Symptom Management WS November, 2016

Malignant Bowel Obstruction: Case Discussion

Parichart Piasupun
RN., MNS., Cert. Palliative Care
Karunruk Palliative Care Center
Faculty of Medicine, Khonkaen university

Case Study

- A 27-year-old man.
- PPS 50%
- Address: Chiangyoun area, Mahasarakarm province.
- **Diagnosis**→ Peri-ampullary carcinoma with liver, right renal and pulmonary (RLL) metastasis.

- Admitted: June 21,16.
- PC consultation: Jul 22,16.
- Reason: Proper management.

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History of Illness

Chief Complaint.

- High fever and chills 7 days PTA.

Present Illness:

- 7 days PTA (June 14,16): Presented at Srinagarind ER with high fever and chills, no jaundice, no abdominal pain → referred to Khon Kaen hospital (No bed available) → fever resolved with ATB.
- Later he was referred back to Srinagarind hospital with recurrent fever, jaundice and abdominal pain, he then was admitted.

Past History

- 9 M PTA: peri-ampullary CA with liver metastasis, EGD: cauliflower mass below ampulla, distal CBD obstruction → biliary metallic stent.
- Biopsy: well-differentiated papillary adeno CA.
- 6 M PTA: Cisplatin+5FU x 5 cycles, last Feb 23,16. later surgeon plan for palliative CMT.
- 3 M PTA: developed acute cholangitis & septicemia.
- 2 M PTA: GI bleeding, stent revised due to tumor occlusion.
- 1 M PTA: CT scan showed multiple liver abscess, percutaneous drainage, ERCP and stent revised.

This Admission

- Acute cholangitis from stent occlusion → drainage + ATB (Colistin)
- Liver abscess.
- Gastric outlet obstruction: NPO, retained NG tube, IVF (5%DN/2 1000 ml iv drip 120 ml/h)
  Omeprazol 40 mg IV q12h.
  Plan for gastrojejunostomy Jul 25,16.
- Fentanyl patch (25 mcg) q72h.for pain control.
- Anemia from tumor bleeding: HCT 23 → blood Tx.

Lab and Investigation

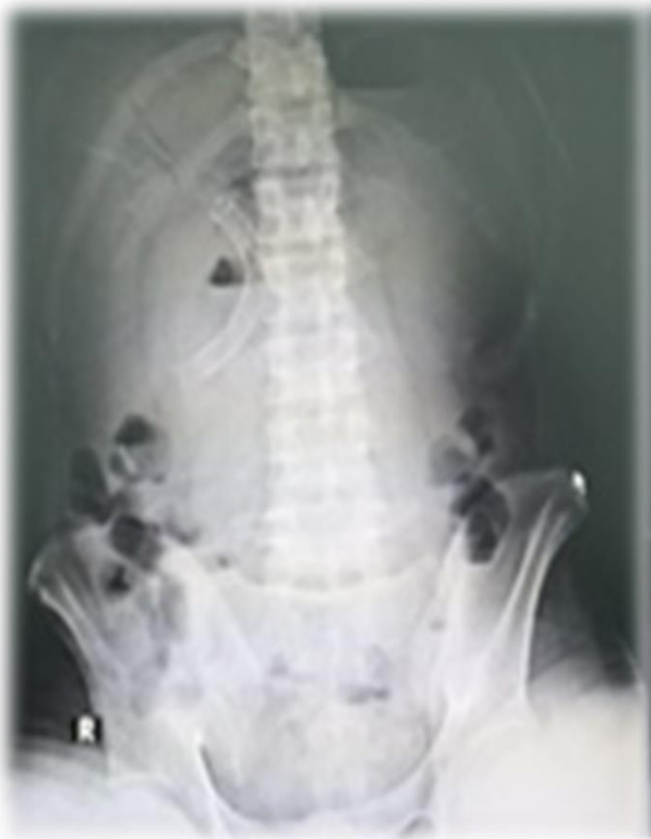
- **CBC:** HCT= 23%, WBC = 6,900/cmm, Plt.= 73,000/cmm
- **Blood chem:** BUN 9.1,Cr 0.9 (GFR87)
  Na 133, K 4, HCO_3 23.2, Cl 94, Alb 3, Ca 8.6 mg/dl
- **H/C: E.** coli ESBL
- **PCD c/s:** A. baum. MDR
- Drain c/s: enterococcus

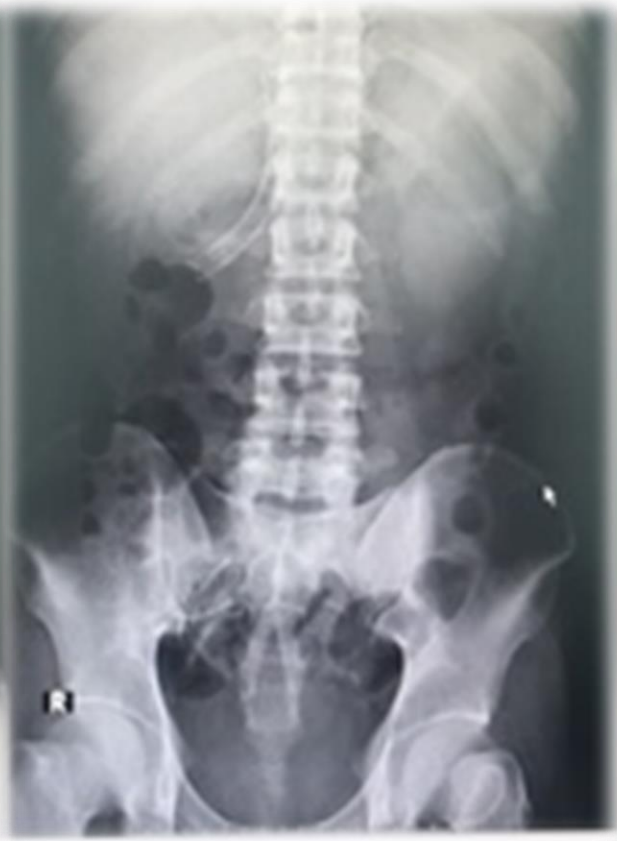
CT abdomen (Jun 24,16)

Mass at head of pancreas, tumoral growth within biliary stent, multiple liver abscess & metastasis scattered Rt lobe liver, subsegmental atelectasis, ground glass opacity & linear reticular infiltration at bilat LL & RML

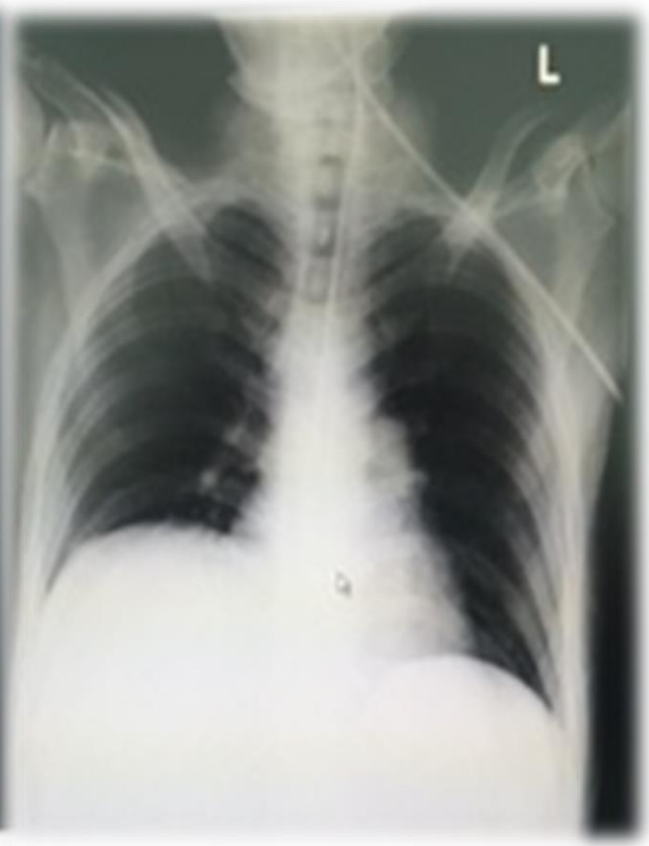
Lab and Investigation

Film abdomen 22/7/2016





CXR 22/7/2016



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Physical Examination

On the first visited, Thai man, fully conscious, looked fatigue, NG tube retained with no content.

- V/S: BT 38.7°C, PR 102/min, RR 16/min, BP113/52 mmHg.
- HEENT: moderately pale, marked jaundice.
- Lung: decreased breath sound Rt. Lung, fine crepitation both lungs.
- Abdomen: soft, mild distension, mild tenderness, bowel sound 4 /min.

Symptom Assessment

- Constant sharp pain in abdomen PS 5-6/10, worse 8/10, best 4/10, on fentanyl patch 25 mcg q72h
- Constipation: watery stool after unison enema
- Constant nausea
- Vomiting: 2-3 times/day → amount 1,200-1,500 ml/day
- NG tube retained without content
- Ondansetron (8) 1x2 for vomiting
- Insomnia, dyspnea on exertion, and fatigue.
- Dry mouth.

PC Team Involvement

Pain →

- 22/7/16: Switch fentanyl patch to MO 1:1 IV drip 0.5 cc/h, MO 3 mg IV PRN q2h.
- 23/7/16: MO 1:1 IV drip 1 cc/h, MO 4 mg IV PRN q2h.

N/V →

- Switch ondanzetron to hadol 1 mg IV hs.
- Metoclopramide 10 mg IV q6h
- Rechecked NG content every day

Constipation →

- Senokort 2 hs.
- Uneson enema

Dyspnea & Fatigue →

- Non-pharmacological approach
- Blood transfusion for anemia

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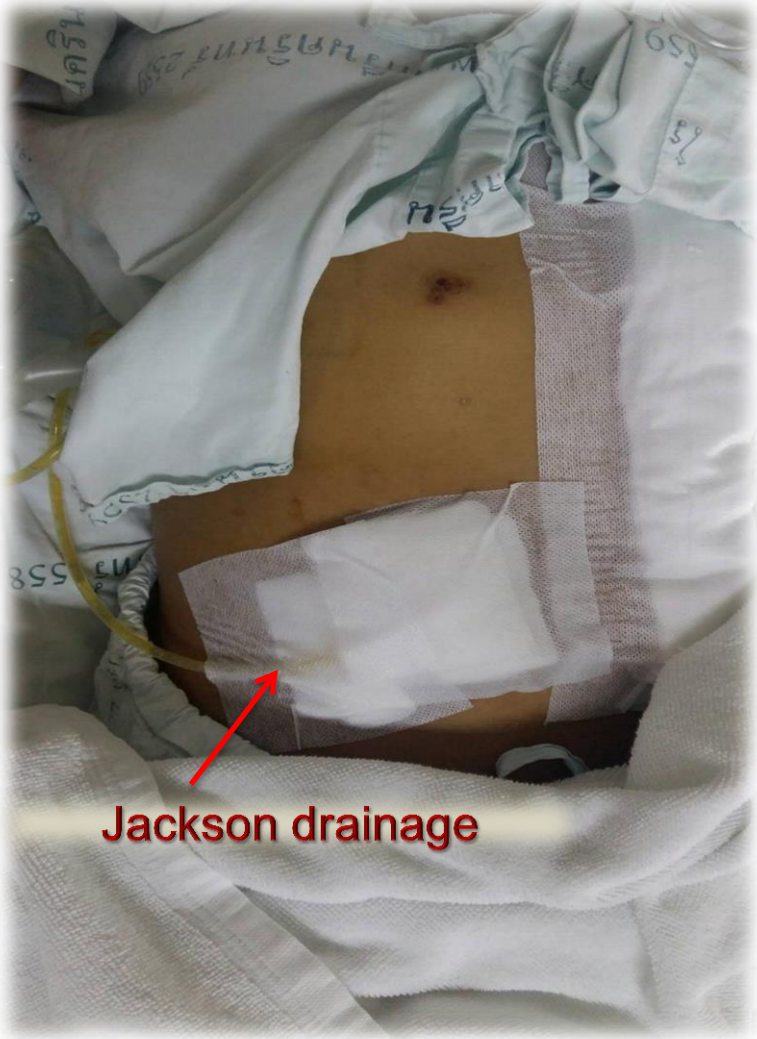
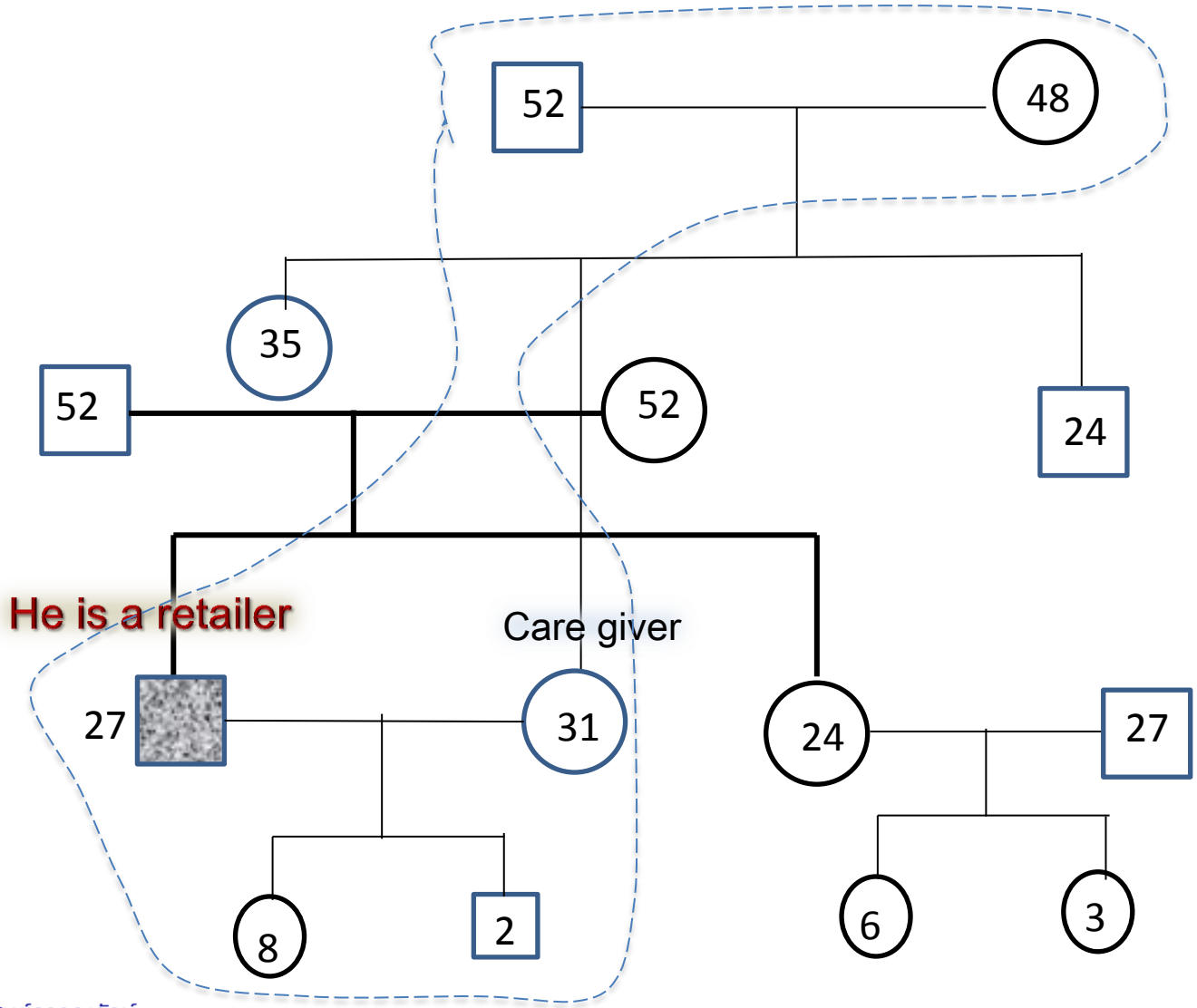


- **25 July,16:** Exploratory laparoscopy with gastrojejunostomy.
- MO 1:1 IV drip 1 cc/h then titrated to 2 cc/h.
- MO 8 mg IV PRN q2h.
- Metoclopramide 40 mg + Ranitidine 200 mg + NSS up to 24 ml IV drip 1 ml/hr.
- NG content 300 ml/day

Genogram



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Psychosocial Assessment

- He has no fear of death but worried about his children.
- His perception about his cancer was that it could not be cured and was in terminal stage.
- He decided to go home, and did not want any life support. His end of life goal is a natural death at home.

Discharge Planning

- Aug 1,16 – prepare to go home.
- Family meeting communicating prognosis and care plan.
- Wife taught how to use syringe driver and symptom monitoring & management.
- Reassured 24-hour-contact available.
- Refer information to district nurse near the patient's home, drug in syringe driver:
  MO 80 mg + Metoclopramide 40 mg + Ranitidine 300 mg + NSS CSCI in 24h. and MO 10 mg SC PRN q2h for BTP.

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Jackson drainage

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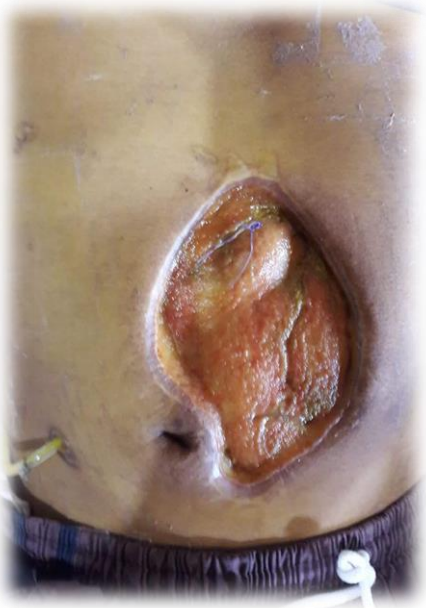
Wound disruption from infection → wet dressing

Continuity of Care at Home

- **4 Aug,16** - required MO 10 mg SC PRN 3/day. MO increased to 110 mg/day + Metoclopramide & Ranitidine same dose.
- Wife came for med refill at PC OPD every week.
- **7 Aug,16 -** developed hiccups, responded to increased dose of Metoclopramide up to 60 mg/d.
- **14 Aug,16 -** Hiccups came back, increased Metoclopramide to 80 mg/day.

Continuity of Care at Home

- Pain well controlled.
- Ate soft diet, bowel opened every day.
- Able to walk around his house using walker flame.
- District nurse made regular home visit for wound dressing and syringe refill.
- Wound slowly healed.
- **9 Sep,16** → died peacefully at home (40 days after discharged).



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