introduction to palliative care (3 worksheets)
- Helping the patient with pain (9 worksheets)
- Helping the patient with symptoms other than pain (11 worksheets)
- Moving the ill patient (2 worksheets)
- Psychological needs (8 worksheets)
- Helping patients with reduced hydration and nutrition (8 worksheets)
- Procedures in palliative care (4 worksheets)
- Understanding and helping the person with alternative communication (learning disabilities) (5 worksheets)
- The last hours and days (4 worksheets)
- Bereavement (3 worksheets)

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Helping the Patient with Advanced Disease: a Workbook  
Regnard C. ed.

Oxford: Radcliffe Medical Press [www.radcliffe-oxford.com](http://www.radcliffe-oxford.com)