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A Short Note on Palliative Surgery for Malignant Bowel Obstruction

Aarthi Singh*

Department of Palliative Care Surgery, University of Hyderabad, India

Introduction

The treatment of malignant internal organ obstruction (MBO) is one in all the foremost common dilemmas facing surgeons treating cancer patients. The clinical symptoms of MBO embody obstruction and fistula. Patients with MBO area unit unable to eat and after expertise severe pain, nausea, vomiting, or skin erosion. These symptoms place substantial burden on each patient and their families. Additionally, to conservative care, as well as nasogastric tube drain, antisecretory medications, and corticosteroids, palliative surgery is a promising methodology for treating some patients with MBO. However, palliative surgery for MBO is related to a high morbidity rate because of a poor medicine or alimentary standing. Operative morbidity, like surgical website infection (SSI), prolongs the hospital keep and worsens the standard of lifetime of patients WHO have a restricted era.

We have adopted a laparoscopic approach for choose patients with MBO to scale back the morbidity rate and minimize the invasiveness of operative intervention since 2014. However, whereas many authors have reported on the utility of a laparoscopic approach for the palliation of MBO, info on the outcomes when laparoscopic palliative surgery for MBO remains thin, and the benefits of laparoscopic surgery for MBO have not nonetheless been clearly confirmed.

The aim of this study was to judge the outcomes of laparoscopic palliative surgery in patients with MBO and to assess the practicableness of the laparoscopic approach.

We retrospectively reviewed the medical records of patients who underwent palliative surgery for MBO between 2007 and 2015. Laparoscopic procedures are performed once technically doable since 2014. Thriving palliation was outlined because the ability to tolerate solid food (TSF) for a minimum of two weeks.

Demographic info, clinical parameters, and treatment-related variables were collected retrospectively.

All operations were performed with palliative intent to alleviate MBO and to make the chance for food intake. All operations with curative intention were excluded from the analysis, and people were excluded if all lesions were curably resected. All patients enclosed within the study had been unable to receive a traditional diet before the palliative operation because of obstruction or fistula related to unresectableintra-abdominal malignant tumor.

All patients underwent a physical examination, plain X-ray, and X-radiation (CT) and were diagnosed as MBO. Nasogastric or long enteric tubes for decompression were used before surgical intervention in some patients. Palliative operation or bypass surgery was most well-liked if doable.

Cross or sigmoid colostoma was placed for body part obstruction at the pelvis, and ostomy was placed for patients with MBO because of carcinomatosa. Some patients underwent combination of the on top of procedures. Until 2013, all palliative operations were performed as open surgery; laparoscopic procedures were after used from 2014 at the surgeon's discretion once technically doable.

***Corresponding author:** Aarthi Singh, Department of Palliative Care Surgery, University of Hyderabad, India; E-mail: arathisingh26@gmail.com

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