GI Disorders

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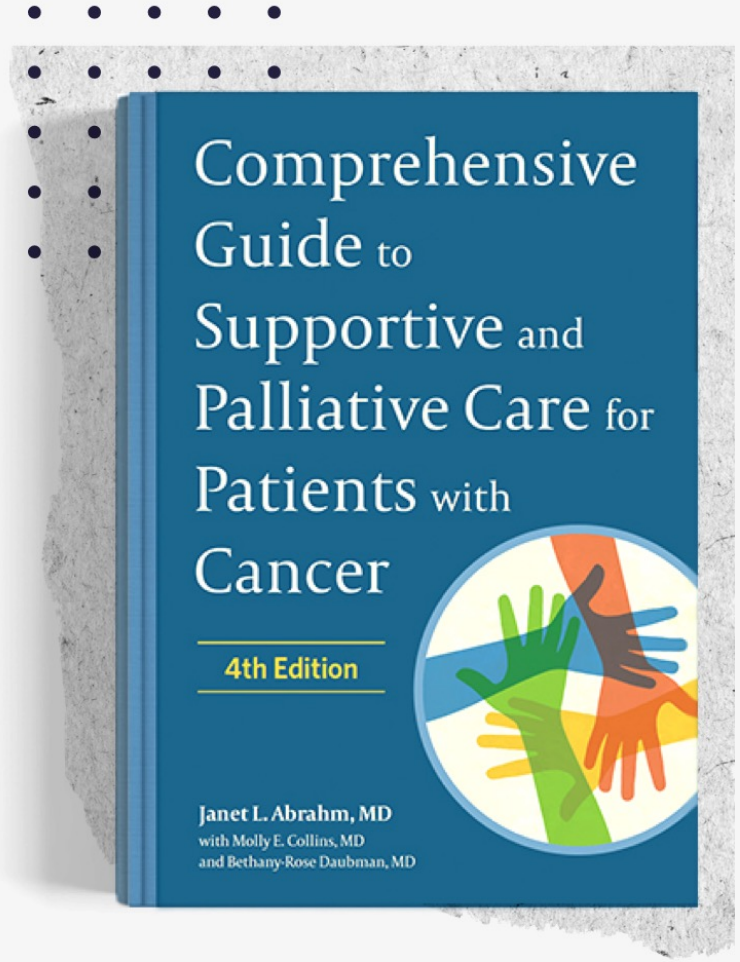
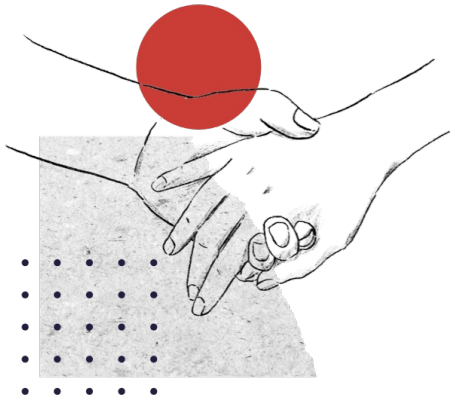
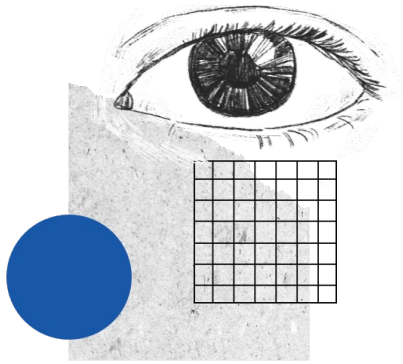


Palliative Care Resources



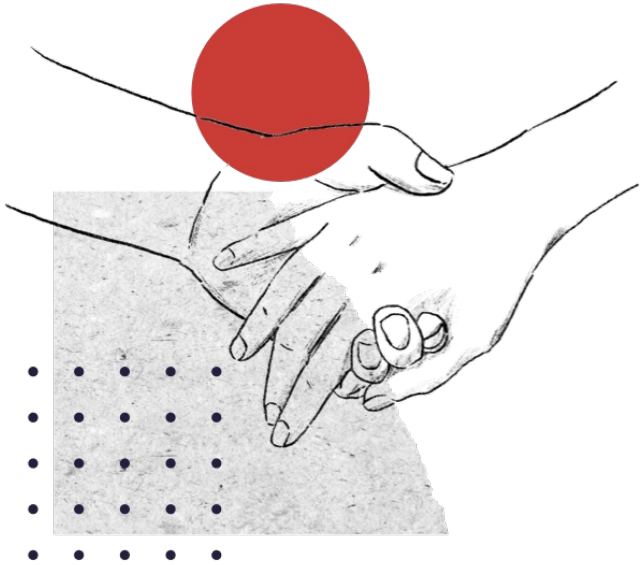
Pain and Symptom Management



Communication with Patients and Families

End of Life and Bereavement

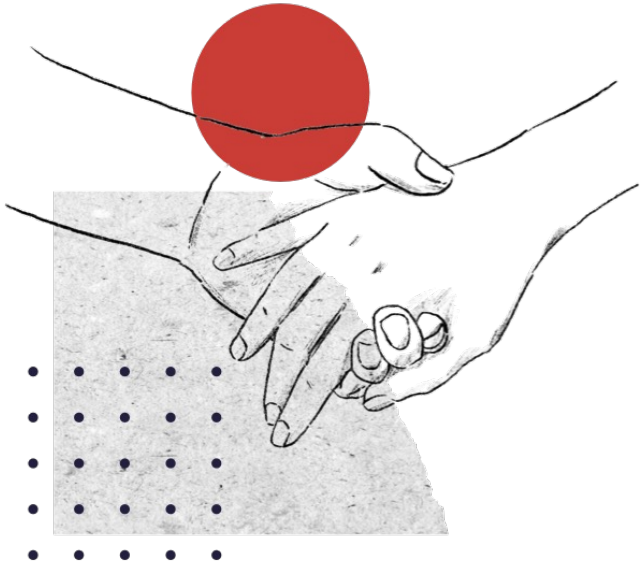
Special Topics



Sam: 50 yo with Locally advanced pancreatic cancer

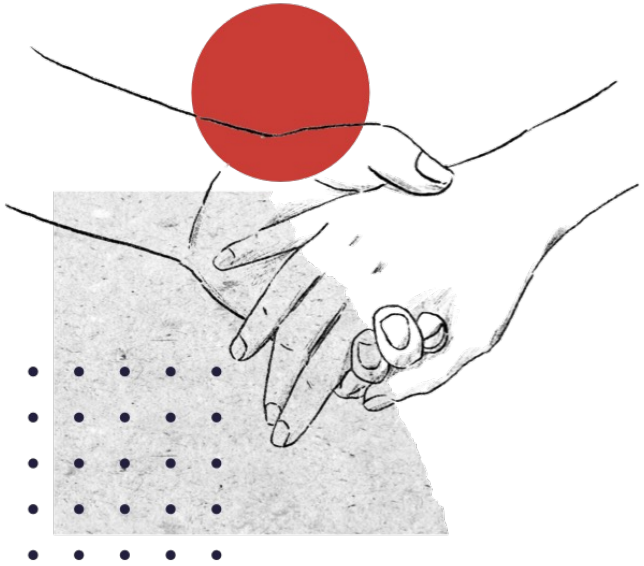
New onset obstipation, abdominal distention, generalized abdominal pain

Which might contribute?



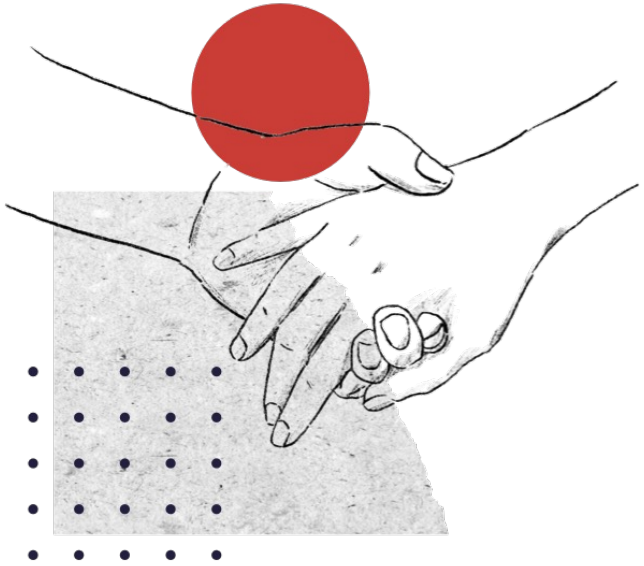
- Na 128, K 3, Cl 100, C02 30, Ca 10, Alb 2.5, Mg 1.0, Cr 1, BUN 25
- s/p celiac block
- Meds: acetaminophen TID, oxycodone 5-10 mg prn (took 15 in past 24h), ondansetron q6h prn (took x 4 past 24h), Metamucil daily

Prevention/non-specific treatment



- Stool softeners?
- Stimulants (e.g. senna, Bisacodyl, MOM, Mg Citrate)
- Osmotics: PEG (e.g. Miralax), lactulose
- Enemas, suppositories
  - Unless neutropenic or expected to be; or thrombocytopenic
  - **Start with enemas if >5 d since stool (mineral oil followed by stimulant)**

Specific Therapies ($$$)



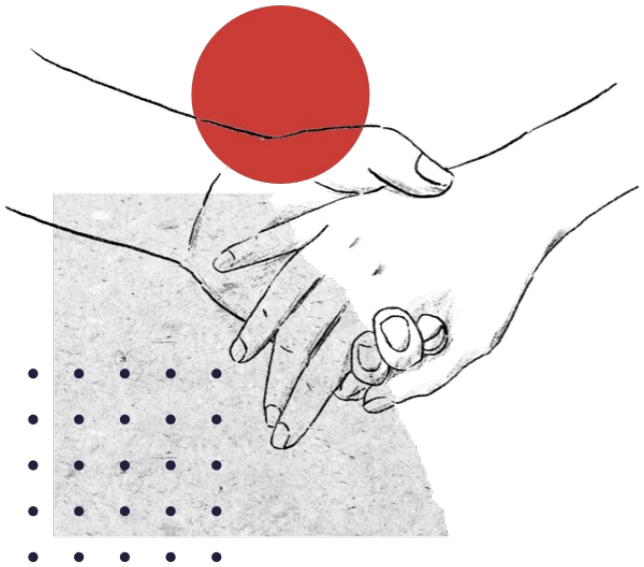
Opioids contributing

- Methylnaltrexone SQ (Relistor)
- Naldemedine (Symproic) po
- Naloxegol (Movantik) po

Add water to stool

- Lubiprostone (Amitiza);
  Plecanide(Trulance) /linaclotide (Linzess)
- Not studied in cancer patients

MBO



Which drugs might help?

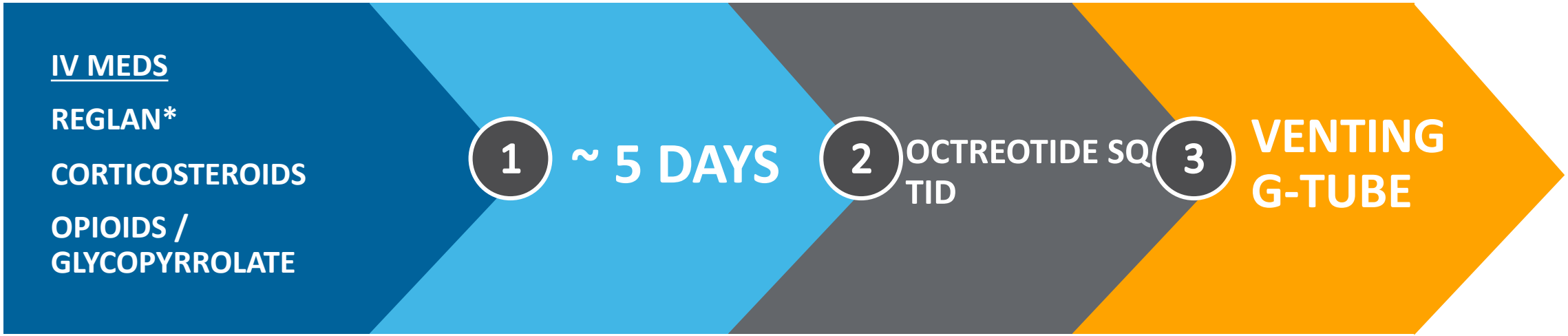
Corticosteroids
Metoclopramide
Scopolamine / hyoscine / glycopyrrolate
PPI
Octreotide

MEDICAL MBO THERAPY

	DECREASE GUT SECRETIONS	IMPROVE GUT MOTILITY	DECREASE GUT MOTILITY	DECREASE INFLAMMATION /EDEMA	SYMPTOM RELIEF
CORTICOSTEROIDS	X			X	X
METOCLOPRAMIDE		X			X
ANTICHOLINERGICS	X		X		X
OPIOIDS			X		X
PPI	X				X
OCTREOTIDE	X		X		X

Medical MBO therapy

NPO + NG TUBE + MULTIPLE MEDICATIONS



MALIGNANT BOWEL OBSTRUCTION PATHWAY

Admission intake assessment to include:
- ESAS, ECOG, and assessment of social support with HPI
- Lactate and prealbumin with lab work
- Abdominal imaging with contrast

Is this an emergency (e.g., peritonitis, concern for perforation/bowel ischemia, large bowel obstruction, closed loop, sepsis, hemodynamic instability)?

Yes

Exit pathway: Multidisciplinary assessment and management per clinical scenario and GOC

No

Initial symptom management:

1. Medication orders:
- PRN opioid: (1) if opioid naïve, hydromorphone 0.2-0.4 mg IV q3h PRN; (2) if opioid tolerant, consult palliative care for conversion of home medications to parenteral dosing and/or rescue dosing
- 1st line anti-emetic if partial obstruction: metoclopramide 10 mg IV q6h
- 1st line anti-emetic if complete obstruction: olanzapine 2.5-5 mg IV q6h PRN (If olanzapine is on shortage, use haloperidol 0.5 mg IV q6h PRN)
- If abdominal cramping prominent, glycopyrrolate 0.2-0.4 mg IV q6h PRN
- IVF resuscitation (Lactated Ringers) as clinically indicated

2. Consider nasogastric tube placement (particularly if significant emesis)
3. If ascites volume ≥500ml on imaging, consider paracentesis

If not contraindicated (e.g., by chemotherapy or imminent surgery), start dexamethasone 4 mg IV BID + PPI or H2 blocker (Note: Dexamethasone should be tapered to 4 mg or less prior to discharge.)

Hospital Day 4:
- If not already completed, from the Serious Illness Conversation Guide, ask: (1) What are your hopes?, (2) What are your worries?, (3) What is your understanding of your illness?
- Document conversation in Advanced Care Planning module and pull into progress note

Hospital Day 4:
Is the patient improving?

Yes

Exit pathway:
Advance diet, taper medications

No

1. Additional symptom management measures:
- NGT if not previously placed
- Octreotide 200 mcg SQ TID

2. Consult palliative care if not already involved

Is the patient improving?

Yes

Exit pathway:
Advance diet, taper medications. Consider IM octreotide as outpatient if persistent bowel obstruction is anticipated.

No

1. Send templated email to multidisciplinary team requesting discussion of additional treatment options (e.g., surgery, G-tube, stent, PCN, parenteral nutrition)
2. Consult nutrition (should include verbal conversation with dietitian re: clinical context prior to pt evaluation)

Are there additional interventions that may benefit the patient?

Yes

No

Exit pathway: **Discuss prognosis (e.g., weeks to months) and comfort-focused care with patient**

Patient's longitudinal clinician to:
- Assess patient illness understanding and discuss prognostic estimate (e.g., months to years)
- Assess whether interventions align with patient's GOC

Does the patient want to proceed with intervention?

Yes

Exit pathway:
Proceed with intervention

No

Exit pathway:
Discuss prognosis and comfort-focused care with patient

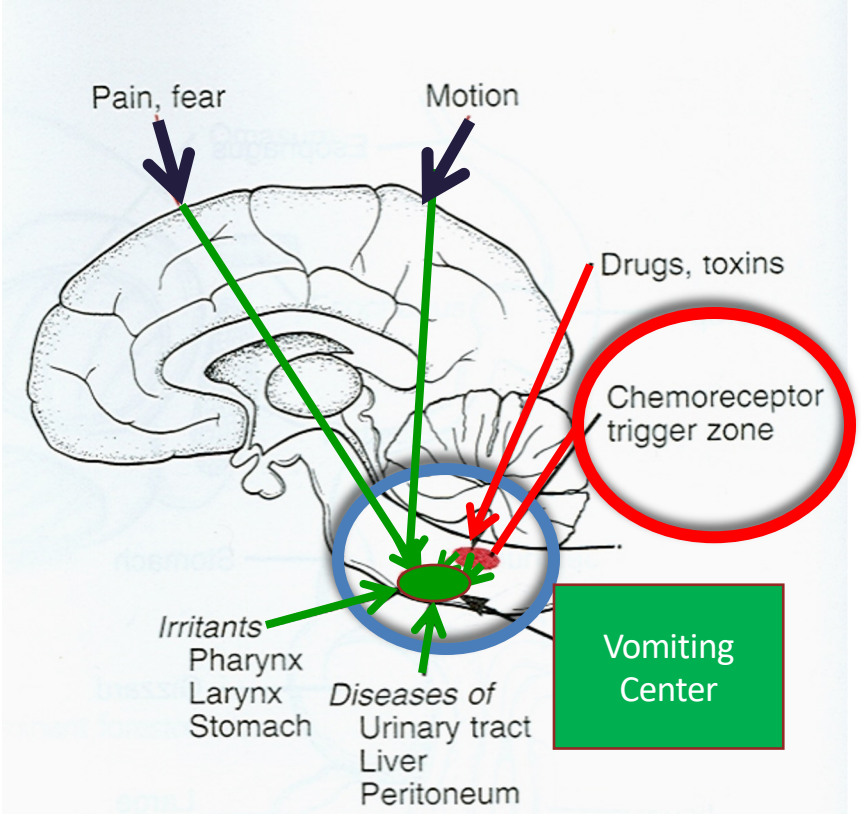
Note: Pathway steps are suggestions and should not replace clinical judgement. Questions? Contact Helen Knight (helen_knight@dfci.harvard.edu) or Colleen Feltmate (cfeltmate@bwh.harvard.edu)

SELENA

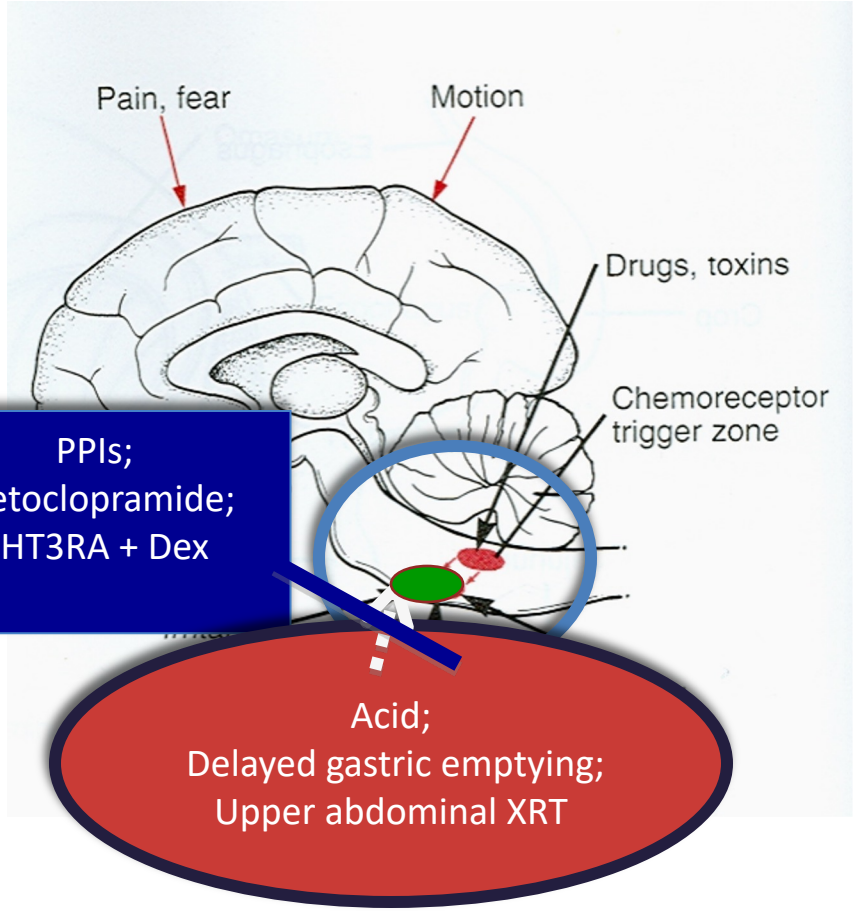
26 YEARS OLD

ADJUVANT CHEMO FOR BREAST CANCER

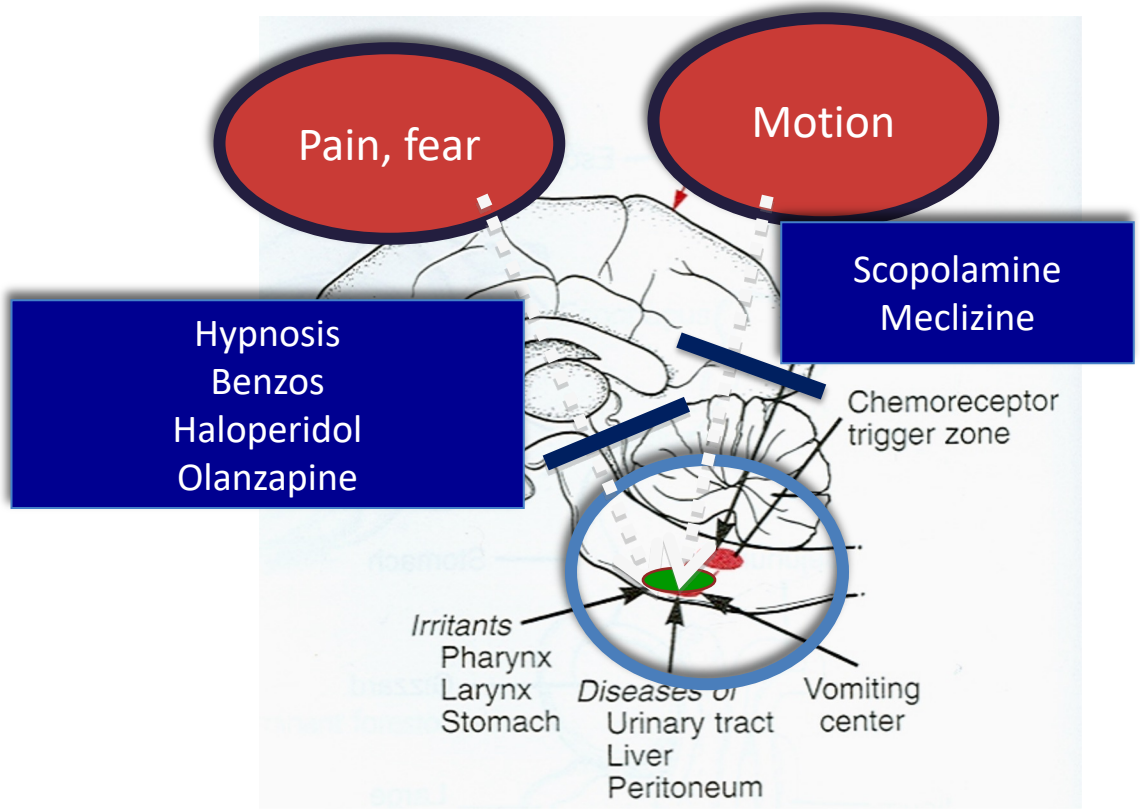
Vomiting center and CTZ



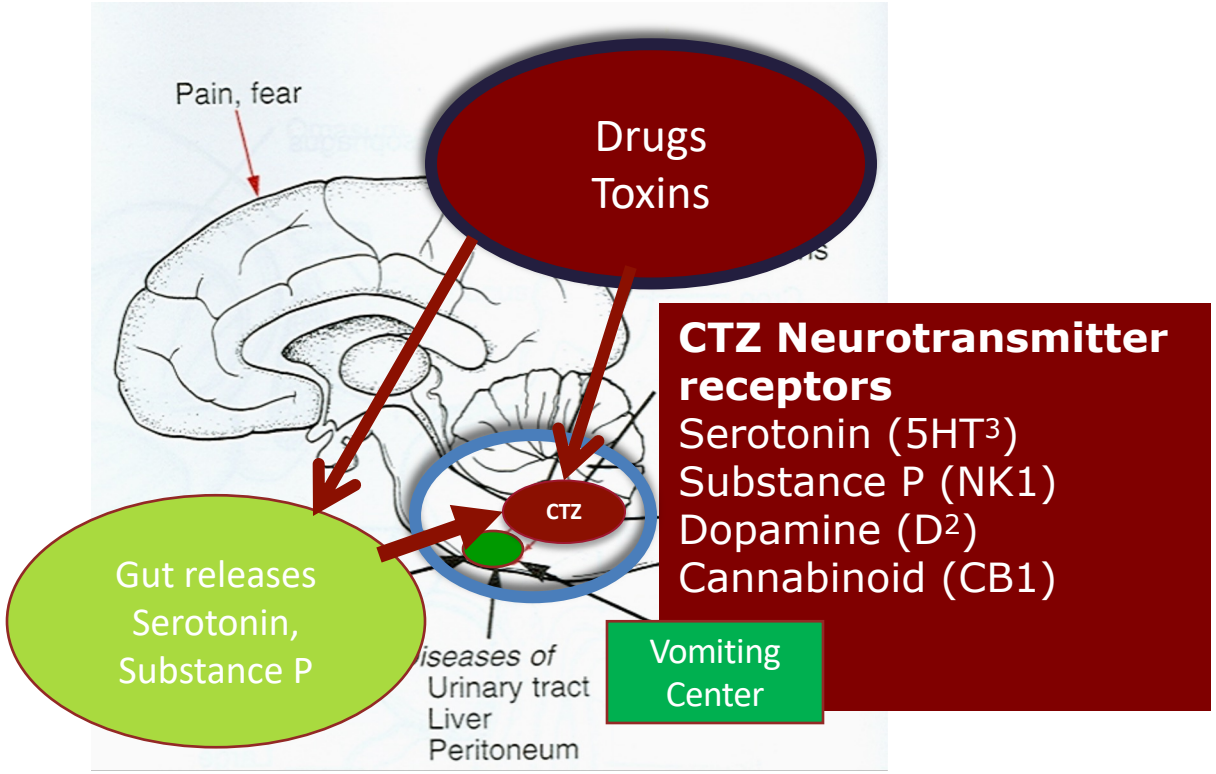
BLOCK GI causes



BLOCK cortical and vestibular causes



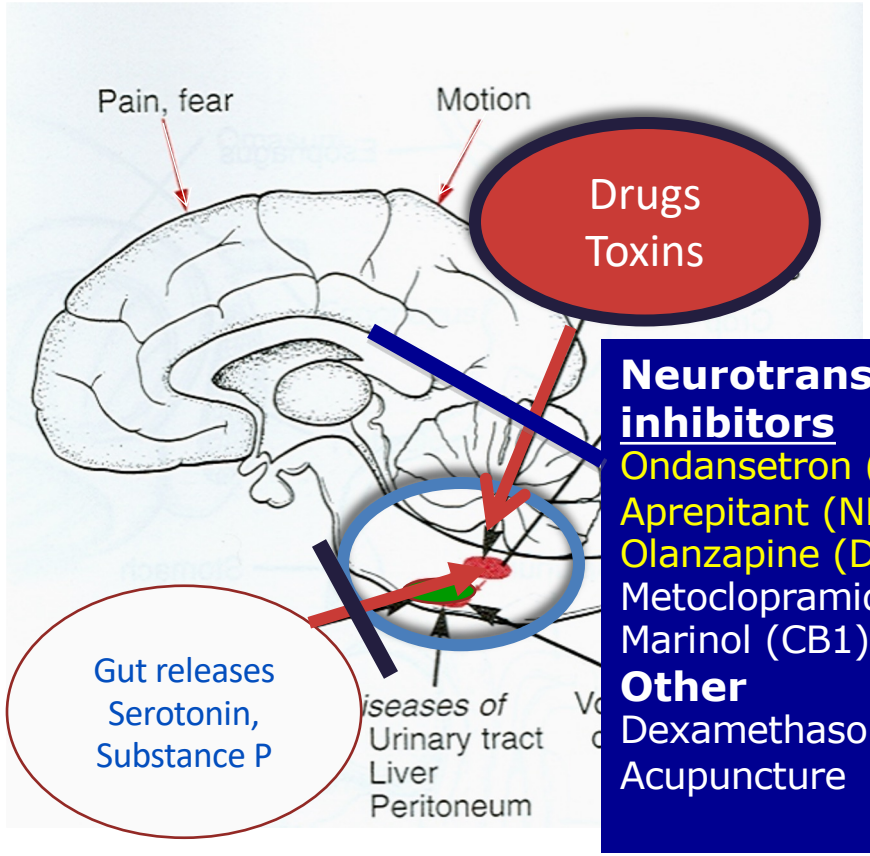
Chemo/XRT induced N/V



CTZ Neurotransmitter receptors

Serotonin ($5HT^3$)
Substance P (NK1)
Dopamine (D^2)
Cannabinoid (CB1)

BLOCK Chemo/XRT N/V



Neurotransmitter <u>receptor inhibitors</u>

Ondansetron ($5HT^3$)
Aprepitant (NK1)
Olanzapine (D^2 and others)
Metoclopramide (D^2)
Marinol (CB1)

Other

Dexamethasone
Acupuncture

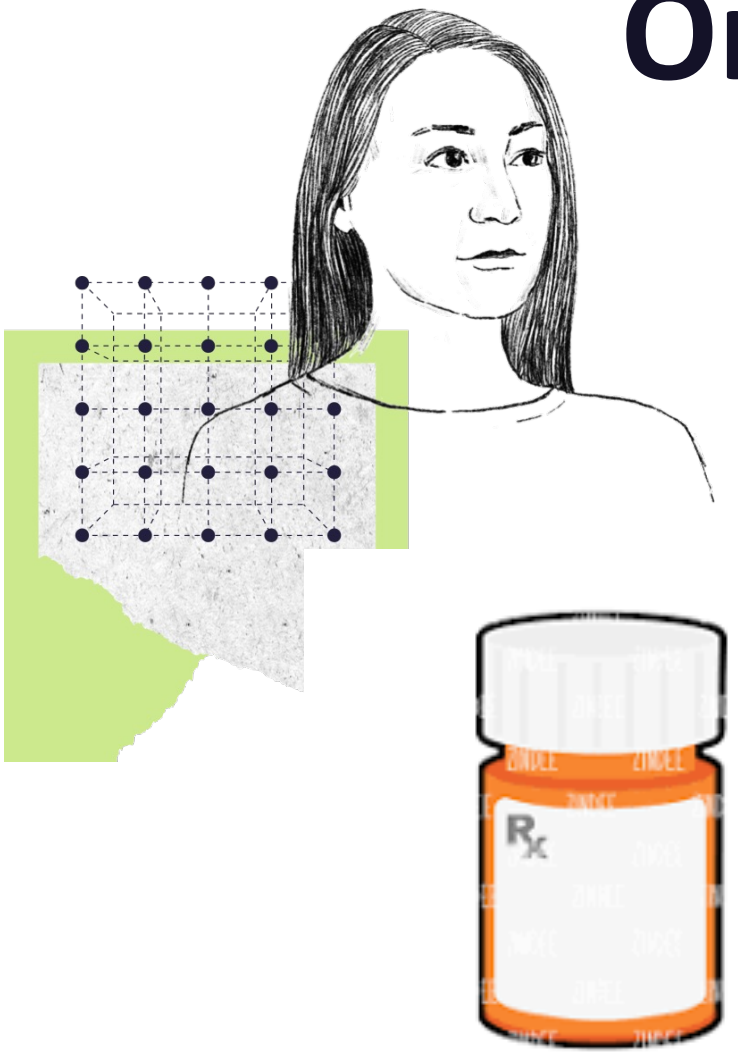
Jia Li

MEC-induced CINV, refractory to Palo and Dex

What to add?

- NK-1 inhibitor
  - e.g. Fosaprepitant
- Olanzapine

Oral agents for HEC and MEC



NEPA

- Fixed dose oral combination of netupitant (300 mg) and palonosetron (0.5 mg)
  No QTc prolongation

Rolapitant

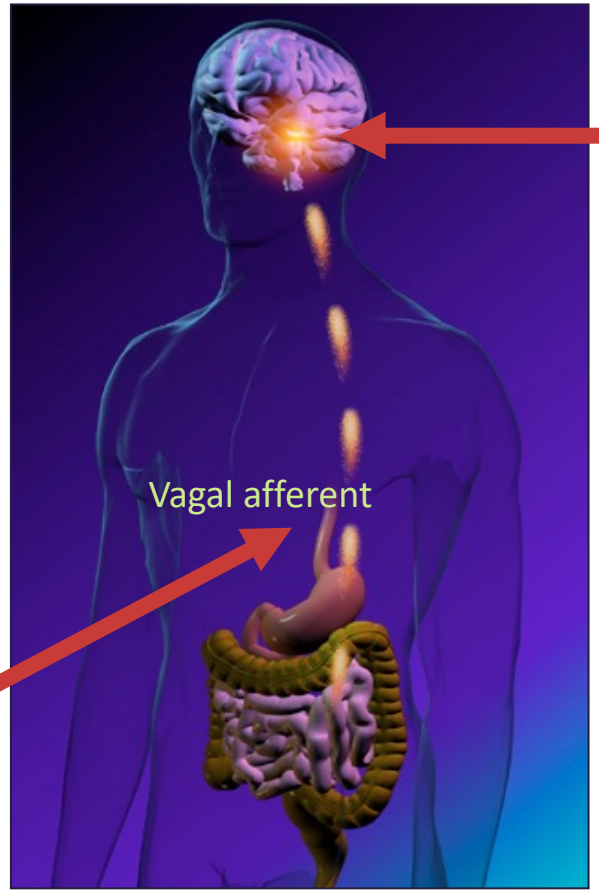
- Does NOT induce or inhibit CYP3A4

WHY DO PATIENTS ON XRT DEVELOP NAUSEA/VOMITING?

Radiation Therapy Releases:

Serotonin
Substance P

Radiation Therapy Stimulates
Vagal afferents



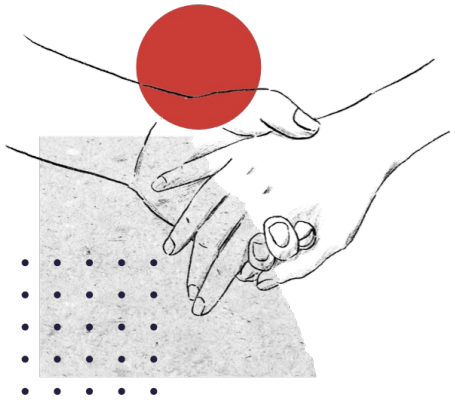
Serotonin
Substance P

bind to CNS CTZ

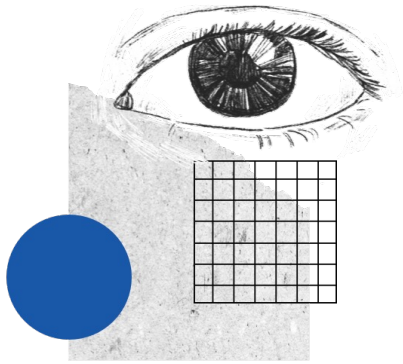
Nausea and Vomiting

Prophylactic therapy?

Palliative Care Resources



Pain and Symptom Management



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