Ileus in patients with cancer in the palliative phase

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Summary

Introduction

Ileus is defined as a reduced or completely interrupted transit through the small or large bowel caused by a partial or total obstruction at one or more sites (mechanical ileus), a reduction or absence of motility (paralytic ileus), or a combination of both. In the palliative phase, an ileus tends to develop gradually (often as a consequence of peritoneal carcinomatosis), and usually obstruction is not complete. Distinguishing between mechanical and paralytic ileus can then be problematic.

Causes

- Peritoneal carcinomatosis (most common cause);
- Obstruction due to a primary or recurrent tumour, or meta-stases;
- Autonomic dysfunction due to:
  - paraneoplastic autonomic neuropathy;
  - medication: chemotherapy (particularly vinca alkaloids), opioids, loperamide or anticholinergic agents.
- Constipation (usually as a contributory factor);
- Adhesions and fibrosis due to previous surgery and/or radiotherapy;
- Other causes:
  - electrolyte disorders (hypokalaemia, hypercalcaemia);
  - postoperatively;
  - acute bacterial peritonitis, sepsis;
  - comorbidity (e.g. diabetes mellitus, ischaemic colitis, inflammatory bowel disease, chronic intestinal pseudo-obstruction);
  - volvulus, invagination, incarcerated hernia.

Diagnostics

Step 1

Take a history and do a physical examination (including rectal examination).

Step 2

On diagnosis of ileus: consult treating clinician (if necessary) and draw up a treatment plan together with the patient:

- Refer the patient for further diagnostics and treatment: see Step 3, or
- Choose symptomatic treatment at home, in a hospice or in hospital: see Step 7.

Step 3

In hospital: carry out further investigations if they will have consequences for the treatment:

- CT scan abdomen:
  - to confirm local obstruction, for which surgery or stent placement may be considered, and/or
  - to diagnose a different, treatable cause, and/or
  - to detect complications requiring an urgent laparotomy, and/or
  - to assess the extent of the disease to determine the prognosis and/or
  - to indicate a need for systematic therapy or a change of systemic therapy.
- Coloscopy: if stent placement is being considered.

Taking a plain abdominal X-ray is not recommended.

Treatment

Step 4

Treat the symptoms and prepare for possible surgery:

- rectal enema twice daily, particularly if fecal impaction is suspected;
- for vomiting and/or as preparation for surgery: temporary gastric decompression using nasogastric tube;
- gastric acid inhibition with pantoprazole 40 mg IV or SC once daily;
- treatment of continuous abdominal pain with morphine and of abdominal cramps with hyoscine butylbromide (starting dose 40 mg/24 hrs, to be increased to 120 mg/24 hrs if necessary);
- nil by mouth and parenteral administration of fluids, unless the patient explicitly does not want this and/or life expectancy is < 1-2 weeks;
- for symptomatic ascites: paracentesis.

Step 5

If the clinical condition allows: assess if bowel function is restored over a 48-72 hour period.
In the event of an acute abdomen: carry out urgent diagnostic tests (see Step 3), if surgery is thought to be appropriate and possible at this point.

Step 6

Consult with the patient, the treating clinician and, if necessary, a surgeon, gastroenterologist, medical oncologist and/or the general practitioner, and draw up a treatment plan based on the wishes of the patient, his/her physical condition and estimated life-expectancy, clinical situation and, if performed, further diagnostic tests.

- Place a stent if:
    - there is a local obstruction of the descending colon due to a process in the bowel wall; and
    - there is a stenosis <4 cm, that can be passed with a guide wire and stent; and
    - an experienced endoscopist (who has placed a minimum of 20 stents) is available; and
    - life expectancy is less than 3 months; or
- Treat operatively if surgery is expected to relieve the obstruction. Preconditions for a potential surgical solution (creation of a stoma or a bypass, resection or adhesiolysis) to the obstruction are:
    - There should be an identifiable site of obstruction based on preoperative imaging.
    - The general condition of the patient should be good enough to undergo abdominal surgery (WHO performance status 1-2 in the weeks before the ileus arose, life expectancy > 3 months, no diffuse peritoniteal carcinomatosis or massive ascites).
- If, on opening the abdomen, the above-mentioned procedures prove not to be possible, consider creating a gastrostomy or jejunostomy (using a large Foley catheter for drainage).
  When deciding how to proceed, consult the treating clinician and a surgeon. If the patient is malnourished (MUST score > 2, SNAQ score > 3), start perioperative parenteral nutrition; or
- If the ileus is due to peritoniteal carcinomatosis or metastases in the bowel wall in a patient with cancer in the palliative phase, start palliative systemic therapy if the following conditions have been met:
    - There is a good chance of a fast response:
        - In recurrent ovarian carcinoma: platinum-containing chemotherapy if the interval between discontinuing platinum-containing systemic therapy and the occurrence of the ileus is 6 months or longer.
          Non-platinum-containing systemic therapy is rarely indicated.
        - In other malignancies: mainly as first-line palliative systemic therapy; second line palliative systemic therapy is rarely indicated.
    - Good physical condition (WHO performance status 1-2).
- Consider starting parenteral nutrition if oral nutrition is not possible. Discuss the benefits and

disadvantages of parenteral nutrition in detail beforehand. At the start of treatment, make clear arrangements about the duration of parenteral nutrition and its discontinuation; or
- Choose symptomatic treatment only: see Step 7.

Step 7 Symptomatic treatment

- If vomiting is persistent and distressing:
  - Consider continuous gastric decompression by nasogastric tube (if life expectancy <4 weeks), or, if technically possible, by PEG (if life expectancy > 4 weeks). Ensure good mouth and nose care. Give parenteral fluids during gastric decompression, unless the patient does not want this and/or life-expectancy is <1-2 weeks.
  - On refusal or intolerance of a nasogastric tube, or strong production from nasogastric tube: treatment with octreotide 200 µg three times daily or 600 µg/24 hrs SC or IV. On proven effect, possibly switch to lanreotide 30 mg IM every 2 weeks.
  - If the cost of octreotide is a problem or if vomiting is accompanied by cramping abdominal pain, and/or if octreotide is not available on time: give intermittent or continuous hyoscine butylbromide (initial dosage 40 mg/24 hrs, to be increased to 120 mg/24 hrs SC or IV, if necessary).
  - If there is no effect after 3 days: stop octreotide and start dexamethasone 8 mg DC-IV once daily; tapering the dose guided by symptoms.
  - If dexamethasone is insufficiently effective: metoclopramide (starting dose 40 mg/24 hrs, in partial obstruction only), or haloperidol (2-4 mg/24 hrs) intermittently or continuously SC/IV. If this is insufficiently effective, granisetron 3 mg once daily, SC or IV, or ondansetron 8 mg twice daily SC or IV.
- In the event of pain:
  - for abdominal cramps: hyoscine butylbromide S/IV intermittently or continuously (starting dose 40 mg/24 hrs, to be increased to 120 mg/24 hrs, if necessary).
  - If poor response to scopolamine butylbromide and/or continuous abdominal pain: morphine or oxycodone intermittently or continuously SC/IV (starting dose in opioid naive patient 30 mg/24 hrs with 5 mg for breakthrough pain, if necessary); on stable pain start or switch to transdermal fentanyl (starting dose 12 µg/hour in opioid naïve patient).
- Start parenteral nutrition only if the patient explicitly wishes to be treated, if oral or enteral feeding has failed, if life expectancy is > 3 months and if there is a WHO performance status of 0-2. Before starting, explain the benefits and disadvantages of parenteral nutrition in detail. At the start of treatment, make clear arrangements about the duration of parenteral nutrition and its discontinuation.
- If parenteral fluids are being administered, evaluate if they can be stopped. If gastric decompression is productive and in patients without gastric decompression who are unable to regularly take sips of water and/or vomit frequently, consider continuing parenteral fluids. Explain the benefits and disadvantages of the parenteral administration of fluids in detail to the patient and their relatives. Make clear arrangements with the patient and their relatives concerning the points in time at which the effect, the usefulness and the desirability of continuing parenteral administration of fluids will be evaluated.

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Accountability: Guideline working group Ileus

It is vital that as a care provider you are familiar with this guideline. For the most recent version of the guideline go to www.pallialine.nl/ileus or see the summary in the PalliArts App.