

13. GASTRO INTESTINAL MALIGNANCIES PALLIATIVE PROCEDURES

Many cases present at a late advanced stage where palliation and terminal care is the only treatment that can be offered. As much as 10% of cases may not be in a position to undergo investigations at least to establish the diagnosis of malignancy and may go untreated because of atypical presentation, example: paraneoplastic syndrome or small size of the tumor. Screening programmes are essential for early detection of GI malignancy and have to be done keeping the prevalence in mind since the cost of screening is prohibitive.

The surgeon should aim for complete cure of the disease wherever feasible. In the following conditions the goals in management should be refocused away from the pursuit of cure and towards the short-term goals of improving quality of life.

- Poor general condition of the patient
- Patient's refusal for major surgical procedure
- Diffuse metastatic disease and inoperable tumours

The surgeon should facilitate the family and the individual in coping with chronic illness and the concept of death while at the same time alleviating disabling symptoms.

Carcinoma esophagus

Palliative procedures in carcinoma esophagus in elderly people is mainly to

- Relieve dysphagia
- Provide enteric route for nutrition
- Minimize morbidity
- Maximize quality of life

Surgical procedure

Surgical bypass

- Gastric bypass
 - ◆ The gastric tube is fashioned based on right gastroepiploic artery and right gastric artery
 - ◆ It is brought to the neck to be anatomized to cervical esophagus via either subcutaneous or retrosternal route
- Colon by pass
- Jejunal bypass

Non- surgical procedures (palliative)

- Endoscopic procedures
- Radiotherapy
- Chemotherapy

Choice of the procedure depends on

- Patient's circumstances

- Geometry of the cancer
- Local facilities available
- Expertise availability

Endoscopic procedures

Endoscopic procedures are done with IV sedation and analgesia.

Dilatation alone is inadequate.

Intubation

- Traction Intubation - celestin tubes
- Pulsion Intubation – atkinson tubes
- Self-expanding metal stents are used to bypass the oesophageal tumours.
 - Quick and most versatile method
 - Not well tolerated
 - Risk of airway compression
 - Pulmonary aspiration
 - Troublesome gastro-esophageal reflux

Complications

- Blockage
- Displacement
- Tumour overgrowth
- Esophageal perforation

Treatment in tertiary centers

1. Laser recanalisation

Laser photocoagulation is an effective method for patients with obstructive advanced esophageal carcinoma.

2. Photo dynamic therapy

Sensitisers like hematoporphyrin is used 48 hours prior to therapy. 630 nm red light is delivered by tunable organ pumped dye laser or gold metal vapour laser. Necrosis follows due to cytotoxic singlet oxygen release. This method is useful for superficial cancers. Sunburn for one month avoided.

3. Electro coagulation technique

Useful for upper one third esophageal tumors and at cardia sites.

4. Ethanol injection

Useful in polypoidal lesions.

Carcinoma stomach

Palliative surgical procedures

The symptoms which require palliation, are

- Pain
- Vomiting
- Dysphagia
- Bleeding

Surgical

- ❖ Palliative gastrectomy
- Partial or total gastrectomy
- ❖ Anterior gastrojejunostomy
- ❖ Devine's exclusion procedures
(antral exclusion procedures)

Non-surgical

- ❖ Intubation
- ❖ Metallic expanding stents
- ❖ Plastic stents
- ❖ Photodynamic therapy

Palliative procedures in colonic malignancy

Palliative procedures should not be overlooked or under estimated in case of diffuse metastatic disease where no curative options are available Palliation mainly focuses on relieving the following symptoms

- + Intestinal obstruction
- + Pain due to nerve compression / invasion
- + Colonic / rectal bleeding

Palliative options available

- ❖ Palliative systemic therapy
- ❖ Palliative focal therapy
- ❖ Supportive care

Palliative systemic therapy

- Chemotherapy
 - ◊ 5-Fluoro uracil
 - ◊ Irinotecan
 - ◊ Oxaliplatin
- Biologic response modifiers
 - ◊ Monoclonal antibodies (Eg. Bevacizumab, Cetuximab etc.)

Palliative focal therapy

- Self expanding metallic stents to relieve obstruction
- Endoscopic laser ablation-to control bleeding and to relieve obstruction (tertiary level)
- Drugs (Local nerve block, Epidural analgesic pump) – to relieve pain

Supportive care

Patient and family often need reassurance and assistance with end-of-life issue in advanced state. They should never feel abandoned in life till the end.

Ostomy care

Care of the patient after ostomy surgery involves the cooperation of the

- ◆ Doctor
- ◆ Enterostomal therapy nurse
- ◆ Family members
- ◆ Patient

Preoperative care

The patient and the family members should receive comprehensive information on the nature of the disease and the need for ostomy, ostomy rehabilitation, plan and management

Site selection

Preoperative counseling about stoma should be given to the patient. Patient should be taken to the stoma clinic and explained in detail about it by showing the pictures of patients with ostomy and also they should be made to interact with patients with ostomy. Site selection should be below umbilicus to the right or left above the infra umbilical fat mound and in rectus sheath. Care should be taken to avoid scar region, skin creases and bony prominences. Upper abdominal site is selected in cases of non-ambulant wheel chaired patient.

Ostomy function and care

- Jejunostomy : Discharge upto 2400ml / day
Electrolyte imbalance
Total parenteral nutrition / fluid / electrolyte monitoring necessary
Frequent pouch emptying – gravity drainage
- Ileostomy : During adaptive phase – high output upto 1500 to 1800ml
Monitor fluid & electrolyte correction
After adaptation is over output reduces to 500 to 800 ml day
- Cecostomy : Output is projectile due to proximity of ileocaecal valve
- Colostomy : Output is thicker in consistency and smaller is volume
- Transverse colostomy
Soft or pasty output
Following meals & at intervals
- Descending / sigmoid colostomy
- Soft-formed stool
 - Better elimination pattern

Ostomy management

- ♦ Proper application of pouch to dry clean skin
- ♦ Protect incision
- ♦ Assess the mucosa with every pouch change
- ♦ Viability and function assessed every day
- ♦ Meticulous surrounding skin care is essential in immediate postoperative period
- ♦ Skin barrier and type of pouch used are important

The appliance should be

- Leak proof and odourless
- Comfortable for all level of activity
- Non-obstructive

Care of the skin

- ♦ Skin should be kept dry and clean
- ♦ Lotions and ointments should not be used
- ♦ Clipping of hairs should be done rather than shaving