Assessment and Management of Common Gastro-Intestinal Symptoms

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Disclosures

• No financial conflicts of interest
• No other relationships to disclose
Objectives

1. Recognize and describe the common gastrointestinal symptoms in patients with palliative diagnoses.

2. Formulate an appropriate treatment plan to manage common GI symptoms in a variety of settings.

3. Discuss the anorexia-cachexia syndrome of cancer with patients and their caregivers
   1. Gain an understanding of the role of artificial nutrition in patients with life-limiting illness.
Mrs. Smith

56 year old female living at home with her husband and 15 year old daughter. Diagnosed 4 months ago with metastatic ovarian cancer after 4-6 months of abdominal “discomfort” and bloating.

Treated with: hyst + BSO and has had 2 cycles of chemo

On home care (post-op wound infection requires dressing changes)

You are  
A) the RN seeing the patient at home  
B) the MD being contacted by the RN in the home
Mrs. Smith

She mentions feeling nauseated to you, and you note that she seems a little dehydrated

What would you ask (either as the RN, or MD).
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• Onset, palliating/provoking factors, severity, associated symptoms, emesis?
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• What has she tried to improve it?
  • Detailed medication inventory often needed
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- Onset, palliating/provoking factors, severity, associated symptoms, emesis?
- What has she tried to improve it?
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- Is she maintaining her hydration status?
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  • Detailed medication inventory often needed

• Is she maintaining her hydration status?

• Last bowel movement?
Why does any of that matter?

• Why do we want to treat her nausea?

• Why do we need to understand her nausea in order to treat it?
Nausea - Causes
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- Thrush
- Constipation
- Chemotherapy side-effect
- Medication side-effect
- Motion-induced
- Dysmotility/ileus
- Metabolic
- Infections
Nausea - Causes

- Thrush
- Constipation
- Chemotherapy side-effect
- Medication side-effect
- Motion-induced
- Dysmotility/ileus
- Metabolic
- Infections
- Small or large bowel obstruction
- Gastric outlet objection
- Brain metastases
What do we do?

- Check for thrush
- Assess constipation score
- Review medication list
- Clarify history + appropriate exam
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Last BM 4 days ago; still passing gas
Tried Dimenhydrinate but ++ drowsy
Last chemo 2 weeks ago

Started Codeine 30 mg 4 x a day 6 days ago
for abdo pain

Dry mucus membranes, tongue coated
Abdomen firm, nontender, distended,
bowel sounds normal
What do we do?

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- Clarify history + appropriate exam
- Determine likely cause of nausea for THIS individual

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- Treat most likely cause: __________
- Ensure adequate hydration (?needing clysis)
- Reassess and adjust differential diagnosis as needed

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To do:

• Cause of nausea?
  • Likely combination of opioid induced constipation and thrush

• Need to treat thrush, and get her bowels moving

• Not drinking well – therefore needs clysis (maintain hydration, and prevent opioid toxicity)

• Treat the nausea with an anti-emetic: _________________
Anti-emetics

- Different medications target different receptors – need to assess which mechanism is causing nausea, then treat appropriately.

Chemo-receptor Trigger Zone (dopamine and serotonin)
  - Drugs (chemo, SSRIs, opioids)
  - Toxins (infection)
  - Metabolic (high calcium, uremia)
  - **Dopamine:**
    - Metoclopramide
    - Domeridone
    - Haloperidol
    - Olanzapine
  - **Serotonin:**
    - Ondansetron **
Anti-emetics

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Gastro-Intestinal tract (dopamine and serotonin)
  - Tumours
  - Intestinal distention
  - Bowel obstruction
  - Dopamine
    - Haloperidol
    - Olanzapine
    - Metoclopramide/domperidone
  - Serotonin
    - Ondansetron

**Why do we consider metoclopramide/domperidone lower priority?**
Anti-emetics

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Brain Cortex
• Anxiety
• Anticipatory Nausea
• Gaba aminobutyric acid (GABA) receptors
Anti-emetics

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Vestibular Apparatus
  - Motion-induced nausea
  - Histaminic receptors
Anti-emetics

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Vomiting Centre (within cerebrum)
• Acetyl choline
• Dopamine
General Anti-emetic thoughts

• Consider starting any anti-emetic as a PRN only
  • Especially if the nausea is intermittent

• Consider specifically metoclopramide before meals, if early satiety, or nausea associated with meals

• Due to side effects (e.g., drowsiness) tend to avoid haloperidol and olanzapine as first line treatment of nausea, except in setting of bowel obstruction

• Subcut route preferred in severe nausea – can be difficult in home setting.
  • These are times when one might consider ondansetron subling, or olanzapine subling

• Oral route often adequate and effective
Thrush

• Nystatin 500,000 units swish and swallow 4 times daily x 7-10 days

• Fluconazole 200 mg by mouth daily x 3 days (careful in liver disease)
Constipation Score
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Constipation

- PEG 3350 1 g dissolved in 1 cup of water, taken by mouth 1-3 times daily (depending on severity of constipation)
  - Note: not all brands are covered by AB Palliative Blue Cross – refer to the Alberta drug benefit list online.

- Mineral oil enema in the evening
  - 
- Soap suds enema in the morning

- Dulcolax suppositories every 3 days if patient prefers.
Constipation

• Preventing constipation is key
• Provide laxative whenever an opioid is prescribed
• Avoid other constipating medications (ondansetron)
• Encourage fluid intake
• Patient and family education – regardless of oral intake, still aiming for soft, easy BM daily.
Mrs. Smith

• She was NOT started on a laxative when the codeine was started. Opioid induced constipation + thrush = likely culprits for nausea

• Reassess in 48-72 hours by phone:
  • Now, she is no longer passing gas, or having bowel movements.
  • Her abdominal pain is crampy, 9/10, and everything she takes by mouth is thrown up within about an hour. She wonders why the emesis smells a little like feces

• Now what?
Malignant Bowel Obstructions

Caused by:

- Primary tumours within the bowels
- Metastatic intra-abdominal tumours compressing bowels
- Adhesions from previous surgeries (radiotherapy damage)
Malignant Bowel Obstruction

• Considerations
  • Goals of Care Designation – Patient/family wishes

  • Complete vs. Incomplete
  • High or Low
  • Reversible or irreversible
    • Stenting
    • Surgery

While investigating, still need to manage symptoms
Malignant Bowel Obstruction

- Pain
- Nausea
- Vomiting
- Diarrhea
- Abdominal distension

- Minimize oral intake
- Dexamethasone
- Anti-emetics (avoid promotility agents)
- Hyoscine butylbromide
- Consider octreotide
- Consider NG tube

- ** Can be a slow/progressive onset **
Mr. Peters – 75 yrs old

- Non-small cell lung cancer – left lower lobe
- No more chemotherapy options – progressed on first and second line treatments, now performance status too poor.
- Metastatic disease to lungs bilaterally, paratracheal lymph nodes, supraclavicular LN, liver++, retroperitoneal LN and a question of “omental caking”.
- Had radiotherapy to left lung – max dose. No other radiation planned at this point.

- Reports: Pain to left chest, right upper abdomen. Always a little nauseated, never hungry, and food gets stuck in his throat.
What do you do?

• Ask what primary concern for him is?

• Assess primary concern

• Develop management plan
Mr. Peters – 75 yrs old

• He is worried about pain – makes it hard to shovel snow

• Wife says “but, he won’t eat, and if he won’t eat, he won’t gain weight, and then he won’t get stronger and he’s going to starve to death”
Mr. Peters

• Assess and manage his chest pain to ensure this is not contributing to his difficulty eating.

• Clarify the swallowing challenge
  • ?refer for imaging
  • ?refer to GI for scope +/- stenting
  • ?role for radiotherapy if LN are obstructing

• Assess weight loss, oral intake
  • Refer to dietitian if ANY concern
Anorexia-Cachexia

- Advanced illness syndrome common in cancer
  - Weight loss associated with altered metabolism due to inflammatory cytokines
  - Catabolic state

- Various tools for assessing degree of malnutrition
  - Refer early and often to Dietitians

- Stages to anorexia-cachexia: in early stages interventions can be controlled.
  - Dietary interventions, exercise, appetite stimulants
- Refractory cachexia cannot be reversed

- Not starvation
Anorexia-Cachexia

• Often caregivers at bedside are more distressed

• Educating patient and caregiver is vital
  • Eat small volumes, often: “what you want, when you want it”
  • DIETITIAN

• In refractory cachexia, artificial nutrition has not been shown to provide comfort/prognostic benefit. Often contributes to burden.
  • NOTE: ID patients BEFORE cachexia is refractory.

• There are times when artificial nutrition is considered
  • Obstructing tumor, therapy responsive tumour (early stage H & N)
  • Anorexic/cachectic patients with therapy responsive tumour
  • Pre-op treatment of malnutrition if surgical resection anticipated
General Principles

• If starting an opioid – start an anti-emetic
  • Metoclopramide 10 mg po q4h ATC
  • Metoclopramine 5mg po QID and q1h PRN

• If starting an opioid – start a laxative
  • PEG 3350 17 grams PO daily and titrate

• Check everyone’s mouth
• Low-threshold to request an abdominal flat plate
• Trial a treatment but reassess often

• If known intra-abdominal tumours, maintain high index of suspicion of bowel obstruction.