CANCER EDUCATION DAY

Palliative Care for GI Cancer Patients

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Presenter Disclosure

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Objectives

- At the conclusion on this presentation, participants should be able to:
  - Better understand palliative care management for malignant bowel obstruction in colorectal cancer patients
  - Better understand palliative care management biliary obstruction and complex pain syndromes for pancreatic cancer patients
  - Identify where to find Palliative Medicine supports in Windsor-Essex, Chatham-Kent and Sarnia-Lambton

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GI Malignancies – Colorectal Cancer

- Colorectal cancer is the 3rd most diagnosed cancer among both men and women around the world (1.85 million of new cases/years; 10.2% of total malignancies) [1].
- At the time of first diagnosis, approximately 25% of patients present as stage IV, with liver metastases, and up to 50% will develop recurrence in the liver during the disease course [2].
- Most of these patients that have liver metastasis are considered unresectable at presentation [3].
- Today, the median overall survival for patients with metastatic colorectal cancer being treated both in phase III trials and in large observational series or registries is about 30 months and is more than double that of 20 years ago [4].

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Palliative Care for Colorectal Cancer

- Malignant Bowel Obstruction:
  - Can occur in up to 15% of patients with advanced malignancy- most commonly due to ovarian and GI malignancies
  - Causes:
    - Tumour mass, constipation, adhesions, volvulus, ileus, peritonitis
  - Symptoms:
    - Pain, abdominal distention, nausea/vomiting, absence of feces and flatus in complete obstruction, diarrhea with partial obstruction (overflow diarrhea)

Malignant Bowel Obstruction

Conservation management:

- Non-pharmacological:
  - NPO
  - IV fluids
  - NG tube for decompression if necessary

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Malignant Bowel Obstruction

Conservation management:

- Pharmacological:
  - Steroids - Dexamethasone 4 – 16 mg SC/IV daily may alleviate the obstruction
  - Anti-emetics – may need to use a combination of agents:
    - Metoclopramide 10 mg SC/IV Q6H beneficial as a pro-kinetic in the case of partial obstruction

      *****Contraindicated in complete obstruction
    - Haldol 0.5-1 mg SC Q4H prn
    - Olanzapine 2.5-5 mg SL BID
    - Dexamethasone

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Malignant Bowel Obstruction

Conservation management:

- Pharmacological:
  - Anti-motility agents –
    - Hyoscine butylbromide 10 - 20 mg SC QID
  - Anti-secretory agents
    - Octreotide (off-label use) 100 – 300 mcg SC Q8H
      - Decreases GI secretions and promotes increased intestinal absorption of fluids therefore helpful for large volume emesis
  - Analgesics
    - Given by SC/IV or transdermal route
    - Should not be avoided for fear of aggravating an obstruction

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Malignant Bowel Obstruction

Palliative Surgical management:

- Diverting colostomy
- Venting PEG placement
- Stent

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Palliative Care for Pancreatic Cancer

- 4th most common cause of cancer death in Canada
- Most often diagnosed at advanced stage of disease due to lack of symptoms at early stage [5].
- Signs and symptoms:
  - Painless jaundice
  - Weight loss
  - Abdominal pain or back pain
  - Nausea or vomiting

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Biliary Obstruction

Signs and Symptoms: jaundice, pruritus, RUQ and epigastric pain

Management:

- Biliary decompression:
  - ERCP – biliary stent
  - Percutaneous biliary stent or drain
- Dexamethasone for liver capsular pain/inflammation
- Hydroxyzine 25mg po TID – QID for pruritus

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Pancreatic Cancer Pain Syndrome

- Pain affects 75% of patients with pancreatic ductal adenocarcinoma (PDAC) at time of diagnosis and over 90% with advanced disease [6].
- Pain in pancreatic cancer can be somatic, visceral and neuropathic in origin
- Causes:
  - Tissue damage
  - Inflammation
  - Ductal obstruction
  - Infiltration

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Pancreatic Cancer Pain Syndrome

- **Pharmacological Pain Management:**
  - Opioids
  - Steroids
  - Neuropathic agents:
    - Gabapentin – starting dose 100 – 300 mg in a single dose at bedtime or 100 mg TID, titrated up to 3,600 mg/day
    - Pregabalin – starting dose 50-75 mg po BID titrated up to 150 – 225 mg po BID
    - Duloxetine (SNRI) – 30-60 mg po Daily

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Pancreatic Cancer Pain Syndrome

- **Pharmacological Pain Management:**
  - Methadone:
    - Synthetic opioid agonist with a strong affinity to the mu opioid receptor with a prolonged duration of action resulting in longer administration intervals – Q8H to Q12H
    - Also acts as antagonist of the N-methyl-D-aspartate (NMDA) receptor.
    - Well suited for the management of difficult pain syndromes
    - NMDA receptors are involved in CNS sensitization, hyperalgesia and allodynia
    - **** Long and unpredictable half-life (12 to 120 hours) therefore adjustments to dosing should be done cautiously

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Pancreatic Cancer Pain Syndrome

- Non-pharmacological Pain Management:
  - Celiac plexus block and neurolysis
  - Splanchnicectomy
  - Intrathecal therapies

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Palliative Care Services

- Windsor- Essex:
  - Outpatient Palliative Care Clinic at WRCC
  - In-home services with Hospice of Windsor-Essex
  - Inpatient Palliative Medicine Consult service
  - Palliative care placement facilities:
    - HDGH Palliative Care Unit (18 beds)
    - Windsor Hospice and Erie Shores Hospice Residential Homes (10 beds each)
- Chatham- Kent:
  - In-home supports with LHIN PCCT NP
  - Chatham-Kent Hospice (10 beds)
- Sarnia:
  - Outpatient Palliative Care Clinic at St. Joseph's Hospice Sarnia-Lambton
  - In-home services with Sarnia Hospice
  - Inpatient Palliative Care Unit at Bluewater Healthcare Hospital
  - Palliative Care Placement:
    - St. Joseph's Hospice Sarnia-Lambton (10 beds)

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Thank you