

Management of bowel obstruction in Gynaecological Cancer Patients - Full Clinical Guideline

Reference no.: UHDB/10:23/B2

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1. Introduction

Bowel obstruction in gynaecological malignancy is most commonly associated with ovarian cancer. Up to 50% of women with ovarian cancer will experience bowel obstruction during their illness. Bowel obstruction is often a manifestation of recurrent disease and is associated with a poor prognosis. The outcomes following bowel obstruction are poorly documented, with a limited evidence base in which to guide management. Management therefore requires a multidisciplinary approach to achieve an individualized management plan for these women.

2. Purpose and Outcomes

- To improve survival in women with bowel obstruction due to Gynaecological Cancer.
- To improve quality of life in women with bowel obstruction due to Gynaecological cancer.

3. Key Responsibilities and Duties

- To give a structured management approach to women with bowel obstruction in Gynaecological cancer
- To allow auditable standards regarding the management of bowel obstruction.

4. Abbreviations

AXR – Abdominal X-Ray

CT – Computerised tomography

FBC – Full blood count IV – Intravenous

IVI – Intra venous infusionU+E – Urea and Electrolytes

5. Main quideline

Diagnosis:

- Symptoms Nausea and Vomiting, Abdominal distension/Pain, Altered bowel habits, Dehydration
- Signs Distended Abdomen, High pitched/Absent Bowel sounds Can be normal with proximal obstruction, Tender/Peritonitic
- · Imaging AXR Fluid levels, Dilated bowel, Faecal loading, CT Abdo/pelvis showing evidence of obstruction.

Immediate management

- RULE OUT ISCHAEMIC BOWEL Urgent/Immediate on call surgical opinion if suspected.
- · Admit under oncology
- FBC, U+E, AXR, CT Chest Abdo Pelvis with oral contrast if tolerated (within 24 hours of admission)
- IV Access
- IVI
- NGT If vomiting consider for decompression even if not vomiting
- Fluid balance.
- · Nutritional review and optimisation and consider nutrition team review.
- · Drain Ascites if significant.
- Inform Gyane-oncology CNS team

Conservative management

- Drip and suck,
- Oral gastrograffin
- Consider prokinetics
- Consider steroids
- Consider steroids +/- Prokinetic (with caution)

Obstruction Resolved

- Inpatient oncology review regarding chemotherapy with a plan to commence as soon as possible.
- Consider discharge on steroids.
- Ensure fluid balance has normalised prior to discharge.

Obstruction not resolved: Consider surgery

- Gynaeoncology review within 24 hours of failure of conservative management.
- Joint consultant oncology, gynaecological oncology and colorectal/consultant surgical review when and if they are felt to have a benefit from surgery.

Consider:

- first/recurrent episodes
- Level of obstruction, number and site
- Previous surgery and Radiotherapy
- Performance status
- Fitness
- Chemotherapy lines naive, interval (>12 months ideally), previous response.
- Histology
- Tumour site.

Not for surgery and symptoms not resolving.

- Palliative input AND oncology review.
- Symptom management

Consider:

- Syringe driver,
- Nutrition input,
- Laxatives,
- Antiemetics,
- Steroids,
- Analgesia,
- Long term NG drainage,
- Palliative Gastrostomy
- Home TPN

Discharge with plan in place to commence palliative chemotherapy if acceptable.

Palliative surgery

Unless evidence of ischaemic bowel, aim to delay palliative surgery until appropriate conservative management has been trialled and appropriate surgical expertise is available.

- Joint colorectal/Gynaecological Oncology.
- Surgical approach depending on patient and disease factors
- Consider further surgery that might be required (i.e exenteration) when planning and placing stomas/mucus fistulae.
- Consider critical care input depending on surgical outcomes and prognosis.
- Enhanced recovery depending on surgical outcomes and prognosis.

6. Monitoring Compliance and Effectiveness

As per agreed business unit audit forward programme

7. References

Kolomainen DF, Riley J, Wood J, Barton DPJ. Surgical management of bowel obstruction in gynaecological cancer. The Obstetrician Gynaecologist 2017;19:63-70

Report of the National Audit of Small Bowel Obstruction https://www.acpgbi.org.uk/resources/report-national-audit-small-bowel-obstruction/

Documentation Control

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