

# GASTROINTESTINAL PROBLEMS IN PALLIATIVE CARE

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# NAUSEA & VOMITING

- Incidence: 40% in Cancer
- A single anti-emetic helps in 2/3 of the patients
- Any added anti-emetic should have a different action
- Nausea, Vomiting and Retching are different symptoms and may need different treatment

# EVALUATION:

- DISTINGUISH! (Nausea, Vomiting, Regurgitation, Expectoration)
- ASSOCIATED SYMPTOMS (headaches, constipation, diarrhoea, fever, pain etc.)
- EXAMINATION (abdominal, Rectal)
- BLOOD TESTS?
- REVIEW drugs/food

# *TREATMENT*

- ***CYCLIZINE***

***Blocks Histamine receptors in vomiting centre***

***USES:***

***Intestinal Obstruction***

***Raised intra-cranial pressure***

***Dose: 50 mg TDS***

# *TREATMENT-2*

- ***METOCLOPRAMIDE***

***Blocks Dopamine receptors in the Gut***

***USES:***

***Gastric stasis & ileus***

***Squashed Stomach Syndrome***

***Dose: 10 mg – 20 mg TDS***

## *TREATMENT-3*

- ***HALOPERIDOL***

***Blocks Dopamine receptors in the CTZ***

***USES:***

***Chemical induced N&V***

***e.g., opiates***

***Dose: 0.5 mg TDS – 3 MG TDS***

# *TREATMENT-4*

## **ONDANSETRON**

***Blocks serotonin receptors in Vomiting centre and Gut***

***USES:***

***Chemo / Radio..therapy***

***Dose: 4 mg TDS***

## *TREATMENT-5*

***LEVOMEPRMAZINE (Nozinan ®, Levinan  
®)***

***Blocks Dopamine, Serotonin,  
Histamine, Acetylcholine receptors***

***USES:***

***Second-line General anti-emetic***

***Dose: 6 mg OD – 50 mg TDS***

# Some other drugs!

## CORTICOSTEROIDS:

*Cerebral Oedema*

*Obstructing Tumours*

*(Usual dose Dexamathasone 4 mg BD)*

## OCTREOTIDE:

*Malignant Bowel obstruction*

*(Usual dose 100-300 mcg in 24 hours)*

## ACID REDUCERS:

*Gastric inflammation*

*(Usual dose Lansoprazole 30 mg OD)*

# COMMON BOWEL PROBLEMS

- Constipation
- Faecal Impaction
- Intestinal Obstruction
- Diarrhoea
- Rectal Discharge

# CONSTIPATION

- Defined as ‘difficulty in defecation’
- People have different bowel habits (normal 2-3 in a day to 1 in 5 days)
- Common in cancer due to various causes

# CAUSES – 1

- Cancer related (Hypercalcaemia)
- Drugs
  - Opioids
  - NSAIDs
  - Antimuscurinics e.g., Tricyclics
  - Anti-emetics (5 HT3 receptor antagonists)
  - Chemotherapy (Vincristine)
  - Diuretics

# CAUSES – 2

- Debility
  - Inactivity
  - Poor nutrition
  - Poor fluid intake
  - Dehydration
  - Weakness
  - Inability to reach toilet
- Psychological (Depression)

# MANAGEMENT

- General measures:
  - Stop or decrease the dose of drugs
  - Mobilise if possible
  - Commode use
  - Diet
    - \* Increase food/fibre intake
    - \* Encourage fluids and fruit juices

# CLASSIFICATION

- Bulk – forming laxatives (Fybogel, Benefibre, Methylcellulose)
- Softeners (Liquid Paraffin)
- Surface wetting agents (Docusate)
- Osmotic laxatives (Lactulose, Macrogols, Magnesium Hydroxide)
- Stimulant (Senna, Danthron, Picosulphate)

# DRUG MANAGEMENT

- Always prescribe laxatives with opioids (Fentanyl and Methadone less constipating)
- Try combination of Stimulant and softener laxative e.g., Liquid Paraffin and Senna
- Encourage fluid intake with laxatives
- If no action for 3 days, consider reassessment with abdominal and rectal examination and consider combination suppositories

# DRUG MANAGEMENT – 2

- Maintain treatment with Osmotic e.g., Macrogols
- Laxative requirement may go up with increase in opioid dose

# FAECAL IMPACTION

- ‘Overflow diarrhoea’
- Careful assessment needed
- Should be treated with rectal enemas
- For soft stools, use Bisacodyl (stimulant)
- For hard stools, use Arachis oil retention enema at night followed by high phosphate enema in morning

# INTESTINAL OBSTRUCTION

- Consider Surgical treatment unless:
- Previous laparotomy findings show contra-indication
- Diffuse intra-abdominal secondaries
- Massive Ascites re-accumulating after paracentesis
- Debilitated patient
- Unwilling patient

# INTESTINAL OBSTRUCTION

- Medical Management:
  - Focus in managing Nausea & Vomiting (use central acting drugs)
  - Consider trial of Dexamethasone
  - Anti-secretory drugs (Octreotide, Hyoscine)
  - I/V fluids and Nasogastric tube are rarely necessary
  - After resolution, consider prevention

# DIARRHOEA

- Common causes in Palliative care:
  - Laxative overdose
  - Faecal impaction with overflow
  - Partial bowel obstruction
  - Gastro-enteritis
  - Radiation enteritis
  - Drugs (Laxatives, PPI, SSRI, Antibiotics)
  - Steatorrhoea

# MANAGEMENT

- Correct the correctible
  - Review diet
  - Antibiotics if infective
  - Review drugs
- Non-specific anti-diarrhoeal (Loperamide, Codeine, Kaolin and Morphine Mixture)
- Pancreatic enzyme supplements
- Anal plugs

# RECTAL DISCHARGE

- Causes:
  - Patulous anus
  - Haemorrhoids
  - Faecal Impaction
  - After Laxatives
  - Rectal tumour
  - Radiation
  - Fistula

# RECTAL DISCHARGE

- Management:
  - Faecal disimpaction
  - Reduce tumour size (radiation, surgical)
  - Reduce inflammation (Prednisolone enema)
  - Hygiene
  - Treat fungal infection
  - Anti-histamine for pruritus ani