Malignant Bowel Obstruction- a systematic review and evaluation of current practice

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BACKGROUND & METHODS

Malignant bowel obstruction (MBO) is a recognized complication of advanced pelvic or abdominal malignancy frequently occurring in advanced stages of illness. Suggested incidences in ovarian carcinoma range from 5.5 to 42% and in colorectal cancer 4.4 to 24%. Where surgery for MBO is inappropriate medical management may help bring about resolution of the unpleasant symptoms.

AIMS AND METHODS

• The aim of this review was to evaluate current evidence and opinion on treatment of symptoms associated with MBO.
• A comprehensive systematic review of the literature was undertaken to evaluate the evidence for the medical management of MBO. A questionnaire-based survey was used to establish professional attitudes, opinions and to review current practice.

THE EVIDENCE

Following exclusions 44 relevant papers were systematically appraised. The papers were critically appraised and the level of evidence for each intervention graded,

GOOD EVIDENCE BASE

**OCTROTIDE IN MALIGNANT BOWEL OBSTRUCTION**

• Octreotide is effective in controlling vomiting in 60% MBO cases regardless of type/level of obstruction
• reduces NG aspirate volume, may avoid placement of NGT and allow removal of NGT
• should be considered where rapid reduction is necessary
• more effective than hyoscine butylbromide; should be considered as first-choice anti-secretive drug despite cost

**ANTIEMETICS IN MALIGNANT BOWEL OBSTRUCTION**

no evidence for the use of any specific anti-emetics for nausea and vomiting of MBO

**ANTISPASMODICS IN MALIGNANT BOWEL OBSTRUCTION**

no evidence for the use of any specific antispasmodic for colic of MBO

**LAXATIVES IN MALIGNANT BOWEL OBSTRUCTION**

no evidence for the use of any specific laxative for constipation of MBO

POOR EVIDENCE BASE

**VENTING GASTROSTOMY IN MALIGNANT BOWEL OBSTRUCTION**

useful for MBO from multiple primaries acceptable minor complication rate & low major complications good symptom resolution particularly nausea and vomiting allow some oral diet and enables discharge home

**CORTICOSTEROIDS IN MALIGNANT BOWEL OBSTRUCTION**

• a trend for evidence that corticosteroids of dose range 6-16mg dexamethasone may bring about the resolution of bowel obstruction. Response should be assessed within four or five days with a view to discontinue if no benefit seen.

EXPERT OPINIONS

65 palliative care professionals surveyed
In both partial and total bowel obstruction cyclizine and levomepromazine are the most popular antiemetics of choice.
Octreotide (dose range 300-1000mcg) is routinely used to treat high volume vomiting; hyoscine butylbromide (dose range 10-240mcg) to treat colic.
76% of professionals routinely prescribe dexamethasone for patients with MBO (dose range 4-16mg)
The availability of venting gastrostomies is variable throughout the region, referral for VG is infrequent and there are mixed attitudes to the effectiveness.

FUTURE DIRECTIONS

• More robust evidence base required to guide anti-emetics/laxatives choice in MBO
• Is there a role for H2 antagonists or PPIs to reduce gastric secretions in MBO?
• Further assessment of the use of olanzapine to treat nausea in patients with MBO
• Further assessment of the use of lanreotide microparticles to reduce secretions in MBO

References:

1. Yamauchi T, Akahane Y. Longitudinal changes of malignant bowel obstruction: a study of 1162 cases. No To Hattatsu. 2002;34:11-6