BOWEL OBSTRUCTION

PURPOSE
The appropriate and timely diagnosis and management of bowel obstruction.

KEY POINTS
1. Bowel obstruction is a common complication of gynaecological malignancies, especially ovarian cancer and is the most common cause of death in this group.
2. Predisposing factors include peritoneal metastases, a history of previous intra abdominal surgery and pelvic disease from any cause.
3. The small bowel is more commonly affected than the large bowel but both may be simultaneously involved.
4. Most women with ovarian cancer and bowel obstruction will live for less than 1 year, the majority dying within 6 months of presentation.
5. Bowel obstruction is a complex management issue which requires the input and involvement of the gynaecological oncology multidisciplinary team.
6. Surgical opinion must be sought if the obstruction has not resolved within 48 hours of conservative management.
7. Attention to symptom control is paramount, but withhold dexamethasone until a surgical opinion has been obtained.

DIAGNOSIS

HISTORY
- Nausea and vomiting are common. Initially the volume and frequency of vomiting depend on the level of the obstruction. High obstructions may be associated with large volume, forceful vomiting of undigested food. Low obstructions may initially have very little vomiting.
- Abdominal distension
- Pain. Colicky abdominal pain often occurs early. Continuous pain can also be present or develops later.
- Absence of stool or flatus. Occurs early in large bowel obstruction and later in higher obstruction. Spurious diarrhoea does not exclude obstruction.

EXAMINATION
- Assess hydration – pulse, BP, skin turgor, axillary moisture. The mouth may be dry and coated.
- Palpation of the abdomen
  - Abdominal masses
May be unremarkable, particularly with high obstructions.
- Abdominal distension
- Acute abdomen is a poor sign.

- Percussion of the abdomen
  - Hypertympanic
  - Ascites may be present

- Auscultate for bowel sounds
  - Reduced
  - Increased
  - High pitched and tinkling
  - Absent
  - A gastric splash may be present

- Rectal examination
  - A full rectum suggests constipation
  - Empty dilated (ballooned) rectum may occur with previous rectal intervention, constipation, obstruction or a large pelvic mass. Imaging may be appropriate.
  - A rectal or pelvic mass may be palpated.

**INVESTIGATIONS**

- Abdominal x-ray (erect / supine, look for fluid levels, faecal loading).
- CT scan with oral contrast.
- Gastrografin swallow with follow through and / or enema if the woman is a possible surgical candidate. Barium studies are best avoided.
- If there is no radiological evidence of an obstructive lesion on Gastrografin swallow with follow through, consider ‘pseudo obstruction’ (motility disorder) as a possible diagnosis.
- FBC, U&Es (including calcium, magnesium, phosphate), LFTs (including albumin, coagulation studies).

**MANAGEMENT**

- **Surgery** – most suitable candidates include those with
  - Good performance status
  - Good nutritional status
  - Minimal ascites
  - Unifocal or non malignant obstruction
  - Options for future disease modifying treatment

- **Absolute contraindications to surgery**
  - Results of previous laparotomy demonstrating that corrective surgery is not possible.
  - Diffuse intra abdominal tumours or multiple palpable masses
  - Irreversible poor nutritional status

- **Relative contraindications to surgery**
  - Previous abdominal radiotherapy
  - Multiple recurrent partial bowel obstructions
  - Short disease free interval
  - Multiple previous lines of chemotherapy
  - Multi focal obstruction
  - Frailty

- **Medical management of malignant bowel obstruction.**
Medical management of malignant bowel obstruction in which surgical treatment is not possible should be supervised by a specialist (usually a Palliative Care Physician) with experience in this condition.

A continuous infusion of Octreotide 300mcg per 24 hours with concomitant haloperidol 2.5-5mg daily to minimise associated nausea may be efficacious. Octreotide can be titrated up to 900mcg / 24 hours although usual response is in the range 300-600 mcg per 24 hours.

Spontaneous resolution of malignant bowel obstructions does happen and close expert observation is necessary as withdrawal of octreotide may be necessary. In patients thought likely to survive for weeks to months, a percutaneous endoscopic gastrostomy (PEG) for decompression and drainage of upper gastro-intestinal secretions (i.e. a venting gastrostomy) should be considered.

- If the prognosis is measured in hours to days prior to the onset of this problem.
  - This is a clinical diagnosis.
  - No further investigations are indicated.
  - Attempt a temporary reversal of obstruction
  - Medical management of bowel obstruction

REFERENCES (STANDARDS)

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<th>National Standards – 1 Clinical Care</th>
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<td>Legislation - Nil</td>
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<tr>
<th>Related Policies – Palliative Care</th>
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<td>Other related documents – Nil</td>
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RESPONSIBILITY

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