

Malignant Large Gut Obstruction-Changing Trends In Management

Most of the malignant large gut obstructions are associated with progressive pathological changes culminating in bowel ischaemia and perforation leading to peritonitis, sepsis or abscess formation. Hence this entity can have varied clinical presentations which will predict the outcome. The presentation can be acute, subacute chronic and recurrent while one has to distinguish it from entities like pseudo-obstruction in which treatment is a little different. History, physical examination, and baseline investigations are usual but radiological assessment is necessary commencing from a plain radiograph and ultrasound and extending evaluation by CT scan, MR scan and colonoscopy. Malignant large gut obstruction can be managed in some patients by dilatation and placement of self-expandable mechanical stents (SEMS) on colonoscopy as a bridge to surgery or even for palliation. Stents are an interim option in patients who are poor surgical candidates or have advanced cancer. Still, the procedure is associated with complications and therefore needs to be attempted by experienced gastroenterologists. Studies suggest bridge-to-surgery interventions like the use of surgical diversion or SEMS which may offer short- and long-term benefits, with acceptable safety profiles, compared to urgent oncologic resection for malignant colorectal obstruction. Guidelines on the management of large gut perforation, obstructive left colon carcinoma, and obstructive right colon carcinoma were released on August 13, 2018, by the World Society of Emergency Surgery. They express evidence-based management of this entity in both stable and unstable patients. In unstable patients' surgical procedures of laparotomy and resection consisting of formal resection with or without anastomosis, with or without stoma have been advised. Subtotal colectomy, segmental colectomy, resection and primary anastomosis,

total colectomy, Hartmann procedure in left-sided obstruction; or right-sided colectomy with primary anastomosis or terminal ileostomy and colonic mucous fistula/internal bypass anastomosis in right-sided obstruction have all been described depending on the condition of patient and stage of obstruction. Laparoscopy is generally not recommended and is reserved only for some specialised centres. Locally advanced and unresectable rectal cancers need multimodality treatment and neo-adjuvant chemo-radiotherapy, after overcoming obstruction by stoma creation. Antibiotics should be used that mainly target gram-negative bacilli and anaerobic bacteria because of potential bacterial translocation in these subjects. One needs to understand the difference between emergent and non-emergent surgical intervention which forms the basis for improving outcomes and thereby preventing sequelae of complications such as bowel necrosis, perforation, peritonitis, uncontrolled sepsis and even death associated with malignant large gut obstruction.

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